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.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Equity and Accountability Act of 2022''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

SEC. 3. FINDINGS.

The Congress finds as follows:

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

(2) Health disparities are a function of not only access to health care, but also the social determinants of health—including the environment, the

physical structure of communities, nutrition and food options, educational attainment, employment, race, ethnicity, sex, geography, language preference, immigrant or citizenship status, sexual orientation, gender identity, socioeconomic status, or disability status—that directly and indirectly affect the health, health care, and wellness of individuals and communities.

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

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

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

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

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

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

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

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

quality family planning services. Such guidelines and documents include the National HIV/AIDS Strategy, the Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis, and recommendations of the Centers for Disease Control and Prevention and the Office of Population Affairs.

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

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

TITLE I—DATA COLLECTION AND REPORTING

SEC. 1001. STRENGTHENING DATA COLLECTION, IMPROVING DATA ANALYSIS, AND EXPANDING DATA REPORTING.

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

(1) PURPOSE.—The purpose of the amendments made by this subsection is to promote culturally and linguistically appropriate data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, age, and socioeconomic status in federally supported health programs.

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

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

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

(C) by adding at the end the following:

''(10) cultural and linguistic competence of health care services and of data collection activities described under section 3101.''.

(3) OFFICE OF MINORITY HEALTH.—Section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)) is amended by inserting ''Middle Easterners and North Africans;'' after ''Blacks;''.

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

(A) in subsection (b)—

(i) in paragraph (10), by striking ''and'' at the end;

(ii) in paragraph (11), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(12) ensures the interoperability of health information systems among federally conducted or supported health care or public health programs, State health agencies, and social service agencies.''; and

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

''(vii) Strategies to enhance the use of health information technology in improving the quality of health care; reducing medical errors; reducing health disparities and ensuring the provision of equitable health services; improving public health; increasing prevention and coordination with community resources; ensuring interoperability among federally conducted or supported health care or public health programs, State health agencies, and social service agencies; and improving the continuity of care among health care settings.''.

(5) DATA COLLECTION, ANALYSIS, AND QUALITY.—Section 3101 of the Public Health Service Act (42 U.S.C. 300kk) is amended—

(A) in subsections (a)(1)(A), (a)(1)(C), (a)(2)(B), and (a)(2)(E), by striking ''and disability status'' and inserting ''sexual orientation, gender identity, age, disability status, and socioeconomic status'';

(B) in subsection (a)(1), by amending subparagraph (D) to read as follows:

''(D) data for additional population groups if such groups can be aggregated into the data

collection standards described under paragraph (2).'';

(C) in subsection (a)(2)—

(i) in subparagraph (C)—

(I) in clause (i), by striking ''and'' at the end;

(II) in clause (ii)—

(aa) by striking ''is a minor or legally incapacitated'' and inserting ''is a minor, requires assistance with communication in speech or writing, or is legally incapacitated''; and

(bb) by striking the semicolon at the end and inserting ''; and''; and

(III) by adding at the end the following:

''(iii) collects data in a manner that is culturally and linguistically appropriate;'';

(ii) in subparagraph (D)(iii), by striking ''and'' at the end;

(iii) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following:

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

(6) in subsection (a)(3), by amending subparagraph (B) to read as follows:

''(B) develop interoperability and security systems for data management among federally conducted or supported health care or public health programs, State health agencies, and social service agencies.''.

(b) COROLLARY PROVISIONS.—

(1) RECOMMENDATIONS BY THE DATA COUNCIL.—The Data Council of the Department of Health and Human Services, in consultation with the Director of the National Center for Health Statistics, the Deputy Assistant Secretary for Minority Health, the Deputy Assistant Secretary for Women's Health, the Administrator of the Centers for Medi-

care & Medicaid, the National Coordinator for Health Information Technology, and other appropriate public and private entities and officials, shall make recommendations to the Secretary of Health and Human Services concerning how to—

(A) implement the amendments made by this section, while minimizing the cost and administrative burdens of data collection and reporting on all parties, including patients and providers;

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

(C) ensure that future patient record systems follow Federal standards promulgated under the HITECH Act (42 U.S.C. 201 note) for the collection and meaningful use of electronic health data on race, ethnicity, sex, pri-

mary language, sexual orientation, gender identity, age, socioeconomic status, and disability status;

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

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

(F) ensure the cultural and linguistic competence of entities that receive Federal support to collect and report data pursuant to the amendments made by subsection (a); and

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

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

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

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

(3) TECHNICAL ASSISTANCE FOR THE ANALYSIS OF HEALTH DISPARITY DATA.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, and in coordination with the Assistant Secretary for Planning and Evaluation, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Center for Health Statistics, the Director of the National Institutes of Health, and the National Coordinator for Health In-

formation Technology, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting Federal standards for health disparity data collection and for analysis of racial, ethnic, and other disparities in health and health care in programs conducted or supported by such agencies by—

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

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

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

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

(E) sharing data with external organizations for research and quality improvement purposes; and

(F) identifying and addressing issues relating to the interoperability of Federal- and State-level health information systems which

undermine the ability of health-related programs collecting data under this section to achieve the purpose described in subsection (a)(1).

(4) REFERENCES.—Except as otherwise specified, any reference to the term ''racial and ethnic minority group'' in any Federal regulation, guidance, order, or document for establishment or implementation of any federally conducted or supported health care or public health program, activity, or survey shall be treated as having the definition given to such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

(5) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, subsection (a), and the amendments made by subsection (a), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2023 through 2027.

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

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

"SEC. 3431. ESTABLISHING GRANTS FOR DATA COLLECTION IMPROVEMENT ACTIVITIES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in consultation with the Deputy Assistant Secretary for Minority Health, the Director of the National Institutes of Health, the Assistant Secretary for Planning and Evaluation, the National Coordinator for Health Information Technology, and the Director of the National Center for Health Statistics, shall establish a technical assistance program under which the Secretary provides grants to eligible entities to assist such entities in complying with section 3101.

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

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

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

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

''(4) develop educational programs to inform health plans, health providers, health-related agencies, and the general public that data collection and reporting by race, ethnicity, primary language, sexual orientation, sex, gender identity, disability status, and socioeconomic status are legal and essential for eliminating health and health care disparities; and

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

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

care organization, or health plan making a demonstrated effort to bring data collections into compliance with section 3101.

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

"SEC. 3432. OVERSAMPLING OF UNDERREPRESENTED GROUPS IN FEDERAL HEALTH SURVEYS.

''(a) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics, and other officials within the Department of Health and Human Services as the Secretary determines appropriate, shall develop and implement a sustainable national strategy for oversampling underrepresented populations within the categories of race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status as determined appropriate by the Secretary in Federal health surveys and program data collections. Such national strategy shall include a strategy for oversampling of Middle Easterners and North Africans, Asian Americans, Native Hawaiians, and Pacific Islanders.

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

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

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

"(C) consult on, and use as models, the 2014 National Health Interview Survey oversample of Native Hawaiian and Pacific Islander populations, the 2016 Behavioral Risk Factor Survey of Health Risk Behaviors Among Arab Adults Within the State of Michigan, and the 2017 Behavioral Risk Factor Surveillance System oversample of American Indian and Alaska Native communities.

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

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

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

SEC. 1002. ELIMINATION OF PREREQUISITE OF DIRECT APPROPRIATIONS FOR DATA COLLECTION AND ANALYSIS.

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

(1) by striking subsection (h); and

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

SEC. 1003. COLLECTION OF DATA FOR THE MEDICARE PROGRAM.

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

''SEC. 1150D. COLLECTION OF DATA FOR THE MEDICARE PROGRAM.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—The Commissioner of Social Security, in consultation with the Administrator

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

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

''(3) DATA FOR ADDITIONAL POPULATION GROUPS.—Where practicable, the information collected by the Commissioner of Social Security under paragraph (1) shall include data for additional population groups if such groups can be aggregated into

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

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

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

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

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

''(6) TRANSMISSION OF DATA.—Upon enrollment in Medicare benefits under title XVIII, the Commissioner of Social Security shall transmit an individual's demographic data as collected under paragraph (1) to the Centers for Medicare & Medicaid Services.

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

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

"(B) incorporate such data in other analysis and reporting on health disparities and the provision of inequitable health care services by a health care provider, as appropriate;

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

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

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

"(8) PROTECTION OF DATA.—The Commissioner of Social Security shall ensure (through the

promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

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

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

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

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

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

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $500 million for 2022 and $100 million for each fiscal year thereafter.''.

SEC. 1004. REVISION OF HIPAA CLAIMS STANDARDS.

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

(1) the use, at a minimum, of standards for data collection on race, ethnicity, sex, primary language, sexual orientation, gender identity, age, disability status, and socioeconomic status developed under section 3101 of the Public Health Service Act (42 U.S.C. 300kk), as amended by section 1001(a)(5); and

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

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

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

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

SEC. 1005. NATIONAL CENTER FOR HEALTH STATISTICS.

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

(1) in paragraph (1), by striking ''2003'' and inserting ''2024'';

(2) in paragraph (2), in the first sentence, by striking ''2003'' and inserting ''2024''; and

(3) in paragraph (3), by striking ''2002'' and inserting ''2024''.

SEC. 1006. DISPARITIES DATA COLLECTED BY THE FEDERAL GOVERNMENT.

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

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

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

ity Health and Health Disparities, and the Deputy Assistant Secretary for Minority Health, shall—

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 1008. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

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

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

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

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

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

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

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

''(b) POSTMARKET STUDIES.—

''(1) IN GENERAL.—If there is evidence of a racial or ethnic disparity in safety or effectiveness with respect to a drug for which there is an approved application under section 505 of this Act or of a biological product for which there is an approved license under section 351 of the Public Health Service Act, the Secretary may by order require the holder of the approved application or license to conduct, by a date specified by the Secretary, postmarket studies to investigate the disparity.

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

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

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

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

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

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

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

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

propriate contraindications, warnings, or precautions related to the disparity that the Secretary considers necessary.

''(d) DEFINITION.—In this section, the term 'evidence of a racial or ethnic disparity in safety or effectiveness', with respect to a drug or biological product, includes—

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

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

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

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

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

section 505H, or comply with any other requirement of such section 505H.''.

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

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

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

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

''(a) DEFINITIONS.—In this section:

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

''(2) NATIVE HAWAIIANS AND PACIFIC ISLANDERS (NHPI).—The term 'Native Hawaiians and Pacific Islanders' or 'NHPI' means people having origins in any of the original peoples of American

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

''(3) NHPI STAKEHOLDER GROUPS.—The term 'NHPI stakeholder group' includes each of the following:

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

''(B) NONPROFIT, NONGOVERNMENTAL ORGANIZATION.—A group of NHPI with a demonstrated history of addressing NHPI issues, including a NHPI coalition.

''(C) DESIGNATED ORGANIZATION.—An entity established to represent NHPI populations and which has statutory responsibilities to provide, or has community support for providing, health care.

''(D) GOVERNMENT REPRESENTATIVES OF NHPI POPULATIONS.—Representatives from Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated

States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

''(b) PRELIMINARY HEALTH SURVEY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics of the Centers for Disease Control and Prevention (referred to in this section as 'NCHS'), shall conduct a preliminary health survey in order to identify the major areas and regions in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands in which NHPI people reside.

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

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

''(B) required for developing or implementing the national strategy under subsection (c).

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

plans for designing questions, implementation, sampling, and analysis, shall be developed in consultation with NHPI stakeholder groups.

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

''(c) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the NCHS and other agencies within the Department of Health and Human Services as the Secretary determines appropriate, shall develop and implement a sustainable national strategy for identifying and evaluating the health status and health care needs of NHPI populations living in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

''(2) CONSULTATION.—In developing and implementing a national strategy, as described in paragraph (1), not later than 180 days after the date of enactment of the Health Equity and Accountability Act of 2022, the Secretary—

"(A) shall consult with representatives of NHPI stakeholder groups; and

"(B) may solicit the participation of representatives from other Federal agencies.

"(d) PROGRESS REPORT.—Not later than 2 years after the date of enactment of the Health Equity and Accountability Act of 2022, the Secretary shall submit to Congress a progress report, which shall include the national strategy described in subsection (c)(1).

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

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

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

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

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

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

"(2) REPORT.—An agreement described in paragraph (1) shall require the Health and Medicine Division to submit to the Secretary and to Congress, not later than 2 years after the date of the enactment of the Health Equity and Accountability Act of 2022, a report containing a description of the results of the study conducted under paragraph (1), including the conclusions and recommendations of the Health and Medicine Division for each of the items described in subparagraphs (A) through (D) of such paragraph.

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

SEC. 1010. CLARIFICATION OF SIMPLIFIED ADMINISTRATIVE REPORTING REQUIREMENT.

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

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

SEC. 1011. DATA COLLECTION REGARDING PANDEMIC PREPAREDNESS, TESTING, INFECTIONS, AND DEATHS.

(a) SKILLED NURSING FACILITIES QUALITY REPORTING.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended by adding at the end the following new subsection:

''(l) REQUIREMENTS RELATING TO REPORTING DURING PUBLIC HEALTH EMERGENCIES.—During a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act, a skilled nursing facility shall, not later than one year after the first day of such declaration, and monthly thereafter during the application of such declaration, submit to the Secretary the following information, with respect to such facility and the residents of such facility:

''(1) Information described in section 483.80(g)(1) of title 42, Code of Federal Regulations.

''(2) The age, race, ethnicity, sex, sexual orientation, gender identity, socioeconomic status, disability status, and preferred language of the residents of such skilled nursing facility.''.

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

(1) DEMOGRAPHIC INFORMATION.—The Secretary of Health and Human Services shall post the following information with respect to skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))), congregate care settings (including skilled nursing facilities, assisted living facilities, prisons and jails, residential

behavioral health care and psychiatric facilities, and facilities providing services for aging adults and people with disabilities), and nursing facilities (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))) on the Nursing Home Compare website (as described in section 1819(i) of the Social Security Act (42 U.S.C. 1395i–3(i))), or a successor website, aggregated by State:

(A) The age, race, ethnicity, sex, sexual orientation, gender identity, socioeconomic status, disability status, and preferred language of the residents of such skilled nursing facilities, congregate care settings (including skilled nursing facilities, assisted living facilities, prisons and jails, residential behavioral health care and psychiatric facilities, and facilities providing services for aging adults and people with disabilities), and nursing facilities with suspected or confirmed infections, including residents previously treated for COVID–19.

(B) The age, race, ethnicity, sex, sexual orientation, gender identity, socioeconomic status, disability status, and preferred language relating to total deaths and public health emergency-related deaths among residents of such

skilled nursing facilities, congregate settings (including skilled nursing facilities, assisted living facilities, prisons and jails, residential behavioral health care and psychiatric facilities, and facilities providing services for aging adults and people with disabilities), and nursing facilities.

(2) CONFIDENTIALITY.—Any information reported under this subsection that is made available to the public shall be made so available in a manner that protects the identity of residents of skilled nursing facilities, congregate care settings (including skilled nursing facilities, assisted living facilities, prisons and jails, residential behavioral health care and psychiatric facilities, and facilities providing services for aging adults and people with disabilities), and nursing facilities.

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

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

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

"SEC. 1150E. EQUITABLE DATA COLLECTION AND DISCLOSURE REGARDING PANDEMICS.

"(a) IN GENERAL.—Not later than 60 days after the Secretary submits to Congress written notification of the determination that a disease or disorder presents a public health emergency or that a public health emergency otherwise exists, subject to the succeeding subsections, the Secretary, acting through the Director of the Centers for Disease Control and Prevention and the Administrator of the Centers for Medicare & Medicaid Services and in consultation with the Director of the Indian Heath Service, shall collect and make publicly available on the website of the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services, and update every day during a pandemic, data collected across all surveillance systems relating to a public health emergency declared under section 319 of the Public Health Service Act that is caused by a disease (as determined by the Secretary), disaggregated by race, ethnicity, sex, sexual orientation, gender identity, age, preferred language, socioeconomic status, disability status, and county, including the following:

''(1) Data relating to all testing for the pathogen or pathogens causing the pandemic, including the number of individuals tested and the number of tests that were positive.

''(2) Data relating to treatment for the pathogen causing the pandemic, including hospitalizations and intensive care unit admissions.

''(3) Data relating to pandemic outcomes, including total fatalities and case fatality rates (expressed as the proportion of individuals who were infected with the pathogen causing the pandemic and died from the pathogen).

''(4) In the case a vaccine is developed in response to a pandemic, data relating to such vaccination, including—

''(A) the number of vaccines administered;

''(B) the number of vaccinations offered, accepted, and refused;

''(C) the most common reasons for refusal; and

''(D) the percentage of vaccine doses allocated and administered to each priority group.

''(b) APPLICATION OF CERTAIN STANDARDS WITH RESPECT TO DATA COLLECTION.—To the extent practicable, data collected under subsection (a) shall follow

standards developed by the Department of Health and Human Services Office of Minority Health and be collected, analyzed, and reported in accordance with the standards promulgated by the Assistant Secretary for Planning and Evaluation under title XXXI of the Public Health Service Act.

''(c) PRIVACY.—In publishing data pursuant to subsection (a), the Secretary shall take all necessary steps to protect the privacy of individuals whose information is included in such data, including—

''(1) complying with privacy protections provided under the regulations promulgated under section 264(c) of the Health Insurance and Accountability Act of 1996; and

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

(d) REPORT REQUIREMENTS FOLLOWING PUBLIC HEALTH EMERGENCIES.—

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

Public Health Service Act has ended, the Secretary shall make publicly available on the website of the Department of Health and Human Services a summary of the final statistics related to such emergency.

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

(A) describing the testing, hospitalization, mortality rates, vaccination rates, and preferred language of patients associated with the pandemic by race and ethnicity, rural and urban areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)), and congregate care settings (including skilled nursing facilities, assisted living facilities, prisons and jails, residential behavioral health care and psychiatric facili-

ties, and facilities providing services for aging adults and people with disabilities) and noncongregate care settings (as such terms are defined by the Secretary); and

(B) proposing evidenced-based response strategies to safeguard the health of these communities in future pandemics.

SEC. 1012. COMMISSION ON ENSURING DATA FOR HEATH EQUITY.

(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a commission, to be known as the ''Commission on Ensuring Data for Heath Equity'' (referred to in this section as the ''Commission'') to provide clear and robust guidance to improve the collection, analysis, and use of demographic data in responding to future public health emergencies.

(b) MEMBERSHIP AND CHAIRPERSON.—

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

(A) the Assistant Secretary for Preparedness and Response;

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

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

(D) the Commissioner of Food and Drugs;

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

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

(G) the Director of the Indian Health Service;

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

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

(J) the Surgeon General;

(K) the Administrator of the Health Resources and Services Administration;

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

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

(N) the Chairperson of the National Council on Disability;

(O) at least 4 State, local, territorial, and Tribal public health officials representing departments of public health, or an Urban Indian

health representative, who shall represent jurisdictions from different regions of the United States with relatively high concentrations of historically marginalized populations and rural populations, to be appointed by the Secretary;

(P) the National Coordinator for Health Information Technology;

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

(R) at least 4 individuals with expertise on health equity and demographic data disparities with knowledge of, or field experience in, language, disability status, sex, sexual orientation, gender identity, or socioeconomic status.

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

(c) DUTIES.—The Commission shall—

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

(2) determine how to best use such data to promote health equity across the United States and reduce racial, Tribal, and other demographic disparities in health outcomes;

(3)(A) gather available data related to treatment of individuals with disabilities during the COVID–19 pandemic and other public health emergencies, including access to vaccinations, denial of treatment for preexisting conditions, removal or denial of disability related equipment (including ventilators and continuous positive airway pressure (commonly referred to as ''CPAP'') machines), and data on completion of do-not-resuscitate orders; and

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

(4) solicit input from public health officials, community-connected organizations, health care providers, State and local agency officials, Tribal officials, and other experts on barriers to, and best practices for, collecting demographic data; and

(5) recommend policy changes that the data indicates are necessary to reduce demographic disparities in health outcomes.

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

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

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

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

(A) racial and other demographic disparities in COVID–19 mortality, including an analysis of comorbidities and case fatality rates;

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

(C) Federal Government policies that disparately exacerbate the COVID–19 impact, and recommendations to improve racial and other demographic disparities in health outcomes;

(3) an analysis of COVID–19 treatment of individuals with disabilities, including equity of access to treatment and equipment and intersections of disability status with other demographic factors, including race;

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

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

(5) the Commission's recommendations with respect to—

(A) how to enhance State, local, territorial, and Tribal capacity to conduct public health research on COVID–19 and in future public health emergencies, with a focus on expanded capacity to analyze data on disparities correlated with race, ethnicity, income, sex, sexual orientation, gender identity, age, disability status, specific geographic areas, and other relevant demographic characteristics;

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

(C) how to improve demographic data collection related to COVID–19 and other public health emergencies in the short-term and long-term, including how to continue to grow and value the Tribal sovereignty of data and information concerning urban and rural Tribal communities;

(D) how to improve transparency and equity of treatment for individuals with disabilities during the COVID–19 public health emergency and future public health emergencies; and

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

(e) STAFF OF COMMISSION.—

(1) ADDITIONAL STAFF.—The Chairperson of the Commission may appoint and fix the pay of additional staff to the Commission as the Chairperson considers appropriate.

(2) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The staff of the Commission may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates.

(3) DETAILEES.—Any Federal Government employee may be detailed to the Commission without reimbursement from the Commission, and the

detailee shall retain the rights, status, and privileges of his or her regular employment without interruption.

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

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

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

(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a Task Force to be known as the ''Task Force on Preventing AI and Algorithmic Bias in Healthcare'' (referred to in this section as the ''Task Force'') to provide clear and robust guidance on how to ensure that the development and integration of artificial intelligence and algorithmic technologies within the health

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

(b) MEMBERSHIP AND CHAIRPERSON.—

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

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

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

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

(D) the Commissioner of Food and Drugs;

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

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

(G) the Director of the Indian Health Service;

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

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

(J) the Surgeon General;

(K) the Administrator of the Health Resources and Services Administration;

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

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

(N) the Chairperson of the National Council on Disability;

(O) the National Coordinator for Health Information Technology;

(P) at least 4 State, local, territorial, and Tribal public health officials representing departments of public health, or an Urban Indian health representative, who shall represent jurisdictions from different regions of the United States with relatively high concentrations of historically marginalized populations, to be appointed by the Secretary;

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

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

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

(2) CHAIRPERSON.—The Chief Information Officer of the Department of Health and Human Services (or the Chief Information Officer's designee) shall serve as the Chairperson of the Task Force.

(c) DUTIES.—The Task Force shall—

(1) examine where to place artificial intelligence and algorithms in the health care service delivery process relative to the use of autonomous human decision-makers;

(2) identify the risks of health care system utilization of artificial intelligence and algorithms in terms of civil rights, civil liberties, and discriminatory bias in health care access, quality, and outcomes; and

(3) prepare and submit the report under subsection (d).

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

(1) submit a written report of the findings of the examination under paragraph (1) and recommendations to Congress with respect to implementation of artificial intelligence and algorithms in

health care delivery and mitigation of the risks associated with that implementation; and

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

(e) PUBLIC COMMENT.—Not later than 60 days after the date of the date of the enactment of this Act, the Task Force shall publish in the Federal Register a notice providing for a public comment period on the duties and activities of the Task Force of not less than 90 days, beginning on the date of that publication.

(f) STAFF OF COMMISSION.—

(1) ADDITIONAL STAFF.—The Chairperson of the Task Force may appoint and fix the pay of additional staff to the Task Force as the Chairperson considers appropriate.

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

(3) DETAILEES.—Any Federal Government employee may be detailed to the Task Force without re-

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

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH AND HEALTH CARE

SEC. 2001. DEFINITIONS; FINDINGS.

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

(b) FINDINGS.—Congress finds the following:

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

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

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

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

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

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

(6) Both the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) and the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.) prohibit discrimination on the basis of disability and require

the provision of appropriate auxiliary aids and services necessary to ensure effective communication with individuals with disabilities. The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual, the nature, length, and complexity of the communication involved, and the context in which the communication is taking place. A public accommodation should consult with individuals with disabilities whenever possible to determine what type of auxiliary aid is needed to ensure effective communication. The public accommodation should use the individual's preferred method of communication whenever possible, unless it would be an undue burden to the public accommodation and an alternative would provide an equally effective means of communication. The ultimate decision as to what measures to take rests with the public accommodation, provided that the method chosen results in effective communication.

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

tion on the basis of race, color, national origin, disability, sex, and age, requires the provision of language services to ensure effective communication with individuals with limited English proficiency, and requires the provision of appropriate auxiliary aids and services necessary to ensure effective communication with individuals with disabilities.

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

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

(10) Access to English as a second language, foreign language, and sign language interpreters, translated and alternative format documents, readers, and other auxiliary aids and services, are essential to ensure effective communication and eliminate

the language barriers that impede access to health care.

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

SEC. 2002. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

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

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

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

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

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

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

(5) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the ''Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons'' (67 Fed. Reg. 41455 (June 18, 2002)), to ensure culturally and linguistically appropriate access to their programs and activities by individuals with limited English proficiency; and

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

health care providers and organizations from discriminating in the provision of services).

(b) FEDERALLY CONDUCTED PROGRAMS AND ACTIVITIES.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, each Federal agency providing financial assistance to, or administering, a health program or activity described in section 2003(a) shall prepare a plan or update a plan to improve culturally and linguistically appropriate access to such program or activity with respect to individuals with limited English proficiency. Not later than 1 year after the date of enactment of this title, each such Federal agency shall ensure that such plan is fully implemented.

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

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

(B) the policies and procedures for identifying, assessing, and meeting the culturally and linguistically appropriate language needs of its

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

(C) the steps the agency will take for such program or activity to be culturally and linguistically appropriate by—

(i) providing a range of language assistance options;

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

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

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

(D) the steps the agency will take for such program or activity to provide reasonable accommodations necessary for individuals with limited English proficiency, including those individuals with a communication disability, to understand communications from the agency;

(E) the steps the agency will take to ensure that applications, forms, and other significant documents for such program or activity

are competently translated into the primary language of a client that is an individual with limited English proficiency where such materials are needed to improve access of such client to such program or activity;

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

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

(H) the resources the agency will provide to ensure that family, particularly minor children, and friends are not used to provide interpretation services, except as permitted under section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116); and

(I) the steps the agency will take and resources the agency will provide to ensure that

individuals know their rights, including the ability to file a complaint.

(3) SUBMISSION OF PLAN TO DOJ.—Each agency that is required to prepare a plan under paragraph (1) shall—

(A) consult with populations who are directly impacted by policies in the plan and their representatives in the development of the plan; and

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

SEC. 2003. ENSURING STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE.

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

(1) of which any part is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance; or

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

able Care Act (42 U.S.C. 18001 et seq.) (or amendments made thereby).

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

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

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

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

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

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

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

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

(C) signage; and

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

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

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

ternal audits, performance improvement programs, patient satisfaction assessments, continuous quality improvement activities, and outcomes-based evaluations of the program or activity and develop ways to standardize assessments;

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

(A) collected in health records;

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

(C) reported in such a way as to be interoperable with health information systems at the Federal and State levels; and

(D) periodically updated;

(8) shall maintain a current demographic, cultural, and epidemiological profile of the community, conduct regular assessments of community health assets and needs, and use the results of such assessments to accurately plan for and implement services

that respond to the cultural and linguistic characteristics of the service area of the program or activity;

(9) shall develop participatory, collaborative partnerships with community-based organizations and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing, implementing, and evaluating policies and practices to ensure culturally and linguistically appropriate service-related activities;

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

(11) shall annually make available to the public information about their progress and successful innovations in implementing the standards under this section, translated materials of such information that is culturally and linguistically appropriate to the communities served under this section, and provide public notice in such communities about the availability of this information; and

(12) shall, if requested, regularly make available to the head of each Federal entity from which Federal funds are provided, information about the

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

(c) COMMENTS ACCEPTED THROUGH NOTICE AND COMMENT RULEMAKING.—An agency carrying out a program or activity described in subsection (a)—

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

(2) may not require such comments to be submitted only in English; and

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

SEC. 2004. CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE IN THE PUBLIC HEALTH SERVICE ACT.

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

"TITLE XXXIV—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

"SEC. 3400. DEFINITIONS.

''(a) IN GENERAL.—In this title:

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

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

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

''(4) EFFECTIVE COMMUNICATION.—The term 'effective communication' means an exchange of information between the provider of health care or health care-related services and the recipient of such

services who is limited in English proficiency, or has a communication impairment such as a hearing, vision, speaking, or cognitive disability, that enables access to, understanding of, and benefit from health care or health care-related services, and full participation in the development of their treatment plan.

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

''(6) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians organized, at least in part, for the purposes of providing physician services under the Medicaid program under title XIX of the Social Security Act, the State Children's Health Insurance Program under title XXI of such Act, or the Medicare program under title XVIII of such Act, including a provider of services under part B of such title XVIII, and may include a hospital, a hospice provider, a palliative care provider, and any other individual or entity furnishing services covered under any such program that is affiliated with the health care group.

''(7) HEALTH CARE.—The term 'health care' includes all health care needed throughout the life cycle and the end of life.

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

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

''(10) HEALTH EDUCATOR.—The term 'health educator' includes a professional with a baccalaureate degree who is responsible for designing, implementing, and evaluating individual and population health promotion, health education (including education on end-of-life care options), end-of-life care, or chronic disease prevention programs.

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

"(12) INDIVIDUAL WITH A DISABILITY.—The term 'individual with a disability' means any individual who has a disability as defined for the purpose of section 504 of the Rehabilitation Act of 1973.

"(13) INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY.—The term 'individual with limited English proficiency' means an individual who self-identifies on the Census as speaking English less than 'very well'.

"(14) INTEGRATED HEALTH CARE DELIVERY SYSTEM.—The term 'integrated health care delivery system' means an interdisciplinary system that brings together providers from the primary health, mental health, substance use disorder, hospice and palliative care, and related disciplines to improve the health outcomes of an individual and the community. Such providers may include hospitals, health, mental health, or substance use prevention and treatment clinics and providers, home health agencies, home- and community-based services providers, congregate care settings (including any skilled nursing facilities, assisted living facilities, prisons and jails, residential behavioral health care and psychiatric facilities, and facilities providing services for aging adults and peo-

ple with disabilities), ambulatory surgery centers, rehabilitation centers, and employed, independent, or contracted physicians.

''(15) INTERPRETING; INTERPRETATION.—The terms 'interpreting' and 'interpretation' mean the transmission of a spoken, written, or signed message from one language or format into another, faithfully, accurately, and objectively.

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

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

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

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

"(C) taglines.

"(18) MINORITY.—

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

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

"(19) MINORITY GROUP.—The term 'minority group' means a racial and ethnic minority group as defined in this section.

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

''(21) QUALIFIED INDIVIDUAL WITH A DISABILITY.—The term 'qualified individual with a disability' means, with respect to a health program or activity, an individual with a disability who, with or without reasonable modifications to policies, practices, or procedures, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of aids, benefits, or services offered or provided by the health program or activity.

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

''(A) means an interpreter for such individual who by means of a remote interpreting service or an onsite appearance—

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

''(ii) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary spe-

cialized vocabulary, terminology, and phraseology; and

"(B) may include—

"(i) sign language interpreters;

"(ii) oral transliterators, which are individuals who represent or spell in the characters of another alphabet; and

"(iii) cued language transliterators, which are individuals who represent or spell by using a small number of handshapes.

"(23) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY.—The term 'qualified interpreter for an individual with limited English proficiency' means an interpreter who by means of a remote interpreting service or an onsite appearance—

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

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

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

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

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

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

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

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

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

''(26) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality.

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

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

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

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

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

''(32) UNDERSERVED COMMUNITIES.—The term 'underserved communities' means populations sharing a particular characteristic, as well as geographic communities, who have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, such as—

''(A) Black, Latino, and Indigenous and Native American persons, Asian Americans and

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

"(B) members of religious minorities;

"(C) lesbian, gay, bisexual, transgender, and queer persons;

"(D) persons with disabilities;

"(E) persons who live in rural areas; and

"(F) persons otherwise adversely affected by persistent poverty or inequality as defined in Executive Order 13985.

"(33) UNDERSERVED POPULATIONS.—The term 'underserved populations' means populations sharing a particular characteristic, as well as geographic communities, who have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as defined in Executive Order 13985.

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

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

width video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and

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

''(35) VITAL DOCUMENT.—The term 'vital document' includes applications for government programs that provide health care services, medical or financial consent forms, financial assistance documents, letters containing important information regarding patient instructions (such as prescriptions, referrals to other providers, and discharge plans) and participation in a program (such as a Medicaid managed care program), notices pertaining to the reduction, denial, or termination of services or benefits, notices of the right to appeal such actions, and notices advising individuals with limited English proficiency with communication disabilities of the availability of free language services, alternative formats, and other outreach materials.

''(b) REFERENCE.—In any reference in this title to a regulatory provision applicable to a 'handicapped individual', the term 'handicapped individual' in such provi-

sion shall have the same meaning as the term 'individual with a disability' as defined in subsection (a).

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

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

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

''(1) INTERPRETATION SERVICES.—

''(A) IN GENERAL.—The Center shall provide resources via the internet to identify and link health care providers to competent and qualified interpreter and translation services.

''(B) TRAINING.—For purposes of providing the services described in subparagraph (A), the Center shall adopt a language access plan that includes training requirements for Center staff to provide such services.

''(2) TRANSLATION OF WRITTEN MATERIAL.—

"(A) VITAL DOCUMENTS.—The Center shall provide, directly or through contract, to providers of health care services and health care-related services, at no cost to such providers and in a timely and reasonable manner, vital documents—

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

"(ii) from competent translation services, the quality of which shall be monitored and reported publicly.

"(B) FORMS.—For each form developed or revised by the Secretary that will be used by individuals with limited English proficiency in health care or health care-related settings, the Center shall, not later than 45 calendar days of the Secretary receiving final approval of the form from the Office of Management and Budget—

"(i) translate the form, at a minimum, into the top 15 non-English lan-

guages in the United States according to the most recent data from the American Community Survey or its replacement; and

"(ii) post all translated forms on the Center's website.

"(3) TOLL-FREE CUSTOMER SERVICE TELEPHONE NUMBER.—The Center shall provide, through a toll-free number, a customer service line for individuals with limited English proficiency that is linked to the toll-free telephone number 1–800–MEDICARE and a toll-free telephone hotline provided for pursuant to section 1311(d)(4)(B) of the Patient Protection and Affordable Care Act by an Exchange established under title I of such Act—

"(A) to obtain information about federally conducted or funded health programs, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the State Children's Health Insurance Program under title XXI of such Act, and coverage available through an Exchange established under title I of the Patient Protection and Affordable Care Act, and other sources of free or reduced care including federally qualified health centers, enti-

ties receiving assistance under title X, and public health departments;

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

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

"(4) HEALTH INFORMATION CLEARINGHOUSE.—

"(A) IN GENERAL.—The Center shall develop and maintain, and make available on the internet and in print, an information clearinghouse that includes the information described in subparagraphs (B) through (F)—

"(i) to facilitate the provision of language services by providers of health care services and health care-related services to reduce medical errors;

"(ii) to improve medical outcomes, improve cultural competence, reduce health care costs caused by miscommunication with individuals with limited English proficiency; and

"(iii) to reduce or eliminate the duplication of efforts to translate materials.

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

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

''(I) intake forms;

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

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

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

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

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

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

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

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

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

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

"(iv) facilitate access to such documents;

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

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

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

"(E) CULTURALLY AND LINGUISTICALLY APPROPRIATE MATERIALS.—The Center shall provide, at no cost, to all health care providers and all providers of health care-related services, information relating to culturally and linguistically appropriate health care for minority pop-

ulations residing in the United States, including—

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

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

"(iii) culturally and linguistically appropriate training tools;

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

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

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

"(i) develop and publish on its website translation glossaries that provide standardized translations of commonly used

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

"(ii) make such glossaries available—

"(I) free of charge;

"(II) in each language in which the Center translates forms under paragraph (2)(B);

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

"(IV) in paper format upon request.

"(G) INFORMATION ABOUT PROGRESS.—The Center shall—

"(i) regularly collect and make publicly available information about the progress of entities receiving grants under section 3402 regarding successful innovations in implementing the requirements of this subsection; and

"(ii) provide public notice in the entities' communities about the availability of such information.

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

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

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

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

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

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

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

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

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

''(a) IN GENERAL.—

''(1) GRANTS.—The Secretary shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve culturally and linguistically appropriate access to health care services for individuals with limited English proficiency and communication disabilities.

''(2) COORDINATION.—In making grants under this section, and in the design and implementation of the program established under this section, the Secretary shall coordinate with, and ensure the participation of, other agencies including the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities

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

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

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

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

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

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

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

''(6) a public hospital;

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

''(8) any other entity designated by the Secretary.

''(c) APPLICATION.—An eligible entity seeking a grant under this section shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such additional information as the Secretary may reasonably require.

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

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

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

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

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

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

''(6) develop and implement grievance resolution processes that are culturally and linguistically appropriate and capable of identifying, preventing,

and resolving complaints by individuals with limited English proficiency;

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

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

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

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

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

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

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

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

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

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

''(f) EVALUATION.—

''(1) BY GRANTEES.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes, in the manner and to the extent required by the Secretary, the activities carried out with funds received under the grant, and how such activities improved access to health care services and health care-related services

and the quality of health care for individuals with limited English proficiency. Such evaluation shall be collected and disseminated through the Robert T. Matsui Center for Culturally and Linguistically Appropriate Health Care established under section 3401. The Director of the Agency for Healthcare Research and Quality shall notify grantees of the availability of technical assistance for the evaluation and provide such assistance upon request.

''(2) BY SECRETARY.—The Director of the Agency for Healthcare Research and Quality shall evaluate or arrange with other individuals or organizations to evaluate projects funded under this section.

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

''SEC. 3403. RESEARCH ON CULTURAL AND LANGUAGE COMPETENCE.

''(a) IN GENERAL.—The Secretary shall expand research concerning language access in the provision of health care services.

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

with other individuals or organizations to conduct such research.

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

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

''(2) To identify health care providers' and health administrators' knowledge and awareness of the barriers to quality health care services that are faced by individuals with limited English proficiency and communication disabilities.

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

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

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

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

"(C) effective privacy safeguards for collected data.

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

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

"(A) provider type;

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

"(C) type of encounter;

"(D) time of encounter, including whether the encounter occurs during regular business hours and after hours; and

"(E) location of encounter.

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

SEC. 2005. PILOT PROGRAM FOR IMPROVEMENT AND DEVELOPMENT OF STATE MEDICAL INTERPRETING SERVICES.

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

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

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

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

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

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

(4) that has a population of qualified LEP enrollees that is linguistically diverse, requiring inter-

preter services in at least 200 non-English languages.

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

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

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

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

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

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

(ii) procuring and scheduling interpreter services for individuals with limited

English proficiency seeking to enroll in the State Medicaid plan;

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

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

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

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

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

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

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

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

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

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

(f) DEFINITIONS.—In this section:

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

(A) who is limited English proficient; and

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

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

(3) STATE MEDICAID PLAN.—The term ''State Medicaid plan'' means a State plan under title XIX

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

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

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

(h) FUNDING.—

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

(2) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization in paragraph (1) are authorized to remain available without fiscal year limitation.

(3) INCREASED FEDERAL FINANCIAL PARTICIPATION.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)) is amended by inserting ''(or, in the case of a State that was awarded a grant under section 2005 of the Health Equity and Accountability Act of 2022, 100 percent

for each quarter occurring during the grant period specified in subsection (b) of such section)'' after ''75 percent''.

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

SEC. 2006. TRAINING TOMORROW'S DOCTORS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: GRADUATE MEDICAL EDUCATION.

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

''(L) TREATMENT OF CULTURALLY AND LINGUISTICALLY APPROPRIATE TRAINING.—In determining a hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program for education and training in culturally and linguistically appropriate service delivery, which shall include all medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act),

shall be counted toward the determination of full-time equivalency.''.

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

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

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

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

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

SEC. 2007. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

(a) LANGUAGE ACCESS GRANTS FOR MEDICARE PROVIDERS.—

(1) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

individuals with limited English proficiency, is disproportionally underserved.

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

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

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

(A) at least 10 grants to providers of services described in paragraph (2)(A)(i);

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

(C) at least 10 grants to organizations described in paragraph (2)(A)(iii); and

(D) at least 10 grants to sponsors described in paragraph (2)(A)(iv).

(4) CONSIDERATIONS IN AWARDING GRANTS.—

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

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

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

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

(iv) The grantees represent each Centers for Medicare & Medicaid Services region, as defined by the Secretary.

(v) The grantees serve Medicare beneficiaries in at least two large metropolitan statistical areas with racial, ethnic, sexual,

gender, disability, and economically diverse populations.

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

(i) a community organization; or

(ii) a consortia of community organizations, State agencies, and local agencies;

that has experience in providing language services.

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

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

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

(i) interpreter and translation services that—

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

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

(bb) if the grantee operates in a State that does not have statewide health care interpreter standards, utilize competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice and comply with the requirements of section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) as published in the Federal Register on May 18, 2016; and

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

(aa) onsite interpretation;

(bb) telephonic interpretation; or

(cc) video interpretation; and

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

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

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

(I) such beneficiary has been informed, in the beneficiary's primary language, of the availability of free interpreter and translation services and the beneficiary instead requests that a family member, friend, or other person provide such services; and

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

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

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

(D) MEDICARE ADVANTAGE ORGANIZATIONS AND PDP SPONSORS.—A grantee that is a Medicare Advantage organization or a prescription drug plan sponsor must provide at least 50 percent of the grant funds that the grantee receives under this subsection directly to the entity's network providers (including all health providers and pharmacists) for the purpose of providing support for such providers to provide competent language services to Medicare beneficiaries who are individuals with limited English proficiency.

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

(6) DETERMINATION OF AMOUNT OF GRANT PAYMENTS.—

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

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

(ii) data provided by the grantee, if the grantee routinely collects data on the primary language of the Medicare beneficiaries that the grantee serves and the

Secretary determines that the data is accurate and shows a greater number of individuals with limited English proficiency than would be estimated using the data under clause (i).

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

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

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

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

(B) ensure the linguistic competence of bilingual providers;

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

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

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

(F) ensure that—

(i) primary language data are collected for recipients of language services and such data are consistent with standards developed under title XXXIV of the Public Health Service Act, as added by section 2002 of this Act, to the extent such standards are available upon the initiation of the demonstration program; and

(ii) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Account-

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

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

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

(A) The number of Medicare beneficiaries to whom competent language services are provided, disaggregated by age and entitlement basis (on the basis of age, disability, or determination of end stage renal disease).

(B) The primary languages of those Medicare beneficiaries.

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

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

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

(F) The costs of providing competent language services.

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

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

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

such Medicare beneficiaries not participating, based on the data provided under paragraph (9) and any other information available to the Secretary.

(B) The effect of delivering language services on—

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

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

(iii) patient satisfaction with respect to both health service delivery and language assistance;

(iv) health outcomes; and

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

(C) The extent to which bilingual staff, interpreters, and translators providing services under such demonstration were trained or accredited and the nature of accreditation or training needed by type of provider, service, or other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to

Medicare beneficiaries if such services are expanded pursuant to section 1115A(c) of the Social Security Act (42 U.S.C. 1315a(c)).

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

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

(12) LIMITED ENGLISH PROFICIENT DEFINED.—In this subsection, the term ''limited English proficient'' refers to individuals who self-identify on the Census as speaking English less than ''very well''.

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

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

(A) in subsection (aa)(1)—

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

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

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

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

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

''Language Assistance Services and Related Terms

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

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

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

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

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

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

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

(A) in paragraph (9), by striking ''and'' at the end;

(B) in paragraph (10), by striking the period at the end and inserting ''; and''; and

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

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

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

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

(c) MEDICARE PARTS C AND D.—

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

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

''(6) REPORTING REQUIREMENTS RELATING TO EFFECTIVE LANGUAGE SERVICES.—A contract under this part shall require a Medicare Advantage organization (and, through application of section 1860D–12(b)(3)(D), a contract under section 1860D–12 shall require a PDP sponsor) to annually submit (for each year of the contract) a report that contains information on the internal policies and procedures

of the organization (or sponsor) related to recruitment and retention efforts directed to workforce diversity and linguistically and culturally appropriate provision of services in each of the following contexts:

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

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

"(C) Evaluation of the language services programs and services offered by the organization (or sponsor) with respect to the enrollee population, such as through analysis of complaints or satisfaction survey results.

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

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

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

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

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

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

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

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

(3) DEFINITION OF MEDICAL ASSISTANCE.—

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

(i) in paragraph (30), by striking ''and'' at the end;

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

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

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

(B) CONFORMING AMENDMENTS.—

(i) Section 1902(nn)(3) of the Social Security Act (42 U.S.C. 1396a(nn)(3)) is amended by striking ''paragraph (30)'' and inserting ''the last paragraph''.

(ii) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the 5th sentence, by striking ''paragraph (30)'' and inserting ''the last paragraph''.

(4) USE OF DEDUCTIONS AND COST SHARING.—Subsections (a)(2) and (b)(2) of section 1916(a)(2) of the Social Security Act (42 U.S.C. 1396o(a)(2)) are each amended—

(A) in subparagraph (G), by inserting a comma after ''plan'';

(B) in subparagraph (H), by striking ''; or'' and inserting a comma;

(C) in subparagraph (I), by striking ''; and'' and inserting '', or''; and

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

''(J) language assistance services described in section 1905(a)(31); and''.

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

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

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

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

(C) in subsection (e)(2)—

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

(ii) by inserting ''language assistance services described in subsection (c)(12),'' before ''visits described in''.

(6) DEFINITION OF CHILD HEALTH ASSISTANCE.—Section 2110(a)(27) of the Social Security Act (42 U.S.C. 1397jj(a)(27)) is amended by striking ''translation'' and inserting ''language assistance services as described in section 2103(c)(12)''.

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

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

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

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

(A) in subsection (a)(1)—

(i) in the matter preceding subparagraph (A), by striking ''75'' and inserting ''95''; and

(ii) in subparagraph (D)(iv), by striking ''translation or interpretation services'' and inserting ''language assistance services''; and

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

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

(1) PAYMENT OF COSTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall make payments (on a quarterly basis) directly to eligible entities to support the provision of language assistance services to individuals with limited English proficiency in an amount equal to an eligible enti-

ty's eligible costs for providing such services for the quarter.

(B) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary such sums as may be necessary for each of fiscal years 2022 through 2026.

(C) RELATION TO MEDICAID DSH.—Payments under this subsection shall not offset or reduce payments under section 1923 of the Social Security Act (42 U.S.C. 1396r–4), nor shall payments under such section be considered when determining uncompensated costs associated with the provision of language assistance services for the purposes of this subsection.

(2) METHODOLOGY FOR PAYMENT OF CLAIMS.—

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

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

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

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

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

(5) REPORTING REQUIREMENTS.—

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

be in a form and manner determined by the Secretary.

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

(6) DEFINITIONS.—In this subsection:

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

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

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

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

(i) is a Medicaid provider that is—

(I) a physician;

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

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

(IV) a hospice provider; or

(V) a palliative care provider;

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

(iii) prepares and submits an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require, to

ascertain the entity's eligibility for funding under this subsection.

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

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

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided and subject to paragraph (2), the amendments made by this section shall take effect on January 1, 2023.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or a State plan for child health assistance under title XXI of such Act (42

U.S.C. 1397aa et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, such State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2008. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, in consultation with the Director of the National Institute on Minority Health and Health Disparities and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to improve health care for patient populations that have low health literacy.

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

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

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

(c) USE OF FUNDS.—

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

(A) to define and increase the understanding of health literacy across all areas of health care, including end of life care;

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

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

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

(2) HEALTH RESOURCES AND SERVICES ADMINISTRATION.—A grant under subsection (a) that is

awarded through the Administrator of the Health Resources and Services Administration shall be used to conduct demonstration projects for interventions for patients with low health literacy that may include—

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

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

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

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

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

(F) the conduct of educational campaigns concerning health directed specifically at patients with mental disabilities, including those with cognitive and intellectual disabilities, designed to reduce the incidence of low health literacy among these populations, which shall

have instructional materials in the plain language standards promulgated under the Plain Writing Act of 2010 (5 U.S.C. 301 note) for Federal agencies; and

(G) other activities determined appropriate by the Administrator.

(d) DEFINITIONS.—In this section:

(1) LOW HEALTH LITERACY.—The term ''low health literacy'' means the inability of an individual to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

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

(A) acting through the Director of the Agency for Healthcare Research and Quality, with respect to grants under subsection (c)(1); and

(B) acting through the Administrator of the Health Resources and Services Administration with respect to grants under subsection (c)(2).

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

such sums as may be necessary for each of fiscal years 2023 through 2027.

SEC. 2009. REQUIREMENTS FOR HEALTH PROGRAMS OR ACTIVITIES RECEIVING FEDERAL FUNDS.

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

(1) the term ''covered entity'' has the meaning given such term in section 92.4 of title 45, Code of Federal Regulations, as in effect on May 18, 2016 (81 Fed. Reg. 31466); and

(2) the term ''health program or activity'' has the meaning given such term in section 92.4 of title 45, Code of Federal Regulations, as in effect on May 18, 2016 (81 Fed. Reg. 31466).

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

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

(2) offer and provide appropriate language assistance services at no additional charge to each patient that is an individual with limited English pro-

ficiency at all points of contact, in a timely manner during all hours of operation;

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

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

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

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

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

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

(C) The covered entity informs the patient that the entity may not require an individual with a limited English proficiency to use a family member or friend as an interpreter.

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

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

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

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

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

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

SEC. 2010. REPORT ON FEDERAL EFFORTS TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.

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

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

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

(3) recommendations on the development and implementation of policies and practices by providers of health care services and health care-related serv-

ices for individuals with limited English proficiency, including people with cognitive, hearing, vision, or print impairments;

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

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

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

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

SEC. 2011. ENGLISH INSTRUCTION FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

(a) GRANTS AUTHORIZED.—The Secretary of Education is authorized to provide grants to eligible entities for the provision of English as a second language (in this section referred to as ''ESL'') instruction to individuals with limited English proficiency, including health care-related English instruction, and shall determine, after con-

sultation with appropriate stakeholders, the mechanism for administering and distributing such grants.

(b) ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means—

(1) a State; or

(2) a community-based organization that predominantly employs and serves racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u-6(g)).

(c) APPLICATION.—An eligible entity that desires to receive a grant under this section shall apply by submitting to the Secretary of Education an application at such time, in such manner, and containing such information as the Secretary may require.

(d) USE OF GRANT.—An eligible entity shall use grant funds provided under this section to—

(1) develop and implement a plan for assuring the availability of ESL instruction, free of charge, to the community served by the eligible entity, that effectively integrates information about the nature of the United States health care system, how to access care, and any special language skills that may be required for individuals with limited English proficiency to access and regularly negotiate the health care system effectively;

(2) develop a plan for making ESL instruction available free to charge to individuals with limited English proficiency in the community served by the eligible entity who are seeking instruction, including, where appropriate, through the use of public-private partnerships; and

(3) provide ESL instruction to individuals with limited English proficiency in the community served by the eligible entity.

(e) SUPPLEMENT, NOT SUPPLANT.—An eligible entity awarded a grant under this section shall use funds made available under this section to supplement, and not supplant, other Federal, State, and local funds that would otherwise be expended to carry out activities under this section.

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

(1) collect and make publicly available annual data on how much Federal, State, and local governments spend annually on ESL instruction;

(2) collect data from eligible entities awarded a grant under this section to identify the unmet needs of individuals with limited English proficiency for appropriate ESL instruction, including—

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

(B) the availability of enrollment in ESL instruction programs in the communities served by each eligible entity awarded a grant under this section, including the extent of waiting lists for ESL instruction, how many programs maintain waiting lists, and, for programs that do not have waiting lists, the reasons why such a list is unnecessary or otherwise not maintained;

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

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

(E) the number of individuals with limited English proficiency and the number of individuals enrolled in ESL instruction programs in the communities served by each eligible entity awarded a grant under this section;

(F) the effectiveness of the ESL instruction provided through grants awarded under this section in meeting the needs of individuals receiving such instruction; and

(G) an assessment of the need for programs that integrate job training and ESL instruction, to assist individuals with limited English proficiency in obtaining better jobs;

(3) determine the cost and most appropriate methods of making ESL instruction available to all individuals with limited English proficiency in the United States who are seeking instruction; and

(4) not later than 1 year after the date of enactment of this Act, issue a report to Congress that—

(A) assesses the information collected in paragraphs (1), (2), and (3) and makes recommendations on steps that should be taken to realize the goal of making ESL instruction available to all individuals with limited English proficiency in the United States who are seeking instruction; and

(B) evaluates the impact of the grant program authorized under this section on the accessibility of, and ability to effectively negotiate, the health care system for individuals with limited English proficiency who have received ESL instruction funded by a grant under this section.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Education $250,000,000 for each of fiscal years 2023 through 2027 to carry out this section.

SEC. 2012. IMPLEMENTATION.

(a) GENERAL PROVISIONS.—

(1) IMMUNITY.—A person injured by a violation of this title (including an amendment made by this title) by a State may bring a civil action in the appropriate Federal court for such injury in accordance with this section.

(2) REMEDIES.—In a civil action under this section for a violation of this title, such remedies shall be available as would be available in a civil action for such violation against any party other than a State.

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

SEC. 2013. LANGUAGE ACCESS SERVICES.

(a) ESSENTIAL BENEFITS.—Section 1302(b)(1) of the Patient Protection and Affordable Care Act (42

U.S.C. 18022(b)(1)) is amended by adding at the end the following:

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

(b) EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—

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

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

(2) CONFORMING AMENDMENTS.—

(A) Section 36B(c)(2)(C) of such Code is amended by striking "clause (iii)" each place it

appears in clauses (i) and (ii) and inserting ''clause (iv)''.

(B) Section 36B(c)(2)(C)(iv) of such Code, as redesignated by this subsection, is amended by striking ''(i) and (ii)'' and inserting ''(i), (ii), and (iii)''.

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

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

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

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

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

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

2719(e) of title 29, Code of Federal Regulations, and section 147.136(e) of title 45, Code of Federal Regulations, (or a successor regulation) respectively, to require group health plans and health insurance issuers offering group or individual health insurance coverage to which such sections apply—

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

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

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

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

(1) amend the single streamlined application form developed pursuant to section 1413 of the Pa-

tient Protection and Affordable Care Act (42 U.S.C. 18083) to collect the preferred spoken and written language for each household member applying for coverage under a qualified health plan through an Exchange under title I of such Act (42 U.S.C. 18001 et seq.);

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

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

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

SEC. 2014. MEDICALLY UNDERSERVED POPULATIONS.

Section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)) is amended to read as follows:

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

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

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

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

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

TITLE III—HEALTH WORKFORCE DIVERSITY

SEC. 3001. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as added by section 2004, is amended by adding at the end the following:

"Subtitle B—Diversifying the Health Care Workplace

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

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

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

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

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

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

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

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

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

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

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

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

"(I) The Indian Health Service.

"(J) The Department of Education.

"(K) Minority-serving academic institutions.

"(L) Consumer organizations.

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

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

"(O) Health workforce accreditation entities.

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

"(Q) Local and State health departments.

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

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

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

''(T) The Veterans Health Administration.

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

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

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

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

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

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

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

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

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

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

''(8) Develop a workforce data collection or tracking system to identify where racial and ethnic minority health professionals practice.

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

''(10) Help with monitoring of standards for diversity, equity, and inclusion.

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

''(d) ANNUAL REPORT.—Not later than 1 year after the establishment of the working group under subsection (a), and annually thereafter, the working group shall pre-

pare and make available to the general public for comment, an annual report on the activities of the working group. Such report shall include the recommendations of the working group for improving health workforce diversity.

''(e) COORDINATION WITH OTHER EFFORTS.—In providing for the establishment of the working group under subsection (a), the Secretary shall take such steps as may be necessary to ensure that the work of the working group does not overlap with, or otherwise duplicate, other Federal Government efforts with respect to ensuring heath equity in data collection in public health emergencies.

''(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.

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

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

health workforce diversity within the Office of Minority Health and coordinate current and future clearinghouses related to health workforce diversity.

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

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

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

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

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

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

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

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

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

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

''SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY, EQUITY, AND INCLUSION.

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

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

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

"(A) part B institutions, as defined in section 322 of the Higher Education Act of 1965;

"(B) historically Black professional or graduate institutions eligible for grants under section 326 of the Higher Education Act of 1965;

"(C) Hispanic-serving health professions schools;

"(D) Hispanic-serving institutions, as defined in section 502 of such Act;

"(E) Tribal Colleges or Universities, as defined in section 316 of such Act;

"(F) Asian American and Native American Pacific Islander-serving institutions, as defined in section 371(c) of such Act;

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

"(H) health professional associations, which may include underrepresented minority health professional associations; and

"(I) institutions, including national and regional community-based organizations with

demonstrated commitment to a diversified workforce—

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

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

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

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

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

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

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

''(3) postbaccalaureate programs;

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

''(5) supporting workforce diversity in kindergarten through 12th grade and other health pipeline programs;

''(6) mentoring programs;

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

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

''(9) leadership training.

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

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

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

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

''(c) DATA COLLECTION.—The head of each agency listed in subsection (a) shall collect data on the number (expressed as an absolute number and a percentage) of underrepresented minority and nonminority applicants who receive and are denied agency funding at every stage

of review. Such data shall be reported annually to the Secretary and the appropriate committees of Congress.

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

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

''(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.

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

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall establish a program to award grants to universities and other institutions to enter into agreements with eligible individuals under which—

''(1) the university or institution supports the eligible individual's career in a nonresearch-related health and wellness profession; and

''(2) the eligible individual commits to performing a period of obligated service in such a career to serve, or to work on health issues affecting, underserved communities, such as racial and ethnic minority communities.

''(b) ELIGIBLE INDIVIDUALS.—To be an eligible individual for purposes of subsection (a), an individual shall be a student in a health professions school, a graduate of such a school who is working in a health profession, an individual working in a health or wellness profession (including mental and behavioral health), or a faculty member of such a school.

''(c) APPLICATION.—To seek a grant under this section, a university or other institution shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS.—A university or other institution receiving a grant under this section shall use the grant for agreements described in subsection (a). Such agreements may—

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

''(2) support an eligible individual's health-related career advancement activities;

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

''(4) establish and promote leadership training programs for eligible individuals to decrease health disparities and to increase cultural competence with

the goal of increasing diversity in leadership positions.

''(e) DEFINITION.—In this section, the term 'career in a nonresearch-related health and wellness profession' means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, psychology, social work, psychiatry, other mental and behavioral health, allied health, community health, social work, or other fields determined appropriate by the Secretary, other than in a position that involves research.

''(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.

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

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

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

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

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

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support research that investigates the effect of health workforce diversity on—

''(1) language access;

''(2) cultural competence;

''(3) patient satisfaction;

''(4) timeliness of care;

''(5) safety of care;

''(6) effectiveness of care;

''(7) efficiency of care;

''(8) patient outcomes;

''(9) community engagement;

''(10) resource allocation;

''(11) organizational structure;

''(12) compliance of care; or

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

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

''SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.

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

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

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

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

''(3) disseminate information about the impact of linguistic and cultural barriers on health care quality and the obligation of health providers who

receive Federal financial assistance to ensure that individuals with limited English proficiency have access to language access services;

''(4) disseminate information about the importance and legality of racial, ethnic, disability status, socioeconomic status, sex, gender identity, and sexual orientation, and primary language data collection, analysis, and reporting;

''(5) design and implement specific educational initiatives to health care providers relating to health and health care disparities;

''(6) assess the impact of the programs established under this section in raising awareness of health and health care disparities and providing information on available resources; and

''(7) design and implement specific educational initiatives to educate the health care workforce relating to unconscious bias.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.''.

SEC. 3002. HISPANIC-SERVING INSTITUTIONS, HISTORICALLY BLACK COLLEGES AND UNIVERSITIES, HISTORICALLY BLACK PROFESSIONAL OR GRADUATE INSTITUTIONS, ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTIONS, TRIBAL COLLEGES, REGIONAL COMMUNITY-BASED ORGANIZATIONS, AND NATIONAL MINORITY MEDICAL ASSOCIATIONS.

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

"SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORICALLY BLACK COLLEGES AND UNIVERSITIES, HISTORICALLY BLACK PROFESSIONAL OR GRADUATE INSTITUTIONS, ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTIONS, AND TRIBAL COLLEGES.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Secretary of Education, shall award grants to Hispanic-serving institutions, historically Black colleges and universities, historically Black professional or graduate institutions eligible for grants under section 326 of the Higher Education Act

of 1965, Asian American and Native American Pacific Islander-serving institutions, Tribal Colleges or Universities, regional community-based organizations, and national minority medical associations, for counseling, mentoring, and providing information on financial assistance to prepare underrepresented minority individuals to enroll in and graduate from health professional schools and to increase services for underrepresented minority students including—

''(1) mentoring with underrepresented health professionals;

''(2) providing financial assistance information for continued education and applications to health professional schools; and

''(3) retaining existing enrolled underrepresented minority students in a health professions school.

''(b) DEFINITIONS.—In this section:

''(1) ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTION.—The term 'Asian American and Native American Pacific Islander-serving institution' has the meaning given such term in section 320(b) of the Higher Education Act of 1965.

"(2) HISPANIC-SERVING INSTITUTION.—The term 'Hispanic-serving institution' means an entity that—

"(A) is a school or program for which there is a definition under section 799B;

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

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

"(D) has been effective in recruiting and retaining Hispanic faculty members;

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

"(F) is a Hispanic Center of Excellence in Health Professions Education designated under section 736(d)(2) of the Public Health Service Act (42 U.S.C. 293(d)(2)).

"(3) HISTORICALLY BLACK COLLEGE AND UNIVERSITY.—The term 'historically Black college and university' has the meaning given the term 'part B

institution' as defined in section 322 of the Higher Education Act of 1965.

''(4) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given such term in section 316(b) of the Higher Education Act of 1965.

''(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In carrying out the National Health Service Corps Loan Repayment Program established under subpart III of part D of title III and the loan repayment program under section 317F, the Secretary shall ensure, notwithstanding such subpart or section, that loan repayments of not less than $50,000 per year per person are awarded for repayment of loans incurred for enrollment or participation of underrepresented minority individuals in health professional schools and other health programs described in this section.

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

SEC. 3003. LOAN REPAYMENT PROGRAM OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317F(c)(1) of the Public Health Service Act (42 U.S.C. 247b–7(c)(1)) is amended by striking

''$500,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 2002'' and inserting ''such sums as may be necessary for each of fiscal years 2023 through 2027''.

SEC. 3004. ALLIED HEALTH WORKFORCE DIVERSITY.

(a) INCREASING WORKFORCE DIVERSITY IN THE PROFESSIONS OF PHYSICAL THERAPY, OCCUPATIONAL THERAPY, RESPIRATORY THERAPY, AUDIOLOGY, AND SPEECH-LANGUAGE PATHOLOGY.—Title VII of the Public Health Service Act is amended—

(1) by redesignating part G (42 U.S.C. 295j et seq.) as part H; and

(2) by inserting after part F (42 U.S.C. 295h) the following new part:

''PART G—INCREASING WORKFORCE DIVERSITY IN THE PROFESSIONS OF PHYSICAL THERAPY, OCCUPATIONAL THERAPY, RESPIRATORY THERAPY, AUDIOLOGY, AND SPEECH-LANGUAGE PATHOLOGY

''SEC. 783. SCHOLARSHIPS AND STIPENDS.

''(a) IN GENERAL.—The Secretary may award grants and contracts to eligible entities to increase educational opportunities in the professions of physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology for eligible individuals by—

"(1) providing student scholarships or stipends, including for—

"(A) completion of an accelerated degree program;

"(B) completion of an associate's, bachelor's, master's, or doctoral degree program; and

"(C) entry by a diploma or associate's degree practitioner into a bridge or degree completion program;

"(2) providing assistance for completion of prerequisite courses or other preparation necessary for acceptance for enrollment in the eligible entity; and

"(3) carrying out activities to increase the retention of students in one or more programs in the professions of physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology.

"(b) CONSIDERATION OF RECOMMENDATIONS.—In carrying out subsection (a), the Secretary shall take into consideration the recommendations of national organizations representing the professions of physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology, including the American Physical Therapy Association, the American Occupational

Therapy Association, the American Speech-Language-Hearing Association, the American Association for Respiratory Care, the American Academy of Audiology, and the Academy of Doctors of Audiology.

''(c) REQUIRED INFORMATION AND CONDITIONS FOR AWARD RECIPIENTS.—

''(1) IN GENERAL.—The Secretary may require recipients of awards under this section to report to the Secretary concerning the annual admission, retention, and graduation rates for eligible individuals in programs of the recipient leading to a degree in any of the professions of physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology.

''(2) FALLING RATES.—If any of the rates reported by a recipient under paragraph (1) fall below the average for such recipient over the 2 years preceding the year covered by the report, the recipient shall provide the Secretary with plans for immediately improving such rates.

''(3) INELIGIBILITY.—A recipient described in paragraph (2) shall be ineligible for continued funding under this section if the plan of the recipient fails to improve the rates within the 1-year period beginning on the date such plan is implemented.

"(d) DEFINITIONS.—In this section:

"(1) ELIGIBLE ENTITIES.—The term 'eligible entity' means an accredited education program that is carrying out a program for recruiting and retaining students underrepresented in the professions of physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology (including racial or ethnic minorities, or students from disadvantaged backgrounds).

"(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who—

"(A) is a member of a class of persons who are underrepresented in the professions of physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology, including individuals who are—

"(i) racial or ethnic minorities;

"(ii) from disadvantaged backgrounds; or

"(iii) individuals with a disability (as defined in section 3(1) of the Americans with Disabilities Act of 1990), or who have an individualized education program (as defined in section 602 of the Individuals with Disabilities Education Act), are cov-

ered under section 504 of the Rehabilitation Act of 1973, or have other documentation establishing the student's disability (as such term is defined in section 3(1) of the Americans with Disabilities Act of 1990);

''(B) has a financial need for a scholarship or stipend; and

''(C) is enrolled (or accepted for enrollment) at an audiology, speech-language pathology, respiratory therapy, physical therapy, or occupational therapy program as a full-time student at an eligible entity.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $8,000,000 for the first fiscal year commencing after the date of enactment of the Health Equity and Accountability Act of 2022 and each of the 4 succeeding fiscal years.''.

(b) ELIGIBILITY CLARIFICATION REGARDING STUDENTS SUPPORTED THROUGH MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.—Section 756(a)(1) of the Public Health Service Act (42 U.S.C. 294e–1(a)(1)) is amended by inserting after ''occupational therapy'' the following: ''(which may include master's and doctoral level programs)''.

SEC. 3005. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS AT SCHOOLS OF PUBLIC HEALTH AND SCHOOLS OF ALLIED HEALTH.

Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by inserting after section 755 of such Act (42 U.S.C. 294e) the following:

"SEC. 755A. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS.

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

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

''(c) REQUIREMENTS.—As a condition of entering into a cooperative agreement with the Secretary under this section, a school of public health or school of allied health

shall agree to design and implement an online degree program that meets the following restrictions:

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

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

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

''(d) PERIOD OF COOPERATIVE AGREEMENTS.—The period during which payments are made through a cooperative agreement entered into under this section may not exceed 3 years.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.''.

SEC. 3006. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) SENSE OF CONGRESS.—It is the sense of Congress that the National Health Care Workforce Commission established by section 5101 of the Patient Protection and Affordable Care Act (42 U.S.C. 294q) should, in car-

rying out its assigned duties under that section, give attention to the needs of racial and ethnic minorities, individuals with lower socioeconomic status, individuals with mental, developmental, and physical disabilities, lesbian, gay, bisexual, transgender, queer, and questioning populations, and individuals who are members of multiple minority or special population groups.

(b) REAUTHORIZATION.—Section 5101(h)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 294q(h)(2)) is amended by striking ''such sums as may be necessary'' and inserting ''$3,000,000 for each of fiscal years 2023 through 2025''.

SEC. 3007. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.

Subtitle B of title XXXIV of the Public Health Service Act, as added by section 3001, is further amended by inserting after section 3417 the following:

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

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Administrator of the Health Resources and Services Administration and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to increase awareness among secondary and postsecondary students of career opportunities in the health professions.

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

''(1) be a clinical, public health, or health services organization, community-based or nonprofit entity, or other entity determined appropriate by the Director of the Centers for Disease Control and Prevention;

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

''(3) work with students, including those from racial and ethnic minority backgrounds, that have expressed an interest in the health professions; and

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

''(c) USE OF FUNDS.—Grant awards under subsection (a) shall be used to support internships that will increase awareness among students of non-research-based, career opportunities in the following health professions:

''(1) Medicine.

''(2) Nursing.

''(3) Public health.

''(4) Pharmacy.

''(5) Health administration and management.

''(6) Health policy.

''(7) Psychology.

''(8) Dentistry.

''(9) International health.

''(10) Social work.

''(11) Allied health.

''(12) Psychiatry.

''(13) Hospice care.

''(14) Community health, patient navigation, and peer support.

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

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

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

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

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

''(4) provide counseling or other services designed to assist disadvantaged individuals in success-

fully completing their education at the postsecondary level.

''(e) STIPENDS.—

''(1) IN GENERAL.—Subject to paragraph (2), an entity receiving a grant under this section may use the funds made available through such grant to award stipends for educational and living expenses to students participating in the internship supported by the grant.

''(2) LIMITATIONS.—A stipend awarded under paragraph (1) to an individual—

''(A) may not be provided for a period that exceeds 6 months; and

''(B) may not exceed $20 per day for an individual (notwithstanding any other provision of law regarding the amount of a stipend).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

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

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, shall

award scholarships to eligible individuals under subsection (b) who seek a career in public health.

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

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

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

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

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

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

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become public health professionals.

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

''(1) are from disadvantaged backgrounds;

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

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

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

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

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Deputy Assistant Secretary for Minority Health, the Assistant Secretary for Mental Health and Substance Use, and the Director of the Indian Health Service, shall award

research fellowships to eligible individuals under subsection (b) to conduct research that will examine gender and health disparities and to pursue a career in the health professions.

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

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

''(2) reside in a health professional shortage area designated by the Secretary under section 332;

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

''(4) demonstrate promise for becoming a leader in the field of women's sexual and reproductive health, including family planning;

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

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

''(c) USE OF FUNDS.—A fellowship awarded under subsection (a) to an eligible individual under subsection (b) shall be used to support an opportunity for the indi-

vidual to become a researcher and advance the research base on the intersection between gender and health.

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

''(1) are from disadvantaged backgrounds; and

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

''(e) FELLOWSHIPS.—The Director of the Centers for Disease Control and Prevention may approve fellowships for individuals under this section for any period of education in the student's graduate or health profession tenure, except that such a fellowship may not be provided to an individual for more than 3 years, and such a fellowship may not exceed $18,000 per academic year for an individual (notwithstanding any other provision of law regarding the amount of a fellowship).

''(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

"SEC. 3421. PAUL DAVID WELLSTONE INTERNATIONAL HEALTH FELLOWSHIP PROGRAM.

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Deputy Assistant Secretary for Minority Health, shall award research fellowships to eligible individuals under subsection (b) to advance their understanding of international health.

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

''(1) have educational experience in the field of international health;

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

''(3) demonstrate promise for becoming a leader in the field of international health;

''(4) be in the fourth year of a 4-year institution of higher education or a recent graduate of a 4-year institution of higher education; and

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

''(c) USE OF FUNDS.—A fellowship awarded under subsection (a) to an eligible individual under subsection (b) shall be used to support an opportunity for the individual to become a health professional and to advance the

knowledge of the individual about international issues relating to health care access and quality.

''(d) PRIORITY.—In awarding fellowships under subsection (a), the Director of the Agency for Healthcare Research and Quality shall give priority to eligible individuals under subsection (b) that—

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

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

''(e) FELLOWSHIPS.—A fellowship awarded under this section may not—

''(1) be provided to an eligible individual for more than a period of 6 months;

''(2) be awarded to a graduate of a 4-year institution of higher education that has not been enrolled in such institution for more than 1 year; or

''(3) exceed $4,000 per academic year (notwithstanding any other provision of law regarding the amount of a fellowship).

''(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.

"SEC. 3422. EDWARD R. ROYBAL HEALTH SCHOLAR PROGRAM.

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

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

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

''(2) serve in a health professional shortage area designated by the Secretary under section 332;

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

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

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

''(1) public health policy;

''(2) health care and pharmaceutical policy;

''(3) health care administration and management;

''(4) health economics; and

''(5) other professions determined appropriate by the Director of the Agency for Healthcare Research and Quality, the Administrator of the Centers for Medicare & Medicaid Services, or the Administrator of the Health Resources and Services Administration.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Agency for Healthcare Research and Quality, the Administrator of the Centers for

Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, in collaboration with the Deputy Assistant Secretary for Minority Health, shall give priority to entities that—

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

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

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

''(e) STIPENDS.—

''(1) IN GENERAL.—Subject to paragraph (2), an entity receiving a grant under this section may use the funds made available through such grant to award stipends for educational and living expenses to students participating in the opportunities supported by the grant.

''(2) LIMITATIONS.—A stipend awarded under paragraph (1) to an individual—

''(A) may not be provided for a period that exceeds 2 months; and

''(B) may not exceed $100 per day (notwithstanding any other provision of law regarding the amount of a stipend).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

"SEC. 3423. LEADERSHIP FELLOWSHIP PROGRAMS.

''(a) IN GENERAL.—The Secretary shall award grants to national minority medical or health professional associations to develop leadership fellowship programs for underrepresented health professionals in order to—

''(1) assist such professionals in becoming future leaders in public health and health care delivery institutions; and

''(2) increase diversity in decision-making positions that can improve the health of underserved communities.

''(b) USE OF FUNDS.—A leadership fellowship program supported under this section shall—

''(1) focus on training mid-career physicians and health care executives who have documented leadership experience and a commitment to public health services in underserved communities; and

''(2) support Federal public health policy and budget programs, and priorities that impact health equity, through activities such as didactic lectures and leader site visits.

''(c) PERIOD OF GRANTS.—The period during which payments are made under a grant awarded under subsection (a) may not exceed 3 years.

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

SEC. 3008. MCNAIR POSTBACCALAUREATE ACHIEVEMENT PROGRAM.

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

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

''(h) FUNDING.—From amounts appropriated pursuant to the authority of section 402A(g), the Secretary shall, to the extent practicable, allocate funds for projects

authorized by this section in an amount that is not less than $31,000,000 for each of the fiscal years 2023 through 2027.''.

SEC. 3009. RULES FOR DETERMINATION OF FULL-TIME EQUIVALENT RESIDENTS FOR COST-REPORTING PERIODS.

(a) DGME DETERMINATIONS.—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as amended by section 2006(a), is amended—

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

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

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

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

''(M) TREATMENT OF CERTAIN RESIDENTS AND INTERNS.—For purposes of cost-reporting periods beginning on or after October 1, 2022, in determining the hospital's number of full-

time equivalent residents for purposes of this paragraph, all time spent by an intern or resident in an approved medical residency training program shall be counted toward the determination of full-time equivalency if the hospital—

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

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

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

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

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

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

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

(3) by inserting after subclause (III) the following new subclause:

"(IV) For purposes of cost-reporting periods beginning on or after October 1, 2022, the provisions of subparagraph (M) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.".

SEC. 3010. DEVELOPING AND IMPLEMENTING STRATEGIES FOR LOCAL HEALTH EQUITY.

(a) GRANTS.—The Secretary of Health and Human Services, acting jointly with the Secretary of Education and the Secretary of Labor, shall make grants to an eligible institution of higher education for the purposes of—

(1) in accordance with subsection (b), developing capacity—

(A) to build an evidence base for successful strategies for increasing local health equity; and

(B) to serve as national models of driving local health equity; and

(2) in accordance with subsection (c), developing a strategic partnership with the community in which the institution is located.

(b) DEVELOPING CAPACITY FOR INCREASING LOCAL HEALTH EQUITY.—As a condition on receipt of a grant under subsection (a), an institution of higher education shall agree to use such grant to build an evidence base

for successful strategies for increasing local health equity, and to serve as a national model of driving local health equity, by supporting—

(1) resources to strengthen institutional metrics and capacity to execute institution-wide health workforce goals that can serve as models for increasing health equity in communities across the United States;

(2) collaborations among a cohort of institutions in implementing systemic change, partnership development, and programmatic efforts supportive of health equity goals across disciplines and populations; and

(3) enhanced or newly developed data systems and research infrastructure capable of informing current and future workforce efforts and building a foundation for a broader research agenda targeting urban health disparities.

(c) STRATEGIC PARTNERSHIPS.—As a condition on receipt of a grant under subsection (a), an institution of higher education shall agree to use the grant to develop a strategic partnership with the community in which such institution is located for the purposes of—

(1) strengthening connections between such institution and the community—

(A) to improve evaluation of, and address, the health and health workforce needs of such community; and

(B) to engage such community in health workforce development;

(2) developing, enhancing, or accelerating innovative undergraduate and graduate programs in the biomedical sciences and health professions; and

(3) strengthening pipeline programs in the biomedical sciences and health professions, including by developing partnerships between institutions of higher education and elementary schools and secondary schools to recruit the next generation of health professionals earlier in the pipeline to a health care career.

(d) ELIGIBLE INSTITUTION OF HIGHER EDUCATION DEFINED.—For purposes of this section, an ''eligible institution of higher education'' includes—

(1) a program authorized under section 317(a) of the Higher Education Act of 1965 (20 U.S.C. 1059d(a)); or

(2) a professional or graduate institution described in section 326 of such Act (20 U.S.C. 1063b).

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

SEC. 3011. HEALTH PROFESSIONS WORKFORCE FUND.

(a) ESTABLISHMENT.—There is established in the Health Resources and Services Administration of the Department of Health and Human Services a Health Professions Workforce Fund to provide for expanded and sustained national investment in the health professions and nursing workforce development programs under title VII and title VIII of the Public Health Service Act (42 U.S.C. 292 et seq.; 42 U.S.C. 296 et seq.).

(b) FUNDING.—

(1) IN GENERAL.—There is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Health Professions Workforce Fund—

(A) $392,000,000 for fiscal year 2023;

(B) $412,000,000 for fiscal year 2024;

(C) $432,000,000 for fiscal year 2025;

(D) $454,000,000 for fiscal year 2026;

(E) $476,000,000 for fiscal year 2027;

(F) $500,000,000 for fiscal year 2028;

(G) $525,000,000 for fiscal year 2029; and

(H) $552,000,000 for fiscal year 2030.

(2) HEALTH PROFESSIONS EDUCATION PROGRAMS.—For the purpose of carrying out health professions education programs authorized under title VII of the Public Health Service Act (42 U.S.C. 292 et seq.), in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated out of any monies in the Health Professions Workforce Fund, the following:

(A) $265,000,000 for fiscal year 2023.

(B) $278,000,000 for fiscal year 2024.

(C) $292,000,000 for fiscal year 2025.

(D) $307,000,000 for fiscal year 2026.

(E) $322,000,000 for fiscal year 2027.

(F) $338,000,000 for fiscal year 2028.

(G) $355,000,000 for fiscal year 2029.

(H) $373,000,000 for fiscal year 2030.

(3) NURSING WORKFORCE DEVELOPMENT PROGRAMS.—For the purpose of carrying out nursing workforce development programs authorized under title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.), in addition to any other amounts authorized to be appropriated for such purpose, there is authorized to be appropriated out of

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

(A) $127,000,000 for fiscal year 2023.

(B) $134,000,000 for fiscal year 2024.

(C) $140,000,000 for fiscal year 2025.

(D) $147,000,000 for fiscal year 2026.

(E) $154,000,000 for fiscal year 2027.

(F) $162,000,000 for fiscal year 2028.

(G) $170,000,000 for fiscal year 2029.

(H) $179,000,000 for fiscal year 2030.

SEC. 3012. FUTURE ADVANCEMENT OF ACADEMIC NURSING.

(a) SUPPORT FOR NURSING EDUCATION AND THE FUTURE NURSING WORKFORCE.—Part D of title VIII of the Public Health Service Act (42 U.S.C. 296p et seq.) is amended by adding at the end the following:

"SEC. 832. NURSING EDUCATION ENHANCEMENT AND MODERNIZATION GRANTS IN UNDERSERVED AREAS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may award grants to schools of nursing for—

''(1) increasing the number of faculty and students at such schools in order to enhance the pre-

paredness of the United States for, and the ability of the United States to address and quickly respond to, public health emergencies declared under section 319 and pandemics; or

''(2) the enhancement and modernization of nursing education programs.

''(b) PRIORITY.—In selecting grant recipients under this section, the Secretary shall give priority to schools of nursing that—

''(1) are located in a medically underserved community;

''(2) are located in a health professional shortage area as defined under section 332(a); or

''(3) are institutions of higher education listed under section 371(a) of the Higher Education Act of 1965.

''(c) CONSIDERATION.—In awarding grants under this section, the Secretary, to the extent practicable, may ensure equitable distribution of awards among the geographic regions of the United States.

''(d) USE OF FUNDS.—A school of nursing that receives a grant under this section may use the funds awarded through such grant for activities that include—

''(1) enhancing enrollment and retention of students at such school, with a priority for students

from disadvantaged backgrounds (including racial or ethnic groups underrepresented in the nursing workforce), individuals from rural and underserved areas, low-income individuals, and first generation college students (as defined in section 402A(h)(3) of the Higher Education Act of 1965);

''(2) creating, supporting, or modernizing educational programs and curriculum at such school;

''(3) retaining current faculty, and hiring new faculty, with an emphasis on faculty from racial or ethnic groups who are underrepresented in the nursing workforce;

''(4) modernizing infrastructure at such school, including audiovisual or other equipment, personal protective equipment, simulation and augmented reality resources, telehealth technologies, and virtual and physical laboratories;

''(5) partnering with a health care facility, nurse-managed health clinic, community health center, or other facility that provides health care in order to provide educational opportunities for the purpose of establishing or expanding clinical education;

''(6) enhancing and expanding nursing programs that prepare nurse researchers and scientists;

''(7) establishing nurse-led intradisciplinary and interprofessional educational partnerships; and

''(8) other activities that the Secretary determines further the development, improvement, and expansion of schools of nursing.

''(e) REPORTS FROM ENTITIES.—Each school of nursing awarded a grant under this section shall submit an annual report to the Secretary on the activities conducted under such grant, and other information as the Secretary may require.

''(f) REPORT TO CONGRESS.—Not later than 5 years after the date of the enactment of this section, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that provides a summary of the activities and outcomes associated with grants made under this section. Such report shall include—

''(1) a list of schools of nursing receiving grants under this section, including the primary geographic location of any school of nursing that was improved or expanded through such a grant;

''(2) the total number of students who are enrolled at or who have graduated from any school of

nursing that was improved or expanded through a grant under this section, which such statistic shall—

"(A) to the extent such information is available, be deidentified and disaggregated by race, ethnicity, age, sex, geographic region, disability status, and other relevant factors; and

"(B) include an indication of the number of such students who are from racial or ethnic groups underrepresented in the nursing workforce, such students who are from rural or underserved areas, such students who are low-income students, and such students who are first generation college students (as defined in section 402A(h)(3) of the Higher Education Act of 1965);

"(3) to the extent such information is available, the effects of the grants awarded under this section on retaining and hiring of faculty, including any increase in diverse faculty, the number of clinical education partnerships, the modernization of nursing education infrastructure, and other ways this section helps address and quickly respond to public health emergencies and pandemics;

"(4) recommendations for improving the grants awarded under this section; and

''(5) any other considerations as the Secretary determines appropriate.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $1,000,000,000, to remain available until expended.''.

(b) STRENGTHENING NURSE EDUCATION.— The heading of part D of title VIII of the Public Health Service Act (42 U.S.C. 296p et seq.) is amended by striking ''**BASIC**''.

SEC. 3013. FINDINGS; SENSE OF CONGRESS RELATING TO GRADUATE MEDICAL EDUCATION.

(a) FINDINGS.—Congress finds the following:

(1) Projections by the Association of American Medical Colleges and other expert entities, such as the Health Resources and Services Administration, have indicated a nationwide shortage of up to 121,900 physicians, split evenly between primary care and specialists, by 2032.

(2) Primarily due to the growing and aging population, over the next decade, physician demand is expected to grow up to 17 percent.

(3) The United States Census Bureau estimates that the United States population will grow from 321,000,000 in 2015 to 347,000,000 in 2025. Fur-

ther, the number of Medicare beneficiaries is estimated to increase from 47,800,000 in 2015 to approximately 66,000,000 in 2025.

(4) Approximately 36 percent of practicing physicians are over the age of 55 and are likely to retire within the next decade.

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

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

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

(8) The health care utilization equity model of the Association of American Medical Colleges estimates that if racial and ethnic minorities and individuals from rural areas utilized health care in a similar way to their Caucasian counterparts living in metropolitan areas, the physician shortage would require an additional 96,000 physicians.

(9) To address the physician shortage in rural and medically underserved areas, medical education and training need to be accessible to underrepresented minorities (including individuals who are African American, Hispanic, Native American, or Native Hawaiian), and need to increase pathway programs for such underrepresented minorities who make up less than 12 percent of individuals enrolled in graduate medical education and for international students who make up 25 percent of individuals enrolled in graduate medical education. Immigration pathways like student, exchange-visitor, and employment visas, and programs like the National Interest Waiver and Conrad 30 J–1 Visa Waiver, help improve health access across the United States.

(10) United States medical school enrollment was expected to grow by 30 percent from 2018 to

2019 to help reduce the shortage of quality physicians in the United States.

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

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

(13) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (having more beneficiaries than any other health care program), supports its ''fair share'' of the costs associated with graduate medical education.

(14) In general, the level of support of graduate medical education by the Medicare program has been capped since 1997 and has not been increased

to support the expansion of graduate medical education programs needed to avert the projected physician shortage or to accommodate the increase in United States medical school graduates.

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

(1) ensuring an appropriate supply of physicians to meet the health care needs in the United States;

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

(3) increasing the racial and ethnic diversity of physicians in the United States; and

(4) mitigating disparities in health and health care.

SEC. 3014. CAREER SUPPORT FOR SKILLED, INTERNATIONALLY EDUCATED HEALTH PROFESSIONALS.

(a) FINDINGS.—Congress finds the following:

(1) According to a 2018 study, the State and local public health workforce has shrunk by more than 50,000 individuals since the beginning of the

2008 Great Recession, and almost one quarter of individuals comprising the governmental public health workforce plan to leave or retire in the coming years.

(2) Shortages are projected for other health professions, including within the fields of nursing (500,000 by 2025), dentistry (15,000 by 2025), pharmacy (38,000 by 2030), mental and behavioral health (236,880 by 2025), and primary care (46,000 by 2025).

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

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

(5) According to the Migration Policy Institute, more than 2,000,000 college-educated immigrants in the United States today are unemployed or underemployed in low- or semi-skilled jobs that fail to draw on their education and expertise.

(6) Approximately 2 out of every 5 internationally educated immigrants are unemployed or underemployed.

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

(8) According to the Drexel University Center for Labor Markets and Policy, the mean annual earnings of underemployed immigrants were $32,000, or 43 percent less than United States born college graduates employed in the college labor market.

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

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

(b) GRANTS TO ELIGIBLE ENTITIES.—

(1) AUTHORITY TO PROVIDE GRANTS.—The Secretary of Health and Human Services acting

through the Bureau of Health Workforce within the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities, or the Office of Minority Health (in this section referred to as the ''Secretary'') may award grants to eligible entities under paragraph (2) to carry out activities described in subsection (c).

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

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

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

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

(1) to provide services to assist unemployed and underemployed skilled immigrants, residing in the United States, who have legal, permanent work authorization and who are internationally educated

health professionals, enter into the health workforce of the United States with employment matching their health professional skills and education, and advance in employment to positions that better match their health professional education and expertise;

(2) to provide training opportunities to reduce barriers to entry and advancement in the health workforce for skilled, internationally educated immigrants;

(3) to educate employers regarding the abilities and capacities of internationally educated health professionals;

(4) to assist in the evaluation of foreign credentials;

(5) to support preceptorships for international medical graduates in hospital primary care training; and

(6) to facilitate access to contextualized and accelerated courses on English as a second language.

SEC. 3015. STUDY AND REPORT ON STRATEGIES FOR INCREASING DIVERSITY.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on strategies for increasing the diversity of the health professional workforce. Such

study shall include an analysis of strategies for increasing the number of health professionals from rural, lower income, and underrepresented minority communities, including which strategies are most effective for achieving such goal.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 3016. CONRAD STATE 30 PROGRAM; PHYSICIAN RETENTION.

(a) CONRAD STATE 30 PROGRAM EXTENSION.—Section 220(c) of the Immigration and Nationality Technical Corrections Act of 1994 (Public Law 103–416; 8 U.S.C. 1182 note) is amended by striking ''September 30, 2015'' and inserting ''September 30, 2022''.

(b) RETAINING PHYSICIANS WHO HAVE PRACTICED IN MEDICALLY UNDERSERVED COMMUNITIES.—Section 201(b)(1) of the Immigration and Nationality Act (8 U.S.C. 1151(b)(1)) is amended by adding at the end the following:

''(F)(i) Alien physicians who have completed service requirements for a national inter-

est waiver requested under section 203(b)(2)(B)(ii), including—

"(I) alien physicians who completed such service before the date of the enactment of the Health Equity and Accountability Act of 2022; and

"(II) the spouse or children of an alien physician described in subclause (I).

"(ii) Nothing in this subparagraph may be construed—

"(I) to prevent the filing of a petition with the Secretary of Homeland Security for classification under section 204(a) or the filing of an application for adjustment of status under section 245 by an alien physician described in 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-

ices as having a shortage of health care professionals; or

''(II) to permit the Secretary of Homeland Security to grant a petition or application described in subclause (I) until the alien has satisfied all of the requirements of the waiver received under section 214(l).''.

(c) EMPLOYMENT PROTECTIONS FOR PHYSICIANS.—

(1) EXCEPTIONS TO 2-YEAR FOREIGN RESIDENCY REQUIREMENT.—Section 214(l)(1) of the Immigration and Nationality Act (8 U.S.C. 1184(l)(1)) is amended—

(A) in the matter preceding subparagraph (A), by striking ''Attorney General shall not'' and inserting ''Secretary of Homeland Security may not'';

(B) in subparagraph (A), by striking ''Director of the United States Information Agency'' and inserting ''Secretary of State'';

(C) in subparagraph (B), by inserting '', except as provided in paragraphs (7) and (8)'' before the semicolon at the end;

(D) in subparagraph (C), by amending clauses (i) and (ii) to read as follows:

"(i) the alien demonstrates a bona fide offer of full-time employment at a health facility or health care organization, which employment has been determined by the Secretary of Homeland Security to be in the public interest; and

"(ii) the alien—

"(I) has accepted employment with the health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals;

"(II) begins employment by the later of the date that is—

"(aa) 120 days after receiving such waiver;

"(bb) 120 days after completing graduate medical education or training under a program approved pursuant to section 212(j)(1); or

"(cc) 120 days after receiving nonimmigrant status or em-

ployment authorization, if the alien or the alien's employer petitions for such nonimmigrant status or employment authorization not later than 120 days after the date on which the alien completes his or her graduate medical education or training under a program approved pursuant to section 212(j)(1); and

''(III) agrees to continue to work for a total of not less than 3 years in the status authorized for such employment under this subsection, except as provided in paragraph (8); and''; and

(E) in subparagraph (D), in the matter preceding clause (i), by inserting '', subject to paragraph (8),'' before ''in the case''.

(2) ALLOWABLE VISA STATUS FOR PHYSICIANS FULFILLING WAIVER REQUIREMENTS IN MEDICALLY UNDERSERVED AREAS.—Section 214(l)(2)(A) of such Act (8 U.S.C. 1184(l)(2)(A)) is amended to read as follows:

''(A) Upon the request of an interested Federal agency or an interested State agency

for recommendation of a waiver under this section by a physician who is maintaining valid nonimmigrant status under section 101(a)(15)(J) and received a favorable recommendation by the Secretary of State, the Secretary of Homeland Security may change the status of such physician to any status authorized for employment under this Act. The numerical limitations set forth in subsection (g)(1)(A) shall not apply to any alien whose status is changed under this subparagraph.''.

(3) VIOLATION OF AGREEMENTS.—Section 214(l)(3)(A) of such Act (8 U.S.C. 1184(l)(3)(A)) is amended by inserting ''substantial requirement of an'' before ''agreement entered into''.

(4) PHYSICIAN EMPLOYMENT IN UNDERSERVED AREAS.—Section 214(l) of such Act (8 U.S.C. 1184(l)), as amended by this section, is further amended by adding at the end the following:

''(4)(A) If an interested State agency denies the application for a waiver under paragraph (1)(B) from a physician pursuing graduate medical education or training pursuant to section 101(a)(15)(J) because the State has requested the maximum number of waivers permitted for that fiscal year, the

physician's nonimmigrant status shall be extended for up to 6 months if the physician agrees to seek a waiver under this subsection (except for paragraph (1)(D)(ii)) to work for an employer described in paragraph (1)(C) in a State that has not yet requested the maximum number of waivers.

''(B) A physician described in subparagraph (A) may only work for the employer referred to in subparagraph (A) during the period beginning on the date on which a new waiver application is filed with such State and ending on the earlier of—

''(i) the date on which the Secretary of Homeland Security denies such waiver; or

''(ii) the date on which the Secretary approves an application for change of status under paragraph (2)(A) pursuant to the approval of such waiver.''.

(5) CONTRACT REQUIREMENTS.—Section 214(l) of such Act, as amended by this section, is further amended by adding at the end the following:

''(5) An alien granted a waiver under paragraph (1)(C) shall enter into an employment agreement with the contracting health facility or health care organization that—

"(A) specifies the maximum number of on-call hours per week (which may be a monthly average) that the alien will be expected to be available and the compensation the alien will receive for on-call time;

"(B) specifies—

"(i) whether the contracting facility or organization will pay the alien's malpractice insurance premiums;

"(ii) whether the employer will provide malpractice insurance; and

"(iii) the amount of such insurance that will be provided;

"(C) describes all of the work locations that the alien will work including a statement that the contracting facility or organization will not add additional work locations without the approval of the Federal agency or State agency that requested the waiver; and

"(D) does not include a non-compete provision.

"(6) An alien granted a waiver under this subsection whose employment relationship with a health facility or health care organization terminates under paragraph (1)(C)(ii) during the 3-year service period

required under paragraph (1) shall be considered to be maintaining lawful status in an authorized period of stay during the 120-day period referred to in items (aa) and (bb) of subclause (III) of paragraph (1)(C)(ii) or the 45-day period referred to in subclause (III)(cc) of such paragraph.''.

(6) RECAPTURING WAIVER SLOTS LOST TO OTHER STATES.—Section 214(l) of such Act, as amended by this section, is further amended by adding at the end the following:

''(7) If a recipient of a waiver under this subsection terminates the recipient's employment with a health facility or health care organization pursuant to paragraph (1)(C)(ii), including termination of employment because of circumstances described in paragraph (1)(C)(ii)(III), and accepts new employment with such a facility or organization in a different State, the State from which the alien is departing may be accorded an additional waiver by the Secretary of State for use in the fiscal year in which the alien's employment was terminated.''.

(7) EXCEPTION TO 3-YEAR WORK REQUIREMENT.—Section 214(l) of such Act, as amended by this section, is further amended by adding at the end the following:

''(8) The 3-year work requirement set forth in subparagraphs (C) and (D) of paragraph (1) shall not apply if—

''(A)(i) the Secretary of Homeland Security determines that extenuating circumstances, including violations by the employer of the employment agreement with the alien or of labor and employment laws, exist that justify a lesser period of employment at such facility or organization; and

''(ii) not later than 120 days after the employment termination date (unless the Secretary determines that extenuating circumstances would justify an extension), the alien demonstrates another bona fide offer of employment at a health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals, for the remainder of such 3-year period;

''(B)(i) the interested State agency that requested the waiver attests that extenuating circumstances, including violations by the employer of the employment agreement with the

alien or of labor and employment laws, exist that justify a lesser period of employment at such facility or organization; and

''(ii) the alien demonstrates, not later than 120 days after the employment termination date (unless the Secretary determines that extenuating circumstances would justify an extension), another bona fide offer of employment at a health facility or health care organization in a geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals, for the remainder of such 3-year period; or

''(C) the alien—

''(i) elects not to pursue a determination of extenuating circumstances pursuant to subclause (A) or (B);

''(ii) terminates the alien's employment relationship with the health facility or health care organization at which the alien was employed;

''(iii) not later than 45 days after the employment termination date, demonstrates another bona fide offer of em-

ployment at a health facility or health care organization in a geographic area or areas, in the State that requested the alien's waiver, which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(iv) agrees to be employed for the remainder of such 3-year period, and 1 additional year for each termination under clause (ii).''.

(d) ALLOTMENT OF CONRAD 30 WAIVERS.—

(1) IN GENERAL.—Section 214(l) of the Immigration and Nationality Act (8 U.S.C. 1184(l)), as amended by subsection (c), is further amended by adding at the end the following:

''(9)(A)(i) All States shall be allotted 35 waivers under paragraph (1)(B) for each fiscal year if 90 percent of the waivers available to the States receiving at least 5 waivers were used in the previous fiscal year.

''(ii) When an allotment occurs under clause (i), all States shall be allotted an additional 5 waivers under paragraph (1)(B) for each subsequent fiscal year if 90 percent of the waivers available to the States receiving at least 5 waivers were used in the previous fiscal year. If

the States are allotted 45 or more waivers for a fiscal year, the States will only receive an additional increase of 5 waivers the following fiscal year if 95 percent of the waivers available to the States receiving at least 1 waiver were used in the previous fiscal year.

''(B) Any increase in allotments under subparagraph (A) shall be maintained indefinitely, unless in a fiscal year the total number of such waivers granted is 5 percent lower than in the last year in which there was an increase in the number of waivers allotted pursuant to this paragraph. In such case—

''(i) the number of waivers allotted beginning in the next fiscal year shall be decreased by 5 for all States; and

''(ii) each additional 5 percent decrease in such waivers granted from the last year in which there was an increase in the allotment, shall result in an additional decrease of 5 waivers allotted for all States, provided that the number of waivers allotted for all States shall not drop below 30.''.

(2) ACADEMIC MEDICAL CENTERS.—Section 214(l)(1)(D) of such Act, as amended by subsection (c)(1)(E), is further amended—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iv) in the case of a request by an interested State agency—

''(I) the head of such agency determines that the alien is to practice medicine in, or be on the faculty of a residency program at, an academic medical center (as defined in section 411.355(e)(2) of title 42, Code of Federal Regulations), without regard to whether such facility is located within an area designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

''(II) the head of such agency determines that—

''(aa) the alien physician's work is in the public interest; and

''(bb) subject to paragraph (6), the grant of such waiver would not cause the number of the waivers granted on behalf of aliens for such State for a fiscal year to exceed 3,

within the limitation under subparagraph (B).''.

(e) AMENDMENTS TO THE PROCEDURES, DEFINITIONS, AND OTHER PROVISIONS RELATED TO PHYSICIAN IMMIGRATION.—

(1) DUAL INTENT FOR PHYSICIANS SEEKING GRADUATE MEDICAL TRAINING.—Section 214(b) of the Immigration and Nationality Act (8 U.S.C. 1184(b)) is amended by striking ''and other than a nonimmigrant described in any provision of section 101(a)(15)(H)(i) except subclause (b1) of such section)'' and inserting ''a nonimmigrant described in any provision of section 101(a)(15)(H)(i) (except subclause (b1) of such section), and an alien coming to the United States to receive graduate medical education or training as described in section 212(j) or to take examinations required to receive graduate medical education or training as described in section 212(j))''.

(2) PHYSICIAN NATIONAL INTEREST WAIVER CLARIFICATIONS.—

(A) PRACTICE AND GEOGRAPHIC AREA.—Section 203(b)(2)(B)(ii)(I) of the Immigration and Nationality Act (8 U.S.C.

1153(b)(2)(B)(ii)(I)) is amended by striking items (aa) and (bb) and inserting the following:

''(aa) the alien physician agrees to work on a full-time basis practicing primary care, specialty medicine, or a combination thereof, in an area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals, or at a health care facility under the jurisdiction of the Secretary of Veterans Affairs; or

''(bb) the alien physician is pursuing such waiver based upon service at a facility or facilities that serve patients who reside in a geographic area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals (without regard to whether such facility or facilities are located within such an area) and a Federal agency, or a local, county, regional, or State department of public health determines the alien physician's work was or will be in the public interest.''.

(B) FIVE-YEAR SERVICE REQUIREMENT.—Section 203(b)(2)(B)(ii) of such Act is amended—

(i) by moving subclauses (II), (III), and (IV) 4 ems to the left; and

(ii) in subclause (II)—

(I) by inserting ''(aa)'' after ''(II)''; and

(II) by adding at the end the following:

''(bb) The 5-year service requirement described in item (aa) shall begin on the date on which the alien physician begins work in the shortage area in any legal status and not on the date on which an immigrant visa petition is filed or approved. Such service shall be aggregated without regard to when such service began and without regard to whether such service began during or in conjunction with a course of graduate medical education.

''(cc) An alien physician shall not be required to submit an employment contract with a term exceeding the balance of the 5-year commitment yet to be served or an

employment contract dated within a minimum time period before filing a visa petition under this subsection.

''(dd) An alien physician shall not be required to file additional immigrant visa petitions upon a change of work location from the location approved in the original national interest immigrant petition.''.

(3) TECHNICAL CLARIFICATION REGARDING ADVANCED DEGREE FOR PHYSICIANS.—Section 203(b)(2)(A) of such Act is amended by adding at the end the following: ''An alien physician holding a foreign medical degree that has been deemed sufficient for acceptance by an accredited United States medical residency or fellowship program shall be considered a member of the professions holding an advanced degree or its equivalent for purposes of this paragraph.''.

(4) SHORT-TERM WORK AUTHORIZATION FOR PHYSICIANS COMPLETING THEIR RESIDENCIES.—

(A) IN GENERAL.—A physician completing graduate medical education or training described in section 212(j) of the Immigration and Nationality Act (8 U.S.C. 1182(j)) as a nonimmigrant described in section

101(a)(15)(H)(i) of such Act (8 U.S.C. 1101(a)(15)(H)(i))—

(i) shall have such nonimmigrant status automatically extended until October 1 of the fiscal year for which a petition for a continuation of such nonimmigrant status has been submitted in a timely manner and the employment start date for the beneficiary of such petition is October 1 of that fiscal year; and

(ii) shall be authorized to be employed incident to status during the period between the filing of such petition and October 1 of such fiscal year.

(B) TERMINATION.—The status and employment authorization of a physician described in subparagraph (A) shall terminate on the date that is 30 days after the date on which a petition described in clause (i)(I) is rejected, denied or revoked.

(C) AUTOMATIC EXTENSION.—The status and employment authorization of a physician described in subparagraph (A) will automatically extend to October 1 of the next fiscal year if all of the visas described in section

101(a)(15)(H)(i) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(i)) that were authorized to be issued for the fiscal year have been issued.

(5) APPLICABILITY OF SECTION 212(e) TO SPOUSES AND CHILDREN OF J–1 EXCHANGE VISITORS.—A spouse or child of an exchange visitor described in section 101(a)(15)(J) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(J)) shall not be subject to the requirements under section 212(e) of such Act (8 U.S.C. 1182(e)).

SEC. 3017. NATIONAL HISPANIC NURSES DAY.

(a) FINDINGS.—Congress finds the following:

(1) A special group of nurses in the Nation are the Hispanic nurses.

(2) Hispanic nurses provide culturally and ethnically competent care and are educated to be sensitive to regional and community customs of persons needing care.

(3) Hispanic nurses are well-positioned to provide leadership to eliminate health care disparities that exist in the Nation.

(4) Since 1975, the National Association of Hispanic Nurses (NAHN) has represented Hispanic nurses (RNs/LPNs) in the United States and is the

only nursing organization for Hispanic nurses whose mission is to advance the health in Hispanic communities and to lead, promote, and advocate for educational, professional, and leadership opportunities for Hispanic nurses.

(5) Since September is the month that has been set aside to honor the contributions of Hispanics, it is only fitting that Hispanic nurses be recognized and honored during this time for their outstanding contributions to their community and country.

(6) The designation of an observation day will help to raise awareness of the accomplishments of Hispanic nurses and pave the way for the important work that they must continue to carry out.

(7) Each February, the National Association of Hispanic Nurses convenes nearly 100 nursing leaders from academia, research, education, and practice in the District of Columbia for a day on Capitol Hill promoting legislation that improves the health of Hispanic communities.

(8) Hispanic nurses are strong allies to Congress as they help inform, educate, and work closely with legislators to improve the education, retention, recruitment, and practice of all nurses and, more

importantly, the health and safety of the patients for whom they provide care.

(9) Hispanic nurses add needed diversity to the nursing profession, and these nurses have engaged in numerous ways to support communities and the needs of an overlooked, under resourced, and underserved population being severely impacted by COVID–19.

(b) SENSE OF CONGRESS.—The Congress—

(1) supports the goals and ideals, and the designation, of National Hispanic Nurses Day, as proposed by the National Association of Hispanic Nurses;

(2) recognizes the significant contributions of Hispanic nurses to the health care system of the United States; and

(3) encourages the people of the United States to observe National Hispanic Nurses Day with appropriate recognition, ceremonies, activities, and programs to demonstrate the importance of Hispanic nurses to the everyday lives of patients and the communities they serve.

SEC. 3018. EXPANDING MEDICAL EDUCATION.

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

"SEC. 749C. GRANTS FOR SCHOOLS OF MEDICINE AND SCHOOLS OF OSTEOPATHIC MEDICINE IN UNDERSERVED AREAS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may award grants to institutions of higher education (including consortiums of such institutions) for the establishment, improvement, or expansion of a school of medicine or osteopathic medicine, or a branch campus of a school of medicine or osteopathic medicine.

''(b) PRIORITY.—In selecting grant recipients under this section, the Secretary shall give priority to any institution of higher education (or consortium of such institutions) that—

''(1) proposes to use the grant for the establishment of a school of medicine or osteopathic medicine, or a branch campus of a school of medicine or osteopathic medicine, in an area—

''(A) in which no other such school is based; and

"(B) that is a medically underserved community or a health professional shortage area; or

"(2) is an institution described in section 371(a) of the Higher Education Act of 1965.

"(c) CONSIDERATIONS.—In awarding grants under this section, the Secretary, to the extent practicable, may ensure equitable distribution of awards among the geographical regions of the United States.

"(d) USE OF FUNDS.—An institution of higher education (or a consortium of such institutions)—

"(1) shall use grant amounts received under this section to—

"(A) recruit, enroll, and retain students, including individuals who are from disadvantaged backgrounds (including racial and ethnic groups underrepresented among medical students and health professions), individuals from rural and underserved areas, low-income individuals, and first generation college students, at a school of medicine or osteopathic medicine or branch campus of a school of medicine or osteopathic medicine; and

"(B) develop, implement, and expand curriculum that emphasizes care for rural and un-

derserved populations, including accessible and culturally and linguistically appropriate care and services, at such school or branch campus; and

''(2) may use grant amounts received under this section to—

''(A) plan and construct—

''(i) a school of medicine or osteopathic medicine in an area in which no other such school is based; or

''(ii) a branch campus of a school of medicine or osteopathic medicine in an area in which no other such school is based;

''(B) plan, develop, and meet criteria for accreditation for a school of medicine or osteopathic medicine or branch campus of a school of medicine or osteopathic medicine;

''(C) hire faculty, including faculty from racial and ethnic groups who are underrepresented among the medical and other health professions, and other staff to serve at such a school or branch campus;

''(D) support educational programs at such a school or branch campus;

''(E) modernize and expand infrastructure at such a school or branch campus; and

''(F) support other activities that the Secretary determines further the establishment, improvement, or expansion of a school of medicine or osteopathic medicine or branch campus of a school of medicine or osteopathic medicine.

''(e) APPLICATION.—To be eligible to receive a grant under subsection (a), an institution of higher education (or a consortium of such institutions), shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a description of the institution's or consortium's planned activities described in subsection (d).

''(f) REPORTING.—

''(1) REPORTS FROM ENTITIES.—Each institution of higher education, or consortium of such institutions, awarded a grant under this section shall submit an annual report to the Secretary on the activities conducted under such grant, and other information as the Secretary may require.

''(2) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of this section and every 5 years thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and

Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that provides a summary of the activities and outcomes associated with grants made under this section. Such reports shall include—

''(A) a list of awardees, including their primary geographic location, and location of any school of medicine or osteopathic medicine, or a branch campus of a school of medicine or osteopathic medicine that was established, improved, or expanded under a grant awarded under this section;

''(B) the total number of students (including the number of students from racial and ethnic groups underrepresented among medical students and health professions, low-income students, and first generation college students) who—

''(i) are enrolled at or who have graduated from any school of medicine or osteopathic medicine, or a branch campus of z school of medicine or osteopathic medicine, that was established, improved, or expanded under a grant awarded under this section, deidentified and disaggregated by

race, ethnicity, age, sex, geographic region, disability status, and other relevant factors, to the extent such information is available; and

''(ii) subsequently participate in an accredited internship or medical residency program upon graduation from any school of medicine or osteopathic medicine, or a branch campus of a school of medicine or osteopathic medicine, that was established, improved, or expanded under a grant awarded under this section, deidentified and disaggregated by race, ethnicity, age, sex, geographic region, disability status, medical specialty pursued, and other relevant factors, to the extent such information is available;

''(C) the effects of the grants awarded under this section on the health care provider workforce, including any impact on demographic representation disaggregated by race, ethnicity, and sex, and the fields or specialties pursued by students who have graduated from any school of medicine or osteopathic medicine, or a branch campus of a school of medicine or

osteopathic medicine, that was established, improved, or expanded under a grant awarded under this section;

''(D) the effects of the grants awarded under this section on health care access in underserved areas, including medically underserved communities and health professional shortage areas; and

''(E) recommendations for improving the grants awarded under this section, and any other considerations as the Secretary determines appropriate.

''(3) PUBLIC AVAILABILITY.—The Secretary shall make reports submitted under paragraph (2) publicly available on the internet website of the Department of Health and Human Services.

''(g) DEFINITIONS.—In this section:

''(1) BRANCH CAMPUS.—

''(A) IN GENERAL.—The term 'branch campus', with respect to a school of medicine or osteopathic medicine, means an additional location of such school that is geographically apart and independent of the main campus, at which the school offers at least 50 percent of the program leading to a degree of doctor of medicine

or doctor of osteopathy that is offered at the main campus.

''(B) INDEPENDENCE FROM MAIN CAMPUS.—For purposes of subparagraph (A), the location of a school described in such subparagraph shall be considered to be independent of the main campus described in such subparagraph if the location—

''(i) is permanent in nature;

''(ii) offers courses in educational programs leading to a degree, certificate, or other recognized educational credential;

''(iii) has its own faculty and administrative or supervisory organization; and

''(iv) has its own budgetary and hiring authority.

''(2) FIRST GENERATION COLLEGE STUDENT.—The term 'first generation college student' has the meaning given such term in section 402A(h)(3) of the Higher Education Act of 1965.

''(3) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term in section 332(a).

''(4) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the

meaning given such term in section 101 of the Higher Education Act of 1965.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $1,000,000,000, to remain available until expended.''.

TITLE IV—IMPROVING HEALTH CARE ACCESS AND QUALITY

SEC. 4000. DEFINITION.

In this title and the amendments made by this title, the term ''health care'' includes all health care needed throughout the life cycle and the end of life.

Subtitle A—Reducing Barriers to Accessing Care

SEC. 4001. PROTECTING PROTECTED AREAS.

Section 287 of the Immigration and Nationality Act (8 U.S.C. 1357) is amended—

(1) by striking ''Service'' each place such term appears and inserting ''Department of Homeland Security'';

(2) by striking ''Attorney General'' each place such term appears and inserting ''Secretary of Homeland Security'';

(3) in subsection (f)(1), by striking ''Commissioner'' and inserting ''Director of U.S. Citizenship and Immigration Services'';

(4) in subsection (h)—

(A) by striking ''of the Immigration and Nationality Act''; and

(B) by striking ''of such Act''; and

(5) by adding at the end the following:

''(i)(1) In this subsection:

''(A) The term 'appropriate congressional committees' means—

''(i) the Committee on Homeland Security and Governmental Affairs of the Senate;

''(ii) the Committee on the Judiciary of the Senate;

''(iii) the Committee on Homeland Security of the House of Representatives; and

''(iv) the Committee on the Judiciary of the House of Representatives.

''(B) The term 'enforcement action'—

''(i) means an apprehension, arrest, inspection interview, request for identification, search, seizure, service of charging documents or subpoenas, or surveillance for the purposes of immigration enforcement; and

"(ii) includes an enforcement action at, or focused on, a protected area that is part of a joint case led by another law enforcement agency.

"(C) The term 'exigent circumstances' means a situation involving—

"(i) the imminent risk of death, violence, or physical harm to any person or property, including a situation implicating terrorism or the national security of the United States;

"(ii) the immediate arrest or pursuit of a dangerous felon, terrorist suspect, or other individual presenting an imminent danger; or

"(iii) the imminent risk of destruction of evidence that is material to an ongoing criminal case.

"(D) The term 'protected area' includes all of the physical space located within 1,000 feet of—

"(i) any medical treatment or mental health care facility, including any hospital, doctor's office, health clinic, alcohol or drug prevention, counseling, or treatment facilities, syringe exchange services, vaccination, treatment, or testing sites, emergent or urgent care facil-

ity, sites that serve pregnant individuals, or community health centers;

"(ii) any public or private school, including any known and licensed day care facility, preschool, sites of early childhood programs, primary school, secondary school, postsecondary school (including colleges and universities), or other institution of learning (including vocational or trade schools);

"(iii) any scholastic or education-related activity or event or before or after school program, including field trips and interscholastic events;

"(iv) any school bus or school bus stop;

"(v) places where children gather such as a playground, recreation center, library, foster care facility, or group home for children;

"(vi) any physical structure of an organization or subdivision of government that—

"(I) assists children, pregnant women, victims of crime or abuse, or individuals with significant mental or physical disabilities;

"(II) provides social services and assistance, including homeless shelters, com-

munity-based organizations, facilities that serve disabled persons, drug or alcohol counseling and treatment facilities, food banks or food pantries, and other places providing emergency and disaster services or assistance with food and nutrition, housing affordability and income or other services funded by State or local government, charitable giving, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Social Security, or the United States Housing Act; or

''(III) provides hospice, palliative, or other available end-of-life care services to terminally ill persons;

''(vii) any church, synagogue, mosque, or other place of worship or religious study, including buildings rented for the purpose of religious services, retreats, counseling, workshops, instruction, and education;

''(viii) any Federal, State, or local courthouse, including the office of an individual's

legal counsel or representative, and a probation, parole, or supervised release office;

"(ix) the site of a funeral, grave-side ceremony, rosary, wedding, or other religious ceremony or observance;

"(x) any public demonstration, such as a march, rally, or parade;

"(xi) any domestic violence shelter, rape crisis center, child advocacy center, supervised visitation center, family justice center, or victim services provider;

"(xii) congressional district offices;

"(xiii) indoor and outdoor premises of departments of motor vehicles;

"(xiv) a place where disaster or emergency response and relief is provided, including evacuation routes, places where shelter or emergency supplies, food, or water are distributed, or places where registration for disaster-relief assistance or family reunification is underway; or

"(xv) any other location specified by the Secretary of Homeland Security for purposes of this subsection.

"(E) The term 'prior approval' means—

"(i) in the case of officers and agents of U.S. Immigration and Customs Enforcement, prior written approval to carry out an enforcement action involving a specific individual or individuals authorized by—

"(I) the Assistant Director of Operations, Homeland Security Investigations;

"(II) the Executive Associate Director, Homeland Security Investigations;

"(III) the Assistant Director for Field Operations, Enforcement and Removal Operations; or

"(IV) the Executive Associate Director for Field Operations, Enforcement and Removal Operations;

"(ii) in the case of officers and agents of U.S. Customs and Border Protection, prior written approval to carry out an enforcement action involving a specific individual or individuals authorized by—

"(I) a Chief Patrol Agent;

"(II) the Director of Field Operations;

"(III) the Director of Air and Marine Operations; or

"(IV) the Internal Affairs Special Agent in Charge; and

"(iii) in the case of other Federal, State, or local law enforcement officers, to carry out an enforcement action involving a specific individual or individuals authorized by—

"(I) the head of the Federal agency carrying out the enforcement action; or

"(II) the head of the State or local law enforcement agency carrying out the enforcement action.

"(2)(A) An enforcement action may not take place at, or be focused on, a protected area unless—

"(i) the action involves exigent circumstances; and

"(ii) prior approval for the enforcement action was obtained.

"(B) If an enforcement action is initiated pursuant to subparagraph (A) and the exigent circumstances permitting the enforcement action cease, the enforcement action shall be discontinued until such exigent circumstances reemerge.

"(C) If an enforcement action is carried out in violation of this subsection—

''(i) no information resulting from the enforcement action may be entered into the record or received into evidence in a removal proceeding resulting from the enforcement action; and

''(ii) the noncitizen who is the subject of such removal proceeding may file a motion for the immediate termination of the removal proceeding.

''(3)(A) This subsection shall apply to any enforcement action by officers or agents of the Department of Homeland Security, including—

''(i) officers or agents of U.S. Immigration and Customs Enforcement;

''(ii) officers or agents of U.S. Customs and Border Protection; and

''(iii) any individual designated to perform immigration enforcement functions pursuant to subsection (g).

''(B) While carrying out an enforcement action at a protected area, officers and agents referred to in subparagraph (A) shall make every effort—

''(i) to limit the time spent at the protected area;

''(ii) to limit the enforcement action at the protected area to the person or persons for whom prior approval was obtained; and

''(iii) to conduct themselves discreetly.

''(C) If, while carrying out an enforcement action that is not initiated at or focused on a protected area, officers or agents are led to a protected area, and no exigent circumstance and prior approval with respect to the protected area, such officers or agents shall—

''(i) cease before taking any further enforcement action;

''(ii) conduct themselves in a discreet manner;

''(iii) maintain surveillance on an individual; and

''(iv) immediately consult their supervisor in order to determine whether such enforcement action should be discontinued.

''(D) The limitations under this paragraph shall not apply to the transportation of an individual apprehended at or near a land or sea border to a hospital or health care provider for the purpose of providing medical care to such individual.

''(4)(A) Each official specified in subparagraph (B) shall ensure that the employees under his or her supervision receive annual training on compliance with—

''(i) the requirements under this subsection with respect to enforcement actions at or focused on pro-

tected areas and enforcement actions that lead officers or agents to a protected area; and

''(ii) the requirements under section 239 of this Act and section 384 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1367).

''(B) The officials specified in this subparagraph are—

''(i) the Chief Counsel of each Field Office of U.S. Immigration and Customs Enforcement;

''(ii) each Field Office Director of U.S. Immigration and Customs Enforcement;

''(iii) each Special Agent in Charge of U.S. Immigration and Customs Enforcement;

''(iv) each Chief Patrol Agent of U.S. Customs and Border Protection;

''(v) the Director of Field Operations of U.S. Customs and Border Protection;

''(vi) the Director of Air and Marine Operations of U.S. Customs and Border Protection;

''(vii) the Internal Affairs Special Agent in Charge of U.S. Customs and Border Protection; and

''(viii) the chief law enforcement officer of each State or local law enforcement agency that enters

into a written agreement with the Department of Homeland Security pursuant to subsection (g).

''(5) Not later than 180 days after the date of the enactment of the Health Equity and Accountability Act of 2022, the Secretary of Homeland Security shall modify the Notice to Appear form (I–862)—

''(A) to provide the subject of an enforcement action with information, written in plain language, summarizing the restrictions against enforcement actions at protected areas set forth in this subsection and the remedies available to the individual if such action violates such restrictions;

''(B) to ensure that the information described in subparagraph (A) is accessible to an individual with limited English proficiency; and

''(C) to ensure that a subject of an enforcement action is not permitted to verify that the officers or agents that carried out such action complied with the restrictions set forth in this subsection.

''(6)(A) The Director of U.S. Immigration and Customs Enforcement and the Commissioner of U.S. Customs and Border Protection shall each submit an annual report to the appropriate congressional committees that includes the information set forth in subparagraph (B) with respect to the respective agency.

''(B) Each report submitted under subparagraph (A) shall include, with respect to the submitting agency during the reporting period—

''(i) the number of enforcement actions that were carried out at, or focused on, a protected area;

''(ii) the number of enforcement actions in which officers or agents were subsequently led to a protected area; and

''(iii) for each enforcement action described in clause (i) or (ii)—

''(I) the date on which it occurred;

''(II) the specific site, city, county, and State in which it occurred;

''(III) whether the site was a protected area and, if so—

''(aa) identification of the protected area;

''(bb) each reason why the enforcement action was taken there;

''(cc) where the enforcement action was taken without prior approval, certification that notification to headquarters of a submitting agency was provided after the enforcement action took place; and

"(dd) a report of what occurred during and immediately after the enforcement action;

"(IV) the components of the agency involved in the enforcement action;

"(V) a description of the enforcement action, including the nature of the criminal activity of its intended target;

"(VI) the number of individuals, if any, arrested or taken into custody;

"(VII) the number of collateral arrests, if any, and the reasons for each such arrest;

"(VIII) a certification whether the location administrator of a protected area was contacted before, during, or after the enforcement action; and

"(IX) the percentage of all of the staff members and supervisors reporting to the officials listed in paragraph (4)(B) who completed the training required under paragraph (4)(A).

"(7) Nothing in the subsection may be construed—

"(A) to affect the authority of Federal, State, or local law enforcement agencies—

"(i) to enforce generally applicable Federal or State criminal laws unrelated to immigration; or

"(ii) to protect residents from imminent threats to public safety; or

"(B) to limit or override the protections provided in—

"(i) section 239; or

"(ii) section 384 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1367).".

SEC. 4002. REPEAL OF REQUIREMENT FOR DOCUMENTATION EVIDENCING CITIZENSHIP OR NATIONALITY UNDER THE MEDICAID PROGRAM.

(a) REPEAL.—Subsections (i)(22) and (x) of section 1903 of the Social Security Act (42 U.S.C. 1396b) are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) STATE PAYMENTS FOR MEDICAL ASSISTANCE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by amending paragraph (46) of subsection (a) to read as follows:

"(46) provide that information is requested and exchanged for purposes of income and eligibility

verification in accordance with a State system which meets the requirements of section 1137 of this Act;'';

(B) in subsection (e)(13)(A)(i)—

(i) in the matter preceding subclause (I), by striking ''sections 1902(a)(46)(B) and 1137(d)'' and inserting ''section 1137(d)''; and

(ii) in subclause (IV), by striking ''1902(a)(46)(B) or''; and

(C) by striking subsection (ee).

(2) REPEAL.—Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 (42 U.S.C. 1396b note) is repealed.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 4003. AVAILABILITY OF BASIC ASSISTANCE TO LAWFULLY PRESENT NONCITIZENS.

(a) ELIMINATION OF ARBITRARY ELIGIBILITY RESTRICTIONS.—

(1) IN GENERAL.—Sections 402, 403, 411, 412, 421, and 422 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8

U.S.C. 1612, 1613, 1621, 1622, 1631, and 1632) are repealed.

(2) CONFORMING AMENDMENTS.—Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1601 et seq.) is amended—

(A) in section 401(b)(5) of (8 U.S.C. 1611(b)(5)), by striking ''the program defined in section 402(a)(3)(A) (relating to the supplemental security income program)'' and inserting ''the Supplemental Security Income Program under title XVI of the Social Security Act (42 U.S.C. 1381 et seq.)'';

(B) in section 404(a) (8 U.S.C. 1614(a)), by striking '', 402, or 403'';

(C) in section 413 (8 U.S.C. 1625)—

(i) by striking ''A State'' and inserting the following:

''(a) STATE OR LOCAL PUBLIC BENEFIT DEFINED.—In this section, except as provided in paragraphs (2) and (3), the term 'State or local public benefit'—

''(1) means—

''(A) any grant, contract, loan, professional license, or commercial license provided by an agency of a State or local government or by ap-

propriated funds of a State or local government; and

''(B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government;

''(2) shall not apply—

''(A) to any contract, professional license, or commercial license for a nonimmigrant whose visa for entry is related to such employment in the United States, or to a citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99–239 or 99–658 (or a successor provision) is in effect;

''(B) with respect to benefits for an alien who as a work authorized nonimmigrant or as an alien lawfully admitted for permanent residence under the Immigration and Nationality Act qualified for such benefits and for whom

the United States under reciprocal treaty agreements is required to pay benefits, as determined by the Secretary of State, after consultation with the Attorney General; or

''(C) to the issuance of a professional license to, or the renewal of a professional license by, a foreign national not physically present in the United States; and

''(3) does not include any Federal public benefit.

''(b) PROOF OF ELIGIBILITY REQUIREMENT.—A 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))'';

(E) in section 435 (8 U.S.C. 1645), by striking ''(as provided under section 403)''; and

(F) in section 436 (8 U.S.C. 1646)—

(i) by striking ''the food stamp program (as defined in section 402(a)(3)(B))'' and inserting ''the supplemental nutrition assistance program established under the

Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.)''; and

(ii) by striking ''the supplemental security income program (as defined in section 402(a)(3)(A))'' and inserting ''the Supplemental Security Income Program under title XVI of the Social Security Act (42 U.S.C. 1381 et seq.)''.

(b) QUALIFIED NONCITIZENS.—Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1601 et seq.) is amended—

(1) in the title heading, by striking ''**ALIENS**'' and inserting ''**NONCITIZENS**'';

(2) in section 401, in the section heading—

(A) by striking ''**QUALIFIED ALIENS**'' and inserting ''**QUALIFIED NONCITIZENS**''; and

(B) by striking ''**ALIENS**'' and inserting ''**NONCITIZENS**'';

(3) by striking ''qualified alien'' each place it appears and inserting ''qualified noncitizen'';

(4) by striking ''qualified aliens'' each place it appears and inserting ''qualified noncitizens'';

(5) by striking ''qualified alien's'' each place it appears and inserting ''qualified noncitizen's'';

(6) by striking ''an alien'' each place that it appears and inserting ''a noncitizen'';

(7) by striking ''alien'' each place it appears and inserting ''noncitizen'';

(8) by striking ''aliens'' each place it appears and inserting ''noncitizens''; and

(9) by striking ''alien's'' each place it appears and inserting ''noncitizen's''.

(c) ACCESS TO BASIC SERVICES FOR LAWFULLY RESIDING NONCITIZENS.—Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) is amended—

(1) in subsection (b)—

(A) in the subsection heading, by striking ''QUALIFIED ALIEN'' and inserting ''QUALIFIED NONCITIZEN''; and

(B) in the matter preceding paragraph (1), by striking ''benefit'' and all that follows through the period at the end of the subsection and inserting ''benefit, is lawfully present in the United States.'';

(2) in subsection (c)—

(A) in the subsection heading, by striking ''ALIENS AS QUALIFIED ALIENS'' and inserting ''NONCITIZENS AS QUALIFIED NONCITIZENS'';

(B) in paragraph (3)(B), by striking ''; or'' and inserting a semicolon'

(C) in paragraph (4), by striking the period at the end and inserting ''; or''; and

(D) by inserting after paragraph (4) the following:

''(5) a noncitizen—

''(A) in a category that was treated as lawfully present for purposes of section 1101 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. 18001);

''(B) who met the requirements of section 402(a)(2)(D) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(D)) on or before January 1, 2023;

''(C) who is granted special immigrant juvenile status as described by section 101(a)(27)(J) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(27)(J));

''(D) who has a pending, bona fide application for nonimmigrant status under section 101(a)(15)(U) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(U));

''(E) who was granted relief under the Deferred Action for Childhood Arrivals program; or

''(F) any other person who is not a citizen of the United States but who resides in a State or territory of the United States and is federally authorized to be present in the United States.''; and

(3) by adding at the end the following:

''(d) NONCITIZEN.—In this title, the term 'noncitizen' means any individual who is not a citizen of the United States.''.

(d) CHILD NUTRITION PROGRAMS.—Section 742 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1615) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''SCHOOL LUNCH AND BREAKFAST PROGRAMS'' and inserting ''CHILD NUTRITION PROGRAMS'';

(B) by striking ''the school lunch program'' and inserting ''any program''; and

(C) by striking ''the school breakfast program under section 4 of the'' and inserting ''any program under the''; and

(2) in subsection (b)(1)—

(A) by striking ''Nothing in this Act shall prohibit or require a State to provide to an individual who is not a citizen or a qualified alien, as defined in section 431(b),'' and inserting ''A State shall not deny''; and

(B) by striking ''paragraph (2)'' and inserting ''paragraph (2) on the basis of an individual's citizenship or citizenship, alienage, or immigration status''.

(e) EXCLUSION OF MEDICAL ASSISTANCE EXPENDITURES FOR CITIZENS OF FREELY ASSOCIATED STATES.—Section 1108(h) of the Social Security Act (42 U.S.C. 1308(h)) is amended—

(1) by striking ''Expenditures'' and inserting:

''(1) IN GENERAL.—Expenditures''; and

(2) by adding at the end the following:

''(2) MEDICAID PROGRAMS.—With respect to eligibility for benefits for a State plan approved under title XIX, other than medical assistance described in section 401(b)(1)(A), paragraph (1) shall not apply to any individual who lawfully resides in 1 of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia,

the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governor of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.''.

(f) CHILD HEALTH INSURANCE PROGRAM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by striking subparagraph (O).

(g) CONFORMING AMENDMENTS.—

(1) SUPPLEMENTAL FOOD ASSISTANCE PROGRAM.—The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) is amended—

(A) in section 5 (7 U.S.C. 2014) —

(i) in subsection (d)—

(I) in paragraph (1), by striking ''law)'' and all that follows through the semicolon at the end and inserting ''law);''; and

(II) in paragraph (10), by striking ''subsection (k)'' and inserting ''subsection (j)'';

(ii) by striking subsection (i);

(iii) in subsection (j), by striking ''subsections (a) through (i)'' and inserting ''subsections (a) through (h)''; and

(iv) by redesignating subsections (j) through (n) as subsection (i) through (m), respectively;

(B) in section 6 (7 U.S.C. 2015)—

(i) in subsection (f)(2)(B), by striking ''an alien lawfully admitted for permanent'' and all that follows through the end of the subsection and inserting ''a noncitizen lawfully present in the United States.''; and

(ii) in subsection (s)(2), by striking ''(i), (k), (l), (m), and (n)'' and inserting ''(j), (k), (l), and (m)''; and

(C) in section 11(e)(2)(B)(v)(II) (7 U.S.C. 2020(e)(2)(B)(v)(II)), by striking ''aliens'' and inserting ''noncitizens''.

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

(A) in paragraph (1)—

(i) in by striking ''paragraphs (2) and (4)'' and inserting ''paragraph (2)''; and

(ii) by striking ''admitted for'' and all that follows through the end of the para-

graph and inserting ''present in the United States.''; and

(B) by striking paragraph (4).

(3) HOUSING ASSISTANCE.—Section 214(a) of the Housing and Community Development Act of 1980 (42 U.S.C. 1436a(a)) is amended—

(A) in paragraph (6), by striking ''; or'' and inserting a semicolon;

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

(C) by adding at the end the following:

''(8) a qualified noncitizen (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641));''.

(4) ASSISTANCE NOT TREATED AS DEBT ABSENT FRAUD.—Section 213A of the Immigration and Nationality Act (8 U.S.C. 1183a) is amended—

(A) in subsection (a)(3)—

(i) in subparagraph (A), by striking ''(as provided under section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''; and

(ii) in subparagraph (B), in the undesignated matter following clause (ii), by

striking ''(as provided under section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996)''; and

(B) in subsection (b)(1)(A), by striking ''benefit,'' and inserting ''benefit by fraud,''; and

(C) in subsection (d)(2)(B), by striking '', 403(c)(2), or 411(b)''.

(5) REPORT.—Section 565 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (8 U.S.C. 1371) is amended—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2).

(h) PRESERVING ACCESS TO HEALTH CARE.—Section 36B(c)(1)(B) of the Internal Revenue Code of 1986 is amended to read as follows:

''(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

''(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved,

"(ii) the taxpayer is a non-citizen lawfully present in the United States,

"(iii) the taxpayer is ineligible for minimum essential coverage under section 5000A(f)(1)(A)(ii), and

"(iv) under the Medicaid eligibility criteria for non-citizens in effect on December 26, 2020, the taxpayer would be ineligible for such minimum essential coverage by reason of the taxpayer's immigration status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.".

(i) FEDERAL AGENCY GUIDANCE.—Not later than 180 days after the date of the enactment of this Act, each Federal agency, as applicable, shall issue guidance with respect to implementing the amendments made by this section.

(j) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 4004. IMPROVE AFFORDABILITY AND REDUCE PREMIUM COSTS OF HEALTH INSURANCE FOR CONSUMERS.

(a) IN GENERAL.—Section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended to read as follows:

"(A) APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

"In the case of household income (expressed as a percent of poverty line) within the following income 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".

(b) CONFORMING AMENDMENT.—Section 36B(c)(1)(A) of the Internal Revenue Code of 1986 is amended by striking "but does not exceed 400 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2021.

SEC. 4005. REMOVING CITIZENSHIP AND IMMIGRATION BARRIERS TO ACCESS TO AFFORDABLE HEALTH CARE UNDER THE ACA.

(a) IN GENERAL.—

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

(A) in subsection (c)(1)(B), as amended by section 4003(h)—

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

(ii) by amending clause (ii) to read as follows:

''(ii) the taxpayer is a noncitizen who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of the individual's immigration status,''; and

(B) by striking subsection (e).

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

(A) by striking subsection (e); and

(B) by redesignating subsections (f) and (g) as subsections (e) and (f), respectively.

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

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

(A) by striking subsection (d); and

(B) by redesignating subsection (e) as subsection (d).

(5) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Section 5000A(d) of the Internal Revenue Code of 1986 is amended—

(A) by striking paragraph (3); and

(B) by redesignating paragraph (4) as paragraph (3).

(b) CONFORMING AMENDMENTS.—

(1) ESTABLISHMENT OF PROGRAM.—Section 1411(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(a)) is amended—

(A) by striking paragraph (1); and

(B) by redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

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

(A) in the heading, by striking ''; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS''; and

(B) by striking paragraph (3).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to years, plan years, and taxable years, as applicable, beginning after December 31, 2022.

SEC. 4006. REMOVING BARRIERS TO ACCESS TO AFFORDABLE HEALTH CARE FOR LAWFULLY RESIDING IMMIGRANTS UNDER MEDICAID AND CHIP.

(a) MEDICAID.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)(4)), as amended by section 4003(g)(2), is amended by adding at the end the following:

"(4) COVERAGE OF LAWFULLY RESIDING IMMIGRANTS.—

"(A) IN GENERAL.—Notwithstanding title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, a State shall provide medical assistance under this title to individuals who are lawfully residing in the United States (including individuals described in paragraph (1), battered individuals described in section 431(c) of such Act, and individuals with an approved or pending application for deferred action or other federally authorized presence), if they otherwise meet the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).

"(B) TREATMENT OF MEDICAL ASSISTANCE PROVIDED TO LAWFULLY RESIDING IMMIGRANTS.—No debt shall accrue under an affidavit of support against any sponsor of an individual provided medical assistance under subparagraph (A) on the basis of provision of as-

sistance to such individual and the cost of such assistance shall not be considered as an unreimbursed cost.

''(C) VERIFICATION REQUIREMENT.—As part of the State's ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of the application of subparagraph (A), a State shall verify that the individual continues to lawfully reside or be lawfully present in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing or present in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing or present in the United States.''.

(b) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 4003(f), is amended by inserting after subparagraph (N) the following new subparagraph:

''(O) Paragraph (4) of section 1903(v) (relating to lawfully residing individuals).''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of enactment of this Act and shall apply to services furnished on or after the date that is 90 days after such date of enactment.

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

deemed to be a separate regular session of the State legislature.

(d) PRESERVING COVERAGE.—

(1) IN GENERAL.—Nothing in this section, including the amendments made by this section, shall prevent lawfully present noncitizens who are ineligible for full benefits under the Medicaid program under title XIX of the Social Security Act from securing a credit for which such lawfully present noncitizens would be eligible under section 36B(c)(1)(B) of the Internal Revenue Code of 1986 and under the Medicaid provisions for lawfully present noncitizens, as in effect on the date prior to the date of enactment of this Act.

(2) DEFINITION.—For purposes of paragraph (1), the term ''full benefits'' means, with respect to an individual and State, medical assistance for all services covered under the State plan under title XIX of the Social Security Act that is not less in amount, duration, or scope, or is determined by the Secretary of Health and Human Services to be substantially equivalent to the medical assistance available for an individual described in section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)).

SEC. 4007. CONSISTENCY IN HEALTH INSURANCE COVERAGE FOR INDIVIDUALS WITH FEDERALLY AUTHORIZED PRESENCE, INCLUDING DEFERRED ACTION.

(a) IN GENERAL.—For purposes of eligibility under any of the provisions described in subsection (b), all individuals granted lawful presence in the United States shall be considered to be lawfully present in the United States.

(b) PROVISIONS DESCRIBED.—The provisions described in this subsection are the following:

(1) EXCHANGE ELIGIBILITY.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031).

(2) REDUCED COST-SHARING ELIGIBILITY.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071).

(3) PREMIUM SUBSIDY ELIGIBILITY.—Section 36B of the Internal Revenue Code of 1986.

(4) MEDICAID AND CHIP ELIGIBILITY.—Titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 1397aa et seq.), including under section 1903(v) of such Act (42 U.S.C. 1396b(v)).

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subsection (a) shall take effect on the date of enactment of this Act.

(2) TRANSITION THROUGH SPECIAL ENROLLMENT PERIOD.—In the case of an individual described in subsection (a) who, before the first day of the first annual open enrollment period under subparagraph (B) of section 1311(c)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)) beginning after the date of enactment of this Act, is granted lawful presence in the United States and who, as a result of such subsection, qualifies for a subsidy under a provision described in paragraph (2) or (3) of subsection (b), the Secretary of Health and Human Services shall establish a special enrollment period under subparagraph (C) of such section 1311(c)(6) during which such individual may enroll in qualified health plans through Exchanges under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 note et seq.) and qualify for such a subsidy. For such an individual who has been granted federally authorized presence in the United States as of the date of enactment of this Act, such special enrollment period shall begin not later than 90 days after such date of enactment. Nothing in this paragraph shall be construed as affecting the authority of the Secretary

to establish additional special enrollment periods under such subparagraph (C).

SEC. 4008. STUDY ON THE UNINSURED.

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

(1) conduct a study, in accordance with the standards under section 3101 of the Public Health Service Act (42 U.S.C. 300kk), on the demographic characteristics of the population of individuals who do not have health insurance coverage or oral health coverage; and

(2) predict, based on such study, the demographic characteristics of the population of individuals who would remain without health insurance coverage after the end of any annual open enrollment or any special enrollment period or upon enactment and implementation of any legislative changes to the Patient Protection and Affordable Care Act (Public Law 111–148) that affect the number of persons eligible for coverage.

(b) REPORTING REQUIREMENTS.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to the Congress the results of

the study under subsection (a)(1) and the prediction made under subsection (a)(2).

(2) REPORTING OF DEMOGRAPHIC CHARACTERISTICS.—The Secretary shall—

(A) report the demographic characteristics under paragraphs (1) and (2) of subsection (a) on the basis of racial and ethnic group (as defined in section 1707(g)(1) of the Public Health Service Act), and stratify the reporting on each racial and ethnic group by other demographic characteristics that can impact access to health insurance coverage, such as sexual orientation, gender identity, primary language, disability status, sex, socioeconomic status, age group, citizenship, and immigration status, in a manner consistent with title I of this Act, including the amendments made by such title; and

(B) not use such report, or any information gathered in preparing such report—

(i) to engage in or anticipate any deportation or immigration related enforcement action by any entity, including the Department of Homeland Security; or

(ii) for the exploitation of, or discrimination against, communities of color or the LGBTQ+ population.

SEC. 4009. MEDICAID FALLBACK COVERAGE PROGRAM FOR LOW-INCOME ADULTS IN NON-EXPANSION STATES.

(a) IN GENERAL.—As soon as possible after the date of enactment of this Act the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(1) directly or by contract, establish a program that offers eligible individuals the opportunity to enroll in health benefits coverage that meets the requirements described in subsection (c) and any requirements applicable to such coverage pursuant to subsection (d); and

(2) ensure that such program is administered consistent with the requirements of section 431.10(c)(2) of title 42, Code of Federal Regulations.

(b) DEFINITION OF ELIGIBLE INDIVIDUAL.—In this section, the term ''eligible individual'' means an individual who—

(1) is described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII));

(2) resides in a State that—

(A) does not expend amounts for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for all individuals described in such section; and

(B) did not expend amounts for medical assistance under such title for all such individuals as of the date of enactment of this Act; and

(3) would not be eligible for medical assistance under such State's plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or a waiver of such plan, as such plan or waiver was in effect on such date.

(c) HEALTH BENEFITS COVERAGE REQUIREMENTS.—The requirements described in this subsection with respect to health benefits coverage are the following:

(1) ESSENTIAL HEALTH BENEFITS.—At a minimum, the coverage meets the minimum standards required under paragraph (5) of section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)) for benchmark coverage described in paragraph (1) of

such section or benchmark equivalent coverage described in paragraph (2) of such section.

(2) PREMIUMS AND COST-SHARING.—No premiums are imposed for the coverage, and deductibles, cost sharing, or similar charges may only be imposed in accordance with the requirements imposed on State Medicaid plans under section 1916 of the Social Security Act (42 U.S.C. 1396o).

(d) APPLICATION OF REQUIREMENTS AND PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT.—The Secretary shall specify that—

(1) any requirement applicable to the furnishing of medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) by States that have elected to make medical assistance available to individuals described in section 1902(a)(10)(A)(i)(VIII) of such title (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) that does not conflict with the requirements specified in subsection (c) applies to the program established under this section; and

(2) other provisions of such title apply to such program.

(e) NO STATE MANDATE.—Nothing in this section shall be construed as requiring a State to make expendi-

tures related to the program established under this section and the Secretary shall not impose any such requirement.

(f) FUNDING.—There are appropriated to the Secretary for each fiscal year beginning with fiscal year 2022 from any funds in the Treasury not otherwise appropriated, such sums as are necessary to carry out this section.

SEC. 4010. INCREASE AND EXTENSION OF TEMPORARY ENHANCED FMAP FOR STATES WHICH BEGIN TO EXPEND AMOUNTS FOR CERTAIN MANDATORY INDIVIDUALS.

(a) IN GENERAL.—Section 1905(ii)(1) of the Social Security Act (42 U.S.C. 1396d(ii)(1)) is amended—

(1) by striking ''8-quarter period'' and inserting ''40-quarter period''; and

(2) by striking ''5 percentage points'' and inserting ''10 percentage points''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9814 of the American Rescue Plan Act of 2021 (Public Law 117–2).

Subtitle B—Improvement of Coverage

SEC. 4101. MEDICAID IN THE TERRITORIES.

(a) ELIMINATION OF GENERAL MEDICAID FUNDING LIMITATIONS (''CAP'') FOR TERRITORIES.—

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

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

(B) in subsection (g)(2), in the matter preceding subparagraph (A), by inserting ''subsection (i) and'' after ''subject to''; and

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

''(i) SUNSET OF MEDICAID FUNDING LIMITATIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections (f) and (g) shall not apply to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa beginning with fiscal year 2024.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended by striking ", the limitation in section 1108(f),,".

(B) Section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) is amended by striking paragraph (4).

(3) EFFECTIVE DATE.—The amendments made by this section shall apply beginning with fiscal year 2024.

(b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR TERRITORIES.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by inserting ''for fiscal years before fiscal year 2024'' after ''American Samoa''.

(c) PERMITTING MEDICAID DSH ALLOTMENTS FOR TERRITORIES.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (6), by adding at the end the following new subparagraph:

''(C) TERRITORIES.—

''(i) FISCAL YEAR 2023.—For fiscal year 2023, the DSH allotment for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa

shall bear the same ratio to $300,000,000 as the ratio of the number of individuals who are low-income or uninsured and residing in such respective territory (as estimated from time to time by the Secretary) bears to the sums of the number of such individuals residing in all of the territories.

''(ii) SUBSEQUENT FISCAL YEAR.—For each subsequent fiscal year, the DSH allotment for each such territory is subject to an increase in accordance with paragraph (3).''; and

(2) in paragraph (9), by inserting before the period at the end the following: '', and includes, beginning with fiscal year 2023, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa''.

SEC. 4102. EXTENSION OF THE SUPPLEMENTAL SECURITY INCOME PROGRAM TO PUERTO RICO, THE UNITED STATES VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA.

(a) IN GENERAL.—Section 303 of the Social Security Amendments of 1972 (86 Stat. 1484) is amended by striking subsection (b).

(b) CONFORMING AMENDMENTS.—

(1) DEFINITION OF STATE.—Section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended by striking the 5th sentence and inserting the following: ''Such term when used in title XVI includes Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.''.

(2) ELIMINATION OF LIMIT ON TOTAL PAYMENTS TO THE TERRITORIES.—Section 1108 of such Act (42 U.S.C. 1308) is amended—

(A) in the section heading, by striking ''**;**
LIMITATION ON TOTAL PAYMENTS'';

(B) by striking subsection (a); and

(C) in subsection (c), by striking paragraphs (2) and (4) and redesignating paragraphs (3) and (5) as paragraphs (2) and (4), respectively.

(3) UNITED STATES NATIONALS TREATED THE SAME AS CITIZENS.—Section 1614(a)(1)(B) of such Act (42 U.S.C. 1382c(a)(1)(B)) is amended—

(A) in clause (i)(I), by inserting ''or national,'' after ''citizen'';

(B) in clause (i)(II), by adding ''; or'' at the end; and

(C) in clause (ii), by inserting ''or national'' after ''citizen''.

(4) TERRITORIES INCLUDED IN GEOGRAPHIC MEANING OF UNITED STATES.—Section 1614(e) of such Act (42 U.S.C. 1382c(e)) is amended by striking ''and the District of Columbia'' and inserting '', the District of Columbia, Puerto Rico, the United States Virgin Islands, Guam, and American Samoa''.

(c) WAIVER AUTHORITY.—The Commissioner of Social Security may waive or modify any statutory requirement relating to the provision of benefits under the Supplemental Security Income Program under title XVI of the Social Security Act in Puerto Rico, the United States Virgin Islands, Guam, or American Samoa, to the extent that the Commissioner deems it necessary in order to adapt the program to the needs of the territory involved.

(d) EFFECTIVE DATE.—This section and the amendments made by this section shall take effect on the 1st day of the 1st Federal fiscal year that begins 1 year or more after the date of the enactment of this Act.

SEC. 4103. EXTENSION OF MEDICARE SECONDARY PAYER.

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting ", and before January 1, 2023" after "prior to such date)"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after January 1, 2023 (with respect to periods beginning on or after the date that is 42 months prior to such date), clauses (i) and (ii) shall be applied by substituting '42-month' for '12-month' each place it appears.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act. For purposes of determining an individual's status under section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)), as amended by subsection (a), an individual who is within the coordinating period as of the date of enactment of this Act shall have that period extended to the full 42 months described in the last sentence of such section, as added by the amendment made by subsection (a)(2).

SEC. 4104. INDIAN DEFINED IN TITLE I OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

(a) DEFINITION OF INDIAN.—Section 1304 of the Patient Protection and Affordable Care Act (42 U.S.C. 18024) is amended by adding at the end the following:

''(f) INDIAN.—In this title:

''(1) IN GENERAL.—The term 'Indian' means—

''(A) an Indian, a California Indian, or an Urban Indian (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)); or

''(B) an individual who is of Indian descent and a member of an Indian community served by a local facility or program of the Indian Health Service.

''(2) INCLUSIONS.—The term 'Indian' includes the following individuals:

''(A) A member of a federally recognized Indian Tribe.

''(B) A resident of an urban center who meets 1 or more of the following criteria:

''(i) A member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized as of the date of enactment of the Health Equity and Accountability Act of 2022 or later by the State in which they reside, or being a descendant, in the first or second degree, of any such member.

"(ii) An Eskimo or Aleut or other Alaska Native.

"(iii) An individual who is determined to be an Indian under regulations promulgated by the Secretary.

"(C) An individual who is considered by the Secretary of the Interior to be an Indian for any purpose.

"(D) An individual who is considered by the Secretary to be an Indian for purposes of eligibility for services provided by the Indian Health Service, including as a California Indian, Eskimo, Aleut, or other Alaska Native.".

(b) CONFORMING AMENDMENTS.—

(1) AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.—Section 1311(c)(6)(D) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)(D)) is amended by striking "(as defined in section 4 of the Indian Health Care Improvement Act)".

(2) REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.—Section 1402(d) of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(d)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''(as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)))''; and

(B) in paragraph (2), in the matter preceding subparagraph (A), by striking ''(as so defined)''.

(3) EXEMPTION FROM PENALTY FOR NOT MAINTAINING MINIMUM ESSENTIAL COVERAGE.—Section 5000A(e) of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and inserting the following:

''(3) INDIANS.—Any applicable individual who is an Indian (as defined in section 1304(f) of the Patient Protection and Affordable Care Act).''.

(c) EFFECTIVE DATE OF IRC AMENDMENT.—The amendment made by subsection (b)(3) shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 4105. REMOVING MEDICARE BARRIER TO HEALTH CARE.

(a) PART A.—Section 1818(a)(3)(B) of the Social Security Act (42 U.S.C. 1395i–2(a)(3)(B)) is amended by striking ''an alien'' and all that follows through ''under

this section'' and inserting ''an individual who is lawfully present in the United States''.

(b) PART B.—Section 1836(a)(2)(B) of the Social Security Act (42 U.S.C. 1395o(a)(2)(B)) is amended by striking ''an alien'' and all that follows through ''under this part'' and inserting ''an individual who is lawfully present in the United States''.

SEC. 4106. LOWERING MEDICARE PREMIUMS AND PRESCRIPTION DRUG COSTS.

(a) MEDICARE COST ASSISTANCE PROGRAM.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SEC. 1899C. MEDICARE COST ASSISTANCE PROGRAM.

''(a) IN GENERAL.—Effective beginning January 1, 2023, in the case of a Medicare Cost Assistance Program eligible individual (as defined in subsection (b)(1)), the Secretary shall provide Medicare cost assistance for the following costs incurred with respect to the individual:

''(1) Premiums under section 1818.

''(2) Premiums under section 1839.

''(3) Coinsurance under this title (including coinsurance described in section 1813).

''(4) Deductibles established under this title (including those described in section 1813 and section 1833(b)).

''(5) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to a percent less than 100 percent therein were deemed a reference to '100 percent'.

''(b) DETERMINATION OF ELIGIBILITY.—

''(1) MEDICARE COST ASSISTANCE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—The term 'Medicare Cost Assistance Program eligible individual' means an individual who—

''(A) is eligible for, and is receiving, medical assistance for the payment of medicare cost-sharing under a State Medicaid program pursuant to clause (i), (iii), or (iv) of section 1902(a)(10)(E) as of December 31, 2022; or

''(B)(i) is entitled to hospital insurance benefits under part A (including an individual entitled to such benefits pursuant to an enrollment under section 1818); and

''(ii) has income at or below 200 percent of the poverty line applicable to a family of the size involved.

''(2) JOINT DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY FOR LIS AND MEDICARE COST ASSISTANCE.—

''(A) IN GENERAL.—The determination of whether an individual is a Medicare Cost Assistance Program eligible individual shall be determined by the Commissioner of Social Security jointly with the determination of whether an individual is a subsidy eligible individual described in section 1860D–14(a)(3). Such determination shall be made with respect to eligibility for Medicare cost assistance under this section and premium and cost-sharing subsidies under section 1860D–14 upon application of an individual for a determination with respect to eligibility for either such assistance or such subsidies. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this paragraph.

''(B) EFFECTIVE PERIOD.—Determinations under this paragraph with respect to eligibility for each of such assistance or such subsidies shall be effective beginning with the month in which the individual applies for a de-

termination described in subparagraph (A) and shall remain in effect until such time as the Secretary determines the individual is no longer eligible as determined under subparagraph (C)(ii).

''(C) REDETERMINATIONS.—With respect to eligibility determinations under this paragraph—

''(i) redeterminations shall be made at the same time with respect to eligibility for Medicare cost assistance under this section and cost-sharing subsidies under section 1860D–14, but not more frequently than once every 12 months;

''(ii) a redetermination shall automatically determine that an individual remains eligible for such assistance or subsidies unless—

''(I) the Commissioner has information indicating that the individual's circumstances have changed such that the individual is no longer eligible for such assistance or subsidies;

''(II) the Commissioner sends notice to the individual regarding such

information that requests a response either confirming or correcting such information; and

''(III) the individual either confirms such information or fails to provide documentation indicating that such circumstances have not changed within 60 days of receiving the notice described in subclause (II);

''(iii) the Commissioner shall establish procedures for appeals of such determinations that are similar to the procedures described in the third sentence of section 1631(c)(1)(A); and

''(iv) judicial review of the final decision of the Commissioner made after a hearing shall be available to the same extent, and with the same limitations, as provided in subsections (g) and (h) of section 205.

''(D) TREATMENT OF MEDICAID BENEFICIARIES.—The Secretary shall provide that individuals who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or who are recipients of supplemental security in-

come benefits under title XVI shall be treated as a Medicare Cost Assistance Program eligible individual and, in the case of such individual who is a part D eligible individual, a subsidy eligible individual described in section 1860D–14(a)(3).

''(E) SIMPLIFIED APPLICATION FORM.—

''(i) IN GENERAL.—The Secretary shall develop and distribute a simplified application form for use by individuals in applying for Medicare cost assistance under this section and premium and cost-sharing subsidies under section 1860D–14. Such form shall be easily readable based on culturally fluid language for all demographics beyond just the various languages offered. An audio version, digital version, and photo-voice option should also be provided for all learners. The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms

available to the Commissioner of Social Security.

''(ii) CONSULTATION.—In developing the form under clause (i), the Secretary shall consult with beneficiary groups.

''(3) INCOME DETERMINATIONS.—For purposes of applying this section—

''(A) in the case of an individual who is not treated as a Medicare Cost Assistance Program eligible individual or a subsidy eligible individual under paragraph (2)(D), income shall be determined in the manner described under section 1612 for purposes of the supplemental security income program, except that support and maintenance furnished in kind shall not be counted as income; and

''(B) the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(c) BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—In the case in which the payment for Medicare cost assistance for a Medicare Cost Assistance Program eligible individual with re-

spect to an item or service is reduced or eliminated, the individual shall not have any legal liability to make payment to a provider of services (as defined in section 1861(u)) or supplier (as defined in section 1861(d)) or to an organization described in section 1903(m)(1)(A) for the service, and any lawful sanction that may be imposed upon a provider of services or supplier or such an organization for excess charges under this title or title XIX shall apply to the imposition of any charge imposed upon the individual in such case.

''(2) CLARIFICATION.—This paragraph shall not be construed as preventing payment of any medicare cost assistance by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary shall establish procedures for the administration of the program under this section.

''(2) FUNDING.—For purposes of carrying out this section, the Secretary shall make payments from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in

such proportion as the Secretary determines appropriate, of such amounts as the Secretary determines necessary to provide Medicare cost assistance under this section.

''(e) REFERENCES TO MEDICARE COST-SHARING.—Effective beginning January 1, 2023, any reference to medicare cost-sharing described in section 1905(p) shall be deemed a reference to Medicare cost assistance under this section.

''(f) OUTREACH EFFORTS.—For provisions relating to outreach efforts to increase awareness of the availability of Medicare cost assistance, see section 1144.''.

(2) SPECIAL ENROLLMENT PERIOD.—

(A) NO PREMIUM PENALTY.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended, in the last sentence, by inserting the following before the period: ''or, effective beginning January 1, 2023, for individuals who are Medicare Cost Assistance Program eligible individuals (as defined in section 1899B(b)(1)).''.

(B) SPECIAL ENROLLMENT PERIOD.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

"(p) SPECIAL ENROLLMENT PERIOD FOR MEDICARE COST ASSISTANCE PROGRAM ELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—Effective beginning January 1, 2023, the Secretary shall establish special enrollment periods for Medicare Cost Assistance Program eligible individuals (as defined in section 1899C(b)(1)).

"(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall—

"(A) begin on the first day of the first month in which the individual applies for a determination under section 1899C(b)(2)(A); and

"(B) remain in effect until such time as the Secretary determines the individual is no longer eligible as determined under section 1899C(b)(2)(C)(ii).".

(C) CONFORMING SUNSET OF STATE AGREEMENTS RELATING TO ENROLLMENT OF QUALIFIED MEDICARE BENEFICIARIES.—

(i) PART A.—Section 1818(g) of the Social Security Act (42 U.S.C. 1395i–2(g)) is amended by adding at the end the following new paragraph:

''(3) SUNSET.—This subsection shall not apply on or after January 1, 2023.''.

(ii) PART B.—Section 1843(h) of the Social Security Act (42 U.S.C. 1395v(h)) is amended by adding at the end the following new paragraph:

''(3) SUNSET WITH RESPECT TO QUALIFIED MEDICARE BENEFICIARIES.—This subsection shall not apply with respect to qualified medicare beneficiaries on or after January 1, 2023.''.

(3) PUBLIC AWARENESS CAMPAIGN.—Section 1144 of the Social Security Act (42 U.S.C. 1320b–14) is amended by adding at the end the following new subsection:

''(d) PUBLIC AWARENESS CAMPAIGN.—

''(1) IN GENERAL.—The Commissioner shall conduct a public awareness campaign to educate Medicare beneficiaries on the availability of Medicare cost assistance for low-income individuals under section 1899B.

''(2) COORDINATION.—In carrying out the public awareness campaign under paragraph (1), the Commissioner shall coordinate with State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improve-

ments for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), the Administrator of the Administration for Community Living, and the Administrator of the Centers for Medicare & Medicaid Services.

''(3) FUNDING.—There is appropriated to the Commissioner, out of any funds in the Treasury not otherwise appropriated, $10,000,000 for each of fiscal years 2023 through 2025, to provide grants to State health insurance assistance programs to carry out outreach and education activities under the public awareness campaign pursuant to this subsection.''.

(b) MOVING MEDICARE COST-SHARING BENEFITS FROM MEDICAID TO MEDICARE.—

(1) ENDING MOST MEDICARE COST-SHARING BENEFITS UNDER MEDICAID.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(A) by inserting ''for calendar quarters beginning before January 1, 2023,'' before ''for making'' each place it appears in clauses (i), (iii), and (iv) of subparagraph (E); and

(B) in the matter following subparagraph (G)—

(i) by inserting ''furnished during calendar quarters beginning before January 1, 2023'' after ''(described in section 1905(p)(3))'';

(ii) by striking ''(XV)'' and inserting '', (XV)'';

(iii) by striking ''and (XVIII)'' and inserting '', (XVIII)'';

(iv) by striking ''and (XIX)'' and inserting ''(XIX)''; and

(v) by inserting '', and (XX) no medical assistance for medicare cost-sharing, other than medical assistance for medicare cost-sharing for qualified disabled and working individuals described in section 1905(s), shall be made available after January 1, 2023'' before the semicolon at the end.

(2) CONFORMING AMENDMENTS.—

(A) TITLE XIX.—

(i) Section 1903(i) of such Act (42 U.S.C. 1396b(i)), as amended by section 4002, is amended—

(I) in paragraph (26), by striking ''or'' at the end;

(II) in paragraph (27), by striking the period at the end and inserting ''; or''; and

(III) by inserting after paragraph (27) the following new paragraph:

''(28) with respect to any amount expended for medical assistance for medicare cost-sharing (other than medical assistance for medicare cost-sharing for qualified disabled and working individuals described in section 1905(s)) furnished during calendar quarters beginning on or after January 1, 2023.''.

(ii) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the first sentence, by inserting ''furnished during calendar quarters beginning before January 1, 2023'' after ''medicare cost-sharing''.

(iii) Section 1933(g) of such Act (42 U.S.C. 1396u–3(g)) is amended—

(I) in paragraph (2)(Q), by striking ''paragraph (4), for each subsequent year'' and inserting ''paragraphs (4) and (5), for each subsequent year before 2023''; and

(II) by adding at the end the following:

''(5) SUNSET.—No individual shall be selected to be a qualifying individual for any calendar year or period under this section beginning on or after January 1, 2023, and no State allocation shall be made for any fiscal year or period under this section beginning on or after January 1, 2023.''.

(iv) Section 1935(a) of such Act (42 U.S.C. 1396u–5(a)) is amended—

(I) in paragraph (2)(A), by striking ''make determinations'' and inserting ''prior to January 1, 2023, make determinations''; and

(II) in paragraph (3), by inserting ''prior to January 1, 2023,'' before ''the State shall''.

(c) ENHANCING PRESCRIPTION DRUG AFFORDABILITY BY EXPANDING ACCESS TO ASSISTANCE WITH OUT-OF-POCKET COSTS UNDER MEDICARE PART D FOR LOW-INCOME SENIORS AND INDIVIDUALS WITH DISABILITIES.—

(1) EXPANDING ACCESS.—Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(A) in subsection (a)—

(i) in the subsection heading, by striking ''150 PERCENT'' and inserting ''200 PERCENT'';

(ii) in paragraph (1)—

(I) in the paragraph heading, by striking ''135 PERCENT'' and inserting ''200 PERCENT''; and

(II) in the matter preceding subparagraph (A)—

(aa) by striking ''135 percent'' and inserting ''200 percent''; and

(bb) by striking ''and who meets the resources requirement described in paragraph (3)(D) or who is covered under this paragraph under paragraph (3)(B)(i)'' and inserting ''or who is covered under this paragraph under paragraph (3)(B)(v)'';

(iii) by striking paragraph (2);

(iv) in paragraph (3)—

(I) in subparagraph (A)—

(aa) in clause (i), by adding ''and'' at the end;

(bb) in clause (ii)—

(AA) by striking ''150 percent'' and inserting ''200 percent''; and

(BB) by striking ''; and'' at the end and inserting a period; and

(cc) by striking clause (iii);

(II) by striking subparagraphs (B) and (C) and inserting the following:

''(B) DETERMINATIONS.—For provisions relating to joint determinations with respect to eligibility for Medicare cost assistance under section 1899C and premium and cost-sharing subsidies under this section, see section 1899C(b)(2).

''(C) INCOME DETERMINATIONS.—For purposes of applying this section—

''(i) in the case of an individual who is not treated as a Medicare cost-sharing assistance eligible individual and a subsidy eligible individual under section

1899C(b)(2)(D), income shall be determined in the manner described under section 1612 for purposes of the supplemental security income program, except that support and maintenance furnished in kind shall not be counted as income; and

"(ii) the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section."; and

(III) by striking subparagraphs (D), (E), and (G); and

(v) in paragraph (4), by striking subparagraph (B); and

(B) in subsection (c)(1), in the second sentence, by striking "subsections (a)(1)(D) and (a)(2)(E)" and inserting "subsection (a)(1)(D)".

(2) TREATMENT OF REDUCTION OF COST-SHARING FOR INDIVIDUALS RECEIVING HOME AND COMMUNITY BASED SERVICES.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended—

(A) by striking ''who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not''; and

(B) by striking ''or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section'' and inserting '', section 1115A, section 1915, or under a State plan amendment''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan year 2023 and subsequent plan years.

SEC. 4107. REDUCING COST-SHARING, ALIGNING INCOME AND RESOURCE ELIGIBILITY TESTS, SIMPLIFYING ENROLLMENT, AND OTHER PROGRAM IMPROVEMENTS FOR LOW-INCOME BENEFICIARIES.

(a) INCREASE IN INCOME ELIGIBILITY TO 135 PERCENT OF FPL FOR QUALIFIED MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Section 1905(p)(2)(A) of the Social Security Act (42 U.S.C. 1396d(p)(2)(A)) is amended by striking ''shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line'' and

all that follows through the period at the end and inserting the following: ''shall be—

''(i) before January 1, 2023, at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; and

''(ii) on or after January 1, 2023, equal to 135 percent of the official poverty line (as so defined and revised) applicable to a family of the size involved.''.

(2) NOT COUNTING IN-KIND SUPPORT AND MAINTENANCE AS INCOME.—Section 1905(p)(2)(D) of the Social Security Act (42 U.S.C. 1396d(p)(2)(D)) is amended by adding at the end the following new clause:

''(iii) In determining income under this subsection, support and maintenance furnished in kind shall not be counted as income.''.

(b) INCREASE IN INCOME ELIGIBILITY TO 200 PERCENT OF FPL FOR SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES.—

(1) ELIGIBILITY OF INDIVIDUALS WITH INCOMES BELOW 150 PERCENT OF FPL.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(A) by adding ''and'' at the end of clause (ii);

(B) in clause (iii)—

(i) by striking ''and 120 percent in 1995 and years thereafter'' and inserting ''120 percent in 1995 and years thereafter before 2023, and 200 percent in 2023 and years thereafter''; and

(ii) by striking ''and'' at the end; and

(C) by striking clause (iv).

(2) REFERENCES.—Section 1905(p)(1) of the Social Security Act (42 U.S.C. 1396d(p)(1)) is amended by adding at and below subparagraph (C) the following flush sentence:

''The term 'specified low-income medicare beneficiary' means an individual described in section 1902(a)(10)(E)(iii).''.

(3) CONFORMING AMENDMENTS.—

(A) The first sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''and section 1933(d)''.

(B) Section 1933 of such Act (42 U.S.C. 1396u–3) is repealed.

(c) 100 PERCENT FMAP.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

''(jj) INCREASED FMAP FOR EXPANDED MEDICARE COST-SHARING POPULATIONS.—

''(1) IN GENERAL.—Notwithstanding subsection (b), with respect to expenditures described in paragraph (2) the Federal medical assistance percentage shall be equal to 100 percent.

''(2) EXPENDITURES DESCRIBED.—The expenditures described in this paragraph are expenditures made on or after January 1, 2023, for medical assistance for medicare cost-sharing provided to any individual under clause (i), (ii), or (iii) of section 1902(a)(10)(E) who would not have been eligible for medicare cost-sharing under any such clause under the income or resource eligibility standards in effect on October 1, 2018.''.

(d) CONSOLIDATION OF LOW-INCOME SUBSIDY RESOURCE ELIGIBILITY TESTS.—

(1) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)) is amended—

(A) by striking subparagraph (D);

(B) by redesignating subparagraphs (E) through (G) as subparagraphs (D) through (F), respectively; and

(C) in the heading of subparagraph (D), as so redesignated, by striking ''ALTERNATIVE''.

(2) CLARIFICATION OF CERTAIN RULES RELATING TO INCOME AND RESOURCE DETERMINATIONS.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)), as amended by paragraph (1), is amended by striking subparagraph (F) and inserting the following new subparagraphs:

''(F) RESOURCE EXCLUSIONS.—In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1613 for purposes of subparagraph (D)—

''(i) no part of the value of any life insurance policy shall be taken into account;

''(ii) no part of the value of any vehicle 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

"(iv) no balance in, or benefits received under, an employee pension benefit plan (as defined in section 3 of the Employee Retirement Income Security Act of 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—

"(i) the individual;

"(ii) the individual's spouse who lives in the same household as the individual (if any); and

"(iii) any other individuals who—

"(I) are related to the individual whose income eligibility is in question

or such individual's spouse who lives in the same household;

"(II) are living in the same household as such individual; and

"(III) are dependent on such individual or such individual's spouse who is living in the same household for at least one-half of their financial support.".

(3) CONFORMING AMENDMENTS.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting "(as determined under paragraph (3)(G))" after "family of the size involved"; and

(B) in paragraph (3), as amended by paragraphs (1) and (2)—

(i) in subparagraph (A), in the matter preceding clause (i), by striking "subparagraph (F)" and inserting "subparagraph (E)";

(ii) in subparagraph (A)(ii), by inserting "(as determined under subparagraph (G))" after "family of the size involved";

(iii) in subparagraph (A)(iii), by striking ''or (E)'';

(iv) in subparagraph (B)(v), in the matter preceding subclause (I), by striking ''subparagraph (F)'' and inserting ''subparagraph (E)''; and

(v) in subparagraph (D)(i), in the matter preceding subclause (I), by striking ''subject to the life insurance policy exclusion provided under subparagraph (G)'' and inserting ''subject to the resource exclusions provided under subparagraph (F)''.

(e) ALIGNMENT OF LOW-INCOME SUBSIDY AND MEDICARE SAVINGS PROGRAM INCOME AND RESOURCE ELIGIBILITY TESTS.—

(1) APPLICATION OF MEDICAID SPOUSAL IMPOVERISHMENT RESOURCE ALLOWANCE TO MSP AND LIS RESOURCE ELIGIBILITY.—Section 1905(p)(1)(C) of the Social Security Act (42 U.S.C. 1396d(p)(1)(C)) is amended to read as follows:

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program subject to the resource exclusions

under subparagraph (G) of section 1860D–14(a)(3)) do not exceed—

"(i) in the case of an individual with a spouse, an amount equal to the sum of the first amount specified in subsection (f)(2)(A)(i) of section 1924 (as adjusted under subsection (g) of such section) and the amount specified in subsection (f)(2)(A)(ii)(II) of such section (as so adjusted); or

"(ii) in the case of an individual who does not have a spouse, an amount equal to ½ of the amount described in clause (i).".

(2) APPLICATION TO QDWIS.—Section 1905(s)(3) of the Social Security Act (42 U.S.C. 1396d(s)(3)) is amended to read as follows:

"(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program subject to the resource exclusions under subparagraph (G) of section 1860D–14(a)(3)) do not exceed—

"(A) in the case of an individual with a spouse, the amount in effect for the year under clause (i) of subsection (p)(1)(C); and

"(B) in the case of an individual who does not have a spouse, the amount in effect for the

year under clause (ii) of subsection (p)(1)(C); and''.

(3) APPLICATION TO LIS.—Clause (i) of section 1860D–14(a)(3)(D) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(D)), as redesignated and amended by subsection (d)(1), is amended to read as follows:

''(i) IN GENERAL.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program subject to the resource exclusions provided under subparagraph (G)) do not exceed the amount in effect for the year under section 1905(p)(1)(C)(ii).''.

(f) ENROLLMENT SIMPLIFICATIONS.—

(1) APPLICATION OF 3-MONTH RETROACTIVE ELIGIBILITY TO QMBS.—

(A) IN GENERAL.—Section 1902(e)(8) of the Social Security Act (42 U.S.C. 1396a(e)(8)) is amended by striking ''after the end of the month in which the determination first occurs'' and inserting ''in or after the third month be-

fore the month in which the individual makes application for assistance''.

(B) PROCESS FOR SUBMITTING CLAIMS DURING RETROACTIVE ELIGIBILITY PERIOD.—Section 1902(e)(8) of the Social Security Act (42 U.S.C. 1396a(e)(8)) is further amended by adding at the end the following: ''The Secretary shall provide for a process under which claims for medical assistance under the State plan may be submitted for services furnished to such an individual during such 3-month period before the month in which the individual made application for assistance.''.

(C) CONFORMING AMENDMENT.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding paragraph (1), by striking ''or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary''.

(2) STATE OPTION FOR 12-MONTH CONTINUOUS ELIGIBILITY FOR SLMBS AND QWDIS.—Section

1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(B) by inserting ''(A)'' after ''(12)''; and

(C) by adding at the end the following:

''(B) At the option of the State, the plan may provide that an individual who is determined to be eligible for benefits under a State plan approved under this title under any of the following eligibility categories, or who is redetermined to be eligible for such benefits under any of such categories, shall be considered to meet the eligibility requirements met on the date of application and shall remain eligible for those benefits until the end of the 12-month period following the date of the determination or redetermination of eligibility, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual:

''(i) A specified low-income medicare beneficiary described in subsection (a)(10)(E)(iii) of this section who is determined eligible for medicare cost sharing described in section 1905(p)(3)(A)(ii).

''(ii) A qualified disabled and working individual described in section 1905(s) who is deter-

mined eligible for medicare cost-sharing described in section 1905(p)(3)(A)(i).''.

(3) STATE OPTION TO USE EXPRESS LANE ELIGIBILITY FOR THE MEDICARE SAVINGS PROGRAM.—Section 1902(e)(13)(A) of the Social Security Act (42 U.S.C. 1396a(e)(13)(A)) is amended by adding at the end the following new clause:

''(iii) STATE OPTION TO EXTEND EXPRESS LANE ELIGIBILITY TO OTHER POPULATIONS.—

''(I) IN GENERAL.—At the option of the State, the State may apply the provisions of this paragraph with respect to determining eligibility under this title for an eligible individual (as defined in subclause (II)). In applying this paragraph in the case of a State making such an option, any reference in this paragraph to a child with respect to this title (other than a reference to child health assistance) shall be deemed to be a reference to an eligible individual.

''(II) ELIGIBLE INDIVIDUAL DEFINED.—In this clause, the term 'eligible individual' means any of the following:

''(aa) A qualified medicare beneficiary described in section 1905(p)(1)

for purposes of determining eligibility for medicare cost-sharing (as defined in section 1905(p)(3)).

''(bb) A specified low-income medicare beneficiary described in subsection (a)(10)(E)(iii) of this section for purposes of determining eligibility for medicare cost-sharing described in section 1905(p)(3)(A)(ii).

''(cc) A qualified disabled and working individual described in section 1905(s) for purposes of determining eligibility for medicare cost-sharing described in section 1905(p)(3)(A)(i).''.

(g) MEDICAID TREATMENT OF CERTAIN MEDICARE PROVIDERS.—Section 1902(n) of the Social Security Act (42 U.S.C. 1396a(n)) is amended by adding at the end the following new paragraph:

''(4) A State plan shall not deny a claim from a provider or supplier with respect to medicare cost-sharing described in subparagraph (B), (C), or (D) of section 1905(p)(3) for an item or service which is eligible for payment under title XVIII on the basis that the provider or supplier does not have a provider agreement in effect

under this title or does not otherwise serve all individuals entitled to medical assistance under this title. The State shall create a mechanism through which provider or suppliers that do not otherwise have provider agreements with the State can bill the State for medicare cost-sharing for qualified medicare beneficiaries.''.

(h) ELIGIBILITY FOR OTHER PROGRAMS.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)) is amended by adding at the end the following new paragraph:

''(7) Notwithstanding any other provision of law, any medical assistance for some or all medicare cost-sharing under this title shall not be considered income or resources in determining eligibility for, or the amount of assistance or benefits provided under, any other public benefit provided under Federal law or the law of any State or political subdivision thereof.''.

(i) TREATMENT OF QUALIFIED MEDICARE BENEFICIARIES, SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES, AND OTHER DUAL ELIGIBLES AS MEDICARE BENEFICIARIES.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

''(p) TREATMENT OF QUALIFIED MEDICARE BENEFICIARIES (QMBS), SPECIFIED LOW-INCOME MEDICARE

BENEFICIARIES (SLMBS), AND OTHER DUAL ELIGIBLES.—Nothing in this title shall be construed as authorizing a provider of services or supplier to discriminate (through a private contractual arrangement or otherwise) against an individual who is otherwise entitled to services under this title on the basis that the individual is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a specified low-income medicare beneficiary, or is otherwise eligible for medical assistance for medicare cost-sharing or other benefits under title XIX.''.

(j) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) GRANTS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall use amounts made available under subparagraph (B) to make grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

(B) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section

1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of the fiscal years 2024 through 2028, to remain available until expended.

(2) AMOUNT OF GRANTS.—The amount of a grant to a State under this subsection from the total amount made available under paragraph (1) shall be equal to the sum of the amount allocated to the State under paragraph (3)(A) and the amount allocated to the State under subparagraph (3)(B).

(3) ALLOCATION TO STATES.—

(A) ALLOCATION BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅔ of the total amount made available under paragraph (1) shall be based on the number of individuals who meet the requirement under subsection (a)(3)(A)(ii) of section

1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) but who have not enrolled to receive a subsidy under such section 1860D–14 relative to the total number of individuals who meet the requirement under such subsection (a)(3)(A)(ii) in each State, as estimated by the Secretary.

(B) ALLOCATION BASED ON PERCENTAGE OF RURAL BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅓ of the total amount made available under paragraph (1) shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A) of such Act (42 U.S.C. 1395w–101(a)(3)(A))) residing in a rural area relative to the total number of such individuals in each State, as estimated by the Secretary.

(4) PORTION OF GRANT BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES TO BE USED TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Each grant awarded under this subsection with respect to amounts allocated under paragraph (3)(A) shall be used to provide outreach to individuals who may be

subsidy eligible individuals (as defined in section 1860D–14(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(A))) or eligible for the program of medical assistance for payment of the cost of medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933 of such Act (42 U.S.C. 1396a(a)(10)(E), 1396u–3).

(k) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments and repeal made by this section take effect on January 1, 2023, and, with respect to title XIX of the Social Security Act, apply to calendar quarters beginning on or after January 1, 2023.

(2) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments and repeal made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before

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

SEC. 4108. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED BY URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''for the 8 fiscal year quarters beginning with the first fiscal year quarter beginning after the date of the enactment of the American Rescue Plan Act of 2021,'' and inserting ''and''.

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

SEC. 4109. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) IN GENERAL.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ", for such 8 fiscal year quarters".

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

SEC. 4110. REPEAL OF REQUIREMENT FOR ESTATE RECOVERY UNDER THE MEDICAID PROGRAM.

Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended—

(1) in subsection (a)—

(A) by amending paragraph (1) to read as follows:

"(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual.";

(B) by striking paragraph (2);

(C) in paragraph (3), by striking ''(1)(B)'' and inserting ''(1)''; and

(D) by redesignating paragraph (3) as paragraph (2); and

(2) by amending subsection (b) to read as follows:

''(b) ADJUSTMENT OR RECOVERY OF MEDICAL ASSISTANCE CORRECTLY PAID UNDER A STATE PLAN.—No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made.''.

SEC. 4111. ALLOW FOR SUSPENSION OF MEDICARE BENEFITS AND PREMIUM LIABILITY FOR INDIVIDUALS WHO ARE INCARCERATED AND PROVIDE A SPECIAL ENROLLMENT PERIOD AROUND THE DATE OF RELEASE.

(a) SPECIAL ENROLLMENT PERIOD FOR INDIVIDUALS INCARCERATED AT TIME OF MEDICARE ELIGIBILITY.—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)) is amended by adding at the end the following new paragraph:

''(5)(A) In the case of an individual who—

''(i) at the time the individual first satisfies paragraph (1) or (2) of section 1836(a), is incarcerated; or

"(ii) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period;

there shall be a special enrollment period described in subparagraph (B).

"(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the first day after which the individual is no longer incarcerated.".

(b) PREMIUM AMOUNT.—Section 1839(a) of the Social Security Act (42 U.S.C. 1395r(a)) is amended—

(1) in paragraph (1), in the second sentence, by striking "or (7)" and inserting "(7) or (8)"; and

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

"(8) In the case of an individual whose coverage period includes months in which by reason of custody under penal authority coverage is excluded pursuant to section 1862(a)(3), the premium amount for such months such individual is in custody under penal authority shall be zero.".

(c) CONFORMING AMENDMENT.—Section 1818(d)(5) of the Social Security Act (42 U.S.C. 1395i–2(d)(5)) is amended by adding at the end the following:

"(D) In the case of an individual who is a person who is excluded from coverage pursuant to section 1862(a)(3) by reason of custody under penal authority, the amount of the monthly premium for such individual shall be zero for any month in which such individual is in custody under penal authority.".

SEC. 4112. FEDERAL EMPLOYEE HEALTH BENEFIT PLANS.

(a) COVERAGE OF PREGNANCY.—The Director of the Office of Personnel Management shall issue such regulations as are necessary to ensure that pregnancy is considered a change in family status and a qualifying life event for an individual who is eligible to enroll, but is not enrolled, in a health benefits plan under chapter 89 of title 5, United States Code.

(b) EFFECTIVE DATE.—The requirement in paragraph (1) shall apply with respect to any contract entered into under section 8902 of such title beginning 12 months after the date of enactment of this Act.

SEC. 4113. CONTINUATION OF MEDICAID INCOME ELIGIBILITY STANDARD FOR PREGNANT INDIVIDUALS AND INFANTS.

Section 1902(l)(2)(A) of the Social Security Act (42 U.S.C. 1396a(l)(2)(A)) is amended—

(1) in clause (i), by striking ''and not more than 185 percent'';

(2) in clause (ii)—

(A) in subclause (I), by striking ''and'' after the comma;

(B) in subclause (II), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following:

''(III) January 1, 2023, is the percentage provided under clause (v).''; and

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

''(v) The percentage provided under clause (ii) for medical assistance provided on or after January 1, 2023, with respect to individuals described in subparagraph (A) or (B) of paragraph (1) shall not be less than—

''(I) the percentage specified for such individuals by the State in an amendment to its State plan (whether approved or not) as of January 1, 2014; or

"(II) if no such percentage is specified as of January 1, 2014, the percentage established for such individuals under the State's authorizing legislation or provided for under the State's appropriations as of that date.".

Subtitle C—Expansion of Access

PART 1—GENERAL PROVISIONS

SEC. 4201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

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

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

"SEC. 3441. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

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

of the Centers for Medicare & Medicaid Services, shall award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to health care.

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

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

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

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

''(C)(i) with respect to which, not less than 50 percent of the entity's patient population is made up of racial and ethnic minority groups (as defined in section 1707(g)(1)); or

''(ii) that—

''(I) serves a disproportionate percentage of local patients who are from a racial and ethnic minority group, or has a patient population at least 50 percent of which is composed of individuals with limited English proficiency; and

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

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

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

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

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

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

"(B) innovative collaborative or similar processes;

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

"(D) case management services;

"(E) physician or patient reminder systems;

"(F) educational interventions;

"(G) comprehensive and patient-centric health care;

"(H) creation and distribution of education materials on available health care options; or

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

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

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

''(A) patient safety;

''(B) timeliness of care;

''(C) effectiveness of care;

''(D) efficiency of care;

''(E) patient centeredness;

''(F) health information technology;

''(G) accessibility and availability of information on health care;

''(H) comprehensiveness of health care; and

''(I) patient involvement and choice in health care; and

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

''(A) staying healthy;

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

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

''(D) preparing for end of life and ensuring that end-of-life care is accessible and available, as well as coping with end-of-life issues; and

''(E) shared decisionmaking.

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2030.

''SEC. 3442. CENTERS OF EXCELLENCE.

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

''(1) meet the requirements of section 3441(b)(1);

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

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

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

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

cially, ethnically, and linguistically diverse populations;

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

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

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2023 through 2030.

''SEC. 3443. RECONSTRUCTION AND IMPROVEMENT GRANTS FOR PUBLIC HEALTH CARE FACILITIES SERVING PACIFIC ISLANDERS AND THE INSULAR AREAS.

''(a) IN GENERAL.—The Secretary shall provide direct financial assistance to designated health care providers and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving

health care facilities and services in a culturally competent and sustainable manner.

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

''(1) is owned or operated by—

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

''(B) a nonprofit organization; and

''(2)(A) provides care or treatment for a substantial number of patients who are uninsured, are receiving assistance under title XVIII of the Social Security Act or under a State plan under title XIX of such Act (or under a waiver of such plan), or are members of a vulnerable population, as determined by the Secretary; or

''(B) serves a disproportionate percentage of local patients that are from a racial and ethnic minority group.

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

''(1) consult with and obtain information on all health care facilities needs from the entities receiving direct financial assistance under subsection (a);

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

''(3) review the total unmet needs of health care facilities serving American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii, including needs for renovation and expansion of existing facilities;

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

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

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

SEC. 4202. BORDER HEALTH GRANTS.

(a) DEFINITIONS.—In this section:

(1) BORDER AREA.—The term ''border area'' means the United States-Mexico Border Area, as defined in section 8 of the United States-Mexico Border Health Commission Act (22 U.S.C. 290n–6).

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means an entity that is located in the border area and is any of the following:

(A) A State, local government, or Tribal government.

(B) A public institution of higher education.

(C) A nonprofit health organization.

(D) A community health center.

(E) A community clinic that is a health center receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b).

(F) A nonprofit organization serving immigrants.

(b) AUTHORIZATION.—From funds appropriated pursuant to subsection (f), the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the United States members of the United States-Mexico Border Health Commission, shall award grants to eligible entities to address priorities and recommendations to improve the health of border area residents that are established by—

(1) the United States members of the United States-Mexico Border Health Commission;

(2) the State border health offices; and

(3) the Secretary.

(c) APPLICATION.—An eligible entity that desires a grant under subsection (b) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require and demonstrating the entity's capacity to provide culturally and linguistically appropriate services to border area residents.

(d) USE OF FUNDS.—An eligible entity that receives a grant under subsection (b) shall use the grant funds for—

(1) programs relating to—

(A) maternal and child health;

(B) primary care and preventative health;

(C) public health and public health infrastructure;

(D) musculoskeletal health and obesity;

(E) health education and promotion;

(F) oral health;

(G) mental and behavioral health;

(H) substance use disorders;

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

(J) medical and health services research;

(K) workforce training and development;

(L) community health workers, patient navigators, and promotores;

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

(N) health disparities in the border area;

(O) environmental health;

(P) outreach and enrollment services with respect to Federal programs (including programs authorized under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 42 U.S.C. 1397aa et seq.));

(Q) end-of-life care; and

(R) addressing social determinants of health; and

(2) other programs determined appropriate by the Secretary.

(e) SUPPLEMENT, NOT SUPPLANT.—Amounts provided to an eligible entity awarded a grant under subsection (b) shall be used to supplement and not supplant other funds available to the eligible entity to carry out the activities described in subsection (d).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $200,000,000 for fiscal year 2024, and such sums as may be necessary for each succeeding fiscal year.

SEC. 4203. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.

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

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

(A) in subparagraph (B)—

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

(ii) by inserting ''(including when such services are provided by the entity

under an arrangement with the hospital)'' after ''hospital''; and

(B) by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2023.

(b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT REQUIREMENT.—

(1) IN GENERAL.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(A) in subparagraph (B)(iii), by striking ''provides not more than'' and inserting ''subject to subparagraph (F), provides not more than''; and

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

''(F) ALTERNATIVE TO 25 INPATIENT BED LIMIT REQUIREMENT.—

''(i) IN GENERAL.—A State may elect to treat a facility, with respect to the designation of the facility for a cost reporting

period, as satisfying the requirement of subparagraph (B)(iii) relating to a maximum number of acute care inpatient beds if the facility elects, in accordance with a method specified by the Secretary and before the beginning of the cost reporting period, to meet the requirement under clause (ii).

''(ii) ALTERNATE REQUIREMENT.—The requirement under this clause, with respect to a facility and a cost reporting period, is that the total number of inpatient bed days described in subparagraph (B)(iii) during such period will not exceed 7,300. For purposes of this subparagraph, an individual who is an inpatient in a bed in the facility for a single day shall be counted as one inpatient bed day.

''(iii) WITHDRAWAL OF ELECTION.—The option described in clause (i) shall not apply to a facility for a cost reporting period if the facility (for any two consecutive cost reporting periods during the previous 5 cost-reporting periods) was treated under such option and had a total number of in-

patient bed days for each of such two cost reporting periods that exceeded the number specified in such clause.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

SEC. 4204. MEDICARE REMOTE MONITORING PILOT PROJECTS.

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct pilot projects under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the purpose of providing incentives to home health agencies to utilize home monitoring and communications technologies that—

(A) enhance health and health care outcomes for Medicare beneficiaries; and

(B) reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 3 of the pilot projects in a State with a population of less than 1,000,000.

(3) DEFINITION OF HOME HEALTH AGENCY.—In this section, the term ''home health agency'' has the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(b) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—The Secretary shall specify the criteria for identifying those Medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects of Medicare beneficiaries who begin receiving home health services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

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

(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for Medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk and adjusted growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts

A and B during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the Medicare savings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.) as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Secretary may initiate comparable projects in additional areas.

(g) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SEC. 4205. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

Section 330(r)(4) of the Public Health Service Act (42 U.S.C. 254b(r)(4)) is amended—

(1) in subparagraph (A), by striking ''primary health care services'' each place it appears and inserting ''primary health care and other mental, dental, and physical health services''; and

(2) in subparagraph (B)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(iii) in the case of a rural health clinic described in such subparagraph—

''(I) that such clinic provides, to the extent possible, enabling services, such as transportation and language assistance (including translation and interpretation); and

''(II) that the primary health care and other services described in such subparagraph are subject to full reimbursement according to the prospective payment system for Federally

qualified health center services under section 1834(o) of the Social Security Act.''.

SEC. 4206. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) IN GENERAL.—For purposes of expediting the provision of telehealth services, for which payment is made under the Medicare Program, across State lines, the Secretary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(3) MEDICARE PROGRAM.—The term ''Medicare Program'' means the program of health insurance

administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 4207. SCORING OF PREVENTIVE HEALTH SAVINGS.

Section 202 of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 602) is amended by adding at the end the following:

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

''(1) DETERMINATION BY THE DIRECTOR.—Upon a request by the chairman or ranking minority member of the Committee on the Budget of the Senate, or by the chairman or ranking minority member of the Committee on the Budget of the House of Representatives, the Director shall determine if a proposed measure would result in reductions in budget outlays in budgetary outyears through the use of preventive health and preventive health services.

''(2) PROJECTIONS.—If the Director determines that a measure would result in substantial reductions in budget outlays as described in paragraph (1), the Director—

''(A) shall include, in any projection prepared by the Director, a description and estimate of the reductions in budget outlays in the

budgetary outyears and a description of the basis for such conclusions; and

''(B) may prepare a budget projection that includes some or all of the budgetary outyears, notwithstanding the time periods for projections described in subsection (e) and sections 308, 402, and 424.

''(3) DEFINITIONS.—As used in this subsection—

''(A) the term 'budgetary outyears' means the 2 consecutive 10-fiscal-year periods beginning with the first fiscal year that is 10 years after the budget year provided for in the most recently agreed to concurrent resolution on the budget; and

''(B) the term 'preventive health' means an action that focuses on the health of the public, individuals, and defined populations in order to protect, promote, and maintain health, wellness, and functional ability, and prevent disease, disability, and premature death that is demonstrated by credible and publicly available epidemiological projection models, incorporating clinical trials or observational studies in humans, to avoid future health care costs.''.

SEC. 4208. SENSE OF CONGRESS ON MAINTENANCE OF EFFORT PROVISIONS REGARDING CHILDREN'S HEALTH.

It is the sense of the Congress that—

(1) the maintenance of effort provisions added to sections 1902 and 2105(d) of the Social Security Act (42 U.S.C. 1396a; 42 U.S.C. 1397ee(d)) by sections 2001(b) and 2101(b) of the Patient Protection and Affordable Care Act were intended to maintain the eligibility standards for the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.) to protect vulnerable and disabled adults, children, and senior citizens, many of whom are also members of communities of color;

(2) the maintenance of effort provisions for children's coverage have been extended by the Congress through September 30, 2027;

(3) the maintenance of effort provisions ensure the continued success of the Medicaid program and Children's Health Insurance Program and were intended to specifically protect vulnerable and disabled children, many of whom are also members of communities of color; and

(4) the maintenance of effort provisions must be strictly enforced and proposals to weaken or waive the maintenance of effort provisions must not be considered.

SEC. 4209. PROTECTION OF THE HHS OFFICES OF MINORITY HEALTH.

(a) IN GENERAL.—Pursuant to section 1707A of the Public Health Service Act (42 U.S.C. 300u–6a), the Offices of Minority Health established within the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services, are offices that, regardless of change in the structure of the Department of Health and Human Services, shall report to the Secretary of Health and Human Services.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that the Offices of Minority Health referred to in subsection (a) play a critical role in addressing health disparities and should be adequately funded and given a prominent role in evaluating and establishing health policies and programs.

SEC. 4210. OFFICE OF MINORITY HEALTH IN VETERANS HEALTH ADMINISTRATION OF DEPARTMENT OF VETERANS AFFAIRS.

(a) ESTABLISHMENT AND FUNCTIONS.—Subchapter I of chapter 73 of title 38, United States Code, is amended by inserting after section 7308 the following new section:

"§ 7308A. Office of Minority Health

''(a) ESTABLISHMENT.—There is established in the Department within the Office of the Under Secretary for Health an office to be known as the 'Office of Minority Health' (in this section referred to as the 'Office').

''(b) HEAD.—The Director of the Office of Minority Health shall be the head of the Office. The Director of the Office of Minority Health shall be appointed by the Under Secretary for Health from among individuals qualified to perform the duties of the position.

''(c) FUNCTIONS.—The functions of the Office are as follows:

''(1) To establish short-range and long-range goals and objectives and coordinate all other activities within the Veterans Health Administration that relate to disease prevention, health promotion, health care services delivery, health and health care education, health care quality, and health care research concerning veterans who are members of a racial or ethnic minority group.

''(2) To support research, demonstrations, and evaluations to test new and innovative models for the discharge of activities described in paragraph (1).

''(3) To increase knowledge and understanding of health risk factors for veterans who are members of a racial or ethnic minority group.

''(4) To develop mechanisms that support better health care information dissemination, education, prevention, and services delivery to veterans from disadvantaged backgrounds, including veterans who are members of a racial or ethnic minority group.

''(5) To enter into contracts or agreements with appropriate public and nonprofit private entities to develop and carry out programs to provide bilingual or interpretive services to assist veterans who are members of a racial or ethnic minority group and who lack proficiency in speaking the English language in accessing and receiving health care services through the Veterans Health Administration.

''(6) To carry out programs to improve access to health care services through the Veterans Health Administration for veterans with limited proficiency in speaking the English language, including the de-

velopment and evaluation of demonstration and pilot projects for that purpose.

''(7) To advise the Under Secretary for Health on matters relating to the development, implementation, and evaluation of health professions education in decreasing disparities in health care outcomes between veterans who are members of a racial or ethnic minority group and other veterans, including cultural competency as a method of eliminating such health disparities.

''(8) To perform such other functions and duties as the Secretary or the Under Secretary for Health considers appropriate.

''(d) DEFINITIONS.—In this section:

''(1) The term 'racial or ethnic minority group' means any of the following:

''(A) American Indians (including Alaska Natives, Eskimos, and Aleuts).

''(B) Asian Americans.

''(C) Native Hawaiians and Pacific Islanders.

''(D) Blacks.

''(E) Hispanics.

''(2) The term 'Hispanic' means individuals whose origin is from Mexico, Puerto Rico, Cuba,

Central or South America, or any other Spanish-speaking country.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such subchapter is amended by inserting after the item relating to section 7308 the following new item:

''7308A. Office of Minority Health.''.

SEC. 4211. STUDY OF DSH PAYMENTS TO ENSURE HOSPITAL ACCESS FOR LOW-INCOME PATIENTS.

(a) IN GENERAL.—Not later than January 1, 2023, the Comptroller General of the United States shall conduct a study on how amendments made by the Patient Protection and Affordable Care Act (Public Law 111–148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152) to titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.) relating to disproportionate share hospital adjustment payments under Medicare and Medicaid (and subsequent amendments made with respect to such payments) affect the timely access to health care services for low-income patients. Such study shall—

(1) evaluate and examine whether States electing to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(VIII)) (including States making such an election through a waiver of

the State plan) to individuals described in such section mitigate the need for payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923 of such Act (42 U.S.C. 1396r–4), including the impact of such States electing to make medical assistance available to such individuals on—

(A) the number of individuals in the United States who are without health insurance and the distribution of such individuals in relation to areas primarily served by disproportionate share hospitals; and

(B) the low-income utilization rate of such hospitals and the resulting fiscal sustainability of such hospitals;

(2) evaluate the appropriate level and distribution of such payments among such disproportionate share hospitals for purposes of—

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

(B) providing timely access to health care services for individuals in medically underserved areas; and

(3) assess, with respect to such disproportionate share hospitals—

(A) the role played by such hospitals in providing critical access to emergency, inpatient, and outpatient health services, including end-of-life services, as well as the location of such hospitals in relation to medically underserved areas; and

(B) the extent to which such hospitals satisfy the requirements established for charitable hospital organizations under section 501(r) of the Internal Revenue Code of 1986 with respect to community health needs assessments, financial assistance policy requirements, limitations on charges, and billing and collection requirements.

(b) REPORTS.—

(1) REPORT TO CONGRESS.—Not later than 180 days after the date on which the study under subsection (a) is completed, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that contains—

(A) the results of the study;

(B) recommendations to Congress for any legislative changes to the payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)) and section 1923 of such Act (42 U.S.C. 1396r–4) that are needed to ensure access to health services for low-income patients that—

(i) are based on the number of individuals without health insurance, the amount of uncompensated care provided by such hospitals, and the impact of reduced payment levels on low-income communities; and

(ii) takes into account any reports submitted by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to congressional committees regarding the costs incurred by charitable hospital organizations for charity care, bad debt, nonreimbursed expenses for services provided to individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of

such Act, and any community benefit activities provided by such organizations.

(2) REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than 180 days after the date on which the study under subsection (a) is completed, the Comptroller General of the United States shall submit to the Secretary of Health and Human Services a report that contains—

(A) the results of the study; and

(B) any recommendations for purposes of assisting in the development of the methodology for the adjustment of payments to disproportionate share hospitals, as required under section 1886(r) of the Social Security Act (42 U.S.C. 1395ww(r)) and the reduction of such payments under section 1923(f)(7) of such Act (42 U.S.C. 1396r–4(f)(7)), taking into account the reports referred to in paragraph (1)(B)(ii).

SEC. 4212. REAUTHORIZATION OF PROGRAMS UNDER THE NATIVE HAWAIIAN HEALTH CARE IMPROVEMENT ACT.

(a) NATIVE HAWAIIAN HEALTH CARE SYSTEMS.—Section 6(h)(1) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11705(h)(1)) is amended by

striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

(b) ADMINISTRATIVE GRANT FOR PAPA OLA LOKAHI.—Section 7(b) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11706(b)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

(c) NATIVE HAWAIIAN HEALTH SCHOLARSHIPS.—Section 10(c) of the Native Hawaiian Health Care Improvement Act (42 U.S.C. 11709(c)) is amended by striking ''may be necessary for fiscal years 1993 through 2019'' and inserting ''are necessary''.

PART 2—RURAL

SEC. 4221. ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 2007(b)(1), is amended by adding at the end of the following new subsection:

''Rural Community Hospital; Rural Community Hospital Services

''(mmm)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

''(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

''(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

''(C) makes available 24-hour emergency care services;

''(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2010; and

''(E) applies to the Secretary for such designation.

''(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

''(3) Paragraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

''(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2012) with the same service area (as defined by the Secretary in regulations in effect on such date).

''(B) A facility obtaining a new provider number pursuant to a change of ownership.

''(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2012.

''(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.

''(5) Nothing in this subsection shall be construed as prohibiting a rural community hospital participating in the demonstration program under section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2313) from qualifying as a rural community hospital if the rural community hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.''.

(b) PAYMENT.—

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

''Payment for Inpatient Services Furnished in Rural Community Hospitals

''(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(mmm)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

''(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).''.

(2) OUTPATIENT SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(z) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(mmm)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge and any limitation under section 1861(v)(1)(U), or

''(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).''.

(3) EXEMPTION FROM 30-PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting ''(other than for a rural community hospital)'' after ''In determining such reasonable costs for hospitals''.

(c) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(z) of the Social Security Act (as added by subsection (b)(2)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(2) by inserting ''(1)'' after ''(z)''; and

(3) by adding at the end the following:

''(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

''(A) For items and services that would have been paid under section 1833(t) if furnished by a

hospital, the amount of cost-sharing determined under paragraph (8) of such section.

''(B) For items and services that would have been paid under section 1833(h) if furnished by a provider of services or supplier, no cost-sharing shall apply.

''(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider of services, or supplier, as the case may be.''.

(d) CONFORMING AMENDMENTS.—

(1) PART A PAYMENT.—Section 1814(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by inserting ''other than inpatient hospital services furnished by a rural community hospital,'' after ''critical access hospital services,''.

(2) PART B PAYMENT.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)), as amended by section 207(b)(3), is amended—

(A) by striking ''and'' at the end of paragraph (9);

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

(C) by adding at the end the following:

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

(3) TECHNICAL AMENDMENTS.—

(A) CONSULTATION WITH STATE AGENCIES.—Section 1863 of the Social Security Act (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), and (mmm)(1)''.

(B) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting ''section 1834(z)(2),'' after ''section 1833(b),''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2022.

SEC. 4222. RURAL HEALTH QUALITY ADVISORY COMMISSION AND DEMONSTRATION PROJECTS.

(a) RURAL HEALTH QUALITY ADVISORY COMMISSION.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a commission to be known as the Rural Health Quality Advisory Commission (in this section referred to as the ''Commission'').

(2) DUTIES OF COMMISSION.—

(A) NATIONAL PLAN.—The Commission shall develop, coordinate, and facilitate implementation of a national plan for rural health quality improvement. The national plan shall—

(i) identify objectives for rural health quality improvement;

(ii) identify strategies to eliminate known gaps in rural health system capacity and improve rural health quality; and

(iii) provide recommendations for Federal programs to identify opportunities for strengthening and aligning policies and programs to improve rural health quality.

(B) DEMONSTRATION PROJECTS.—The Commission shall design demonstration projects to recommend to the Secretary to test alternative models for rural health quality improve-

ment, including with respect to both personal and population health.

(C) MONITORING.—The Commission shall monitor progress toward the objectives identified pursuant to subparagraph (A)(i).

(3) MEMBERSHIP.—

(A) NUMBER.—The Commission shall be composed of 11 members appointed by the Secretary.

(B) SELECTION.—The Secretary shall select the members of the Commission from among individuals with significant rural health care and health care quality expertise, including expertise in clinical health care, health care quality research, end-of-life care, population or public health, or purchaser organizations.

(4) CONTRACTING AUTHORITY.—Subject to the availability of funds, the Commission may enter into contracts and make other arrangements, as may be necessary to carry out the duties described in paragraph (2).

(5) STAFF.—Upon the request of the Commission, the Secretary may detail, on a reimbursable basis, any of the personnel of the Office of Rural Health Policy of the Health Resources and Services

Administration, the Agency for Healthcare Research and Quality, or the Centers for Medicare & Medicaid Services to the Commission to assist in carrying out this subsection.

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

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

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

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

(b) RURAL HEALTH QUALITY DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Not later than 270 days after the date of the enactment of this section, the Secretary, in consultation with the Rural Health Quality Advisory Commission, the Office of Rural

Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services, shall make grants to eligible entities for a total of 5 demonstration projects to implement and evaluate methods for improving the quality of health care in rural communities. Each such demonstration project shall include—

(A) alternative community models that—

(i) will achieve greater integration of personal and population health services; and

(ii) address safety, effectiveness, patient- or community-centeredness, timeliness, efficiency, and equity (the 6 aims identified by the National Academy of Medicine (formerly known as the ''Institute of Medicine'') in its report entitled ''Crossing the Quality Chasm: A New Health System for the 21st Century'' released on March 1, 2001);

(B) innovative approaches to the financing and delivery of health care services to achieve rural health quality and accessibility goals for patients; and

(C) development of quality improvement support structures to assist rural health systems and professionals in the provision of health care (such as workforce support structures, quality monitoring and reporting, clinical care protocols, and information technology applications).

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

(A) shall include—

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

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

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

(3) CONSULTATION.—In developing the program for awarding grants under this subsection, the Secretary shall consult with the Administrator of the Agency for Healthcare Research and Quality, rural health care providers, rural health care researchers,

and private and nonprofit groups (including national associations) which are undertaking similar efforts.

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

(A) is authorized under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.); and

(B) is necessary to carry out a demonstration project under this subsection.

(5) DEMONSTRATION PROJECT SITES.—The Secretary shall ensure that the 5 demonstration projects funded under this subsection are conducted at a variety of sites representing the diversity of rural communities in the United States.

(6) DURATION.—Each demonstration project under this subsection shall be for a period of 4 years.

(7) INDEPENDENT EVALUATION.—The Secretary shall enter into an arrangement with an entity that has experience working directly with rural health systems for the conduct of an independent evaluation of the program carried out under this subsection.

(8) REPORT.—Not later than 1 year after the conclusion of all of the demonstration projects fund-

ed under this subsection, the Secretary shall submit a report to the Congress on the results of such projects. The report shall include—

(A) an evaluation of patient access to care, patient outcomes, and an analysis of the cost effectiveness of each such project; and

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

(c) APPROPRIATION.—

(1) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section $30,000,000 for the period of fiscal years 2023 through 2027.

(2) AVAILABILITY.—

(A) IN GENERAL.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2027.

(B) REPORT.—For purposes of carrying out subsection (b)(8), funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2028.

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

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

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

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

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

SEC. 4223. RURAL HEALTH CARE SERVICES.

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended to read as follows:

"SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT, AND SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

''(a) PURPOSE.—The purpose of this section is to provide for grants—

''(1) under subsection (b), to promote rural health care services outreach;

''(2) under subsection (c), to provide for the planning and implementation of integrated health care networks in rural areas;

''(3) under subsection (d), to assist rural communities in the Delta Region to reduce health disparities and to promote and enhance health system development; and

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

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

''(1) GRANTS.—The Director of the Office of Rural Health Policy of the Health Resources and Services Administration (referred to in this section as the 'Director') may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

"(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a Tribal government whose grant-funded activities will be conducted within federally recognized Tribal areas;

"(B) shall represent a consortium composed of members—

"(i) that include 3 or more independently owned health care entities; and

"(ii) that may be nonprofit or for-profit entities; and

"(C) shall not previously have received a grant under this subsection for the same or a similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

"(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural populations in the local community or region to be served;

"(C) a plan for quantifying how health care needs will be met through identification of the target population and benchmarks of service delivery or health status, such as—

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

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

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

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

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

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

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

"(c) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

"(1) GRANTS.—

"(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

"(i) achieve efficiencies and economies of scale;

"(ii) expand access to, coordinate, and improve the quality of the health care delivery system through development of organizational efficiencies;

"(iii) implement health information technology to achieve efficiencies, reduce medical errors, and improve quality;

"(iv) coordinate care and manage chronic and terminal illness; and

"(v) strengthen the rural health care system as a whole and across all facets of the health care delivery system, including end-of-life care, in such a manner as to show a quantifiable return on investment to the participants in the network.

"(B) GRANT PERIODS.—The Director may award such a rural health network development grant—

"(i) for a period of 3 years for implementation activities; or

"(ii) for a period of 1 year for planning activities to assist in the initial development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

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

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a Tribal government whose grant-funded activities will be conducted within federally recognized Tribal areas;

''(B) shall represent a network composed of participants—

''(i) that include 3 or more independently owned health care entities; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection (other than a 1-year grant for planning activities) for the same or a similar project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Director an application at such time, in such manner, and containing

such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of—

"(i) the history of collaborative activities carried out by the participants in the network;

"(ii) the degree to which the participants are ready to integrate their functions; and

"(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

"(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network, including a description of—

"(i) return on investment for the community and the network members; and

"(ii) other quantifiable performance measures that show the benefit of the network activities;

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

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

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

"(H) other such information as the Director determines to be appropriate.

"(d) DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT GRANTS.—

"(1) GRANTS.—The Director may award grants to eligible entities to support reduction of health disparities, improve access to health care, and enhance rural health system development in the Delta Region.

"(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title

XVIII of the Social Security Act, a public or non-profit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a Tribal government whose grant-funded activities will be conducted within federally recognized Tribal areas.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of the manner in which the project funded under the grant will meet the health care needs of the Delta Region;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

"(E) a description of how health disparities will be reduced or the health system will be improved;

"(F) a plan for sustaining the project after Federal support for the project has ended;

"(G) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided or how the health care system improves its performance;

"(H) a description of how the grantee will develop an advisory group made up of representatives of the communities to be served to provide guidance to the grantee to best meet community need; and

"(I) other such information as the Director determines to be appropriate.

"(e) SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

"(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small rural health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

''(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

''(A) shall be—

''(i) a rural public or rural nonprofit private health care provider or provider of health care services, such as a rural health clinic; or

''(ii) another rural provider or network of small rural providers identified by the Director as a key source of local care; and

''(B) shall not previously have received a grant under this subsection for the same or a similar project.

''(3) PREFERENCE.—In awarding grants under this subsection, the Director shall give preference to facilities that qualify as rural health clinics under title XVIII of the Social Security Act.

''(4) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

"(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

"(E) a plan for sustaining the project after Federal support for the project has ended;

"(F) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided; and

"(G) other such information as the Director determines to be appropriate.

"(f) GENERAL REQUIREMENTS.—

''(1) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(A) to build or acquire real property; or

''(B) for construction.

''(2) COORDINATION WITH OTHER AGENCIES.—The Director shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

''(g) REPORT.—Not later than September 30, 2024, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsections (b), (c), (d), and (e).

''(h) DEFINITION OF DELTA REGION.—In this section, the term 'Delta Region' has the meaning given to the term 'region' in section 382A of the Consolidated Farm and Rural Development Act (7 U.S.C. 2009aa).

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2024 through 2027.''.

PART 3—INDIAN COMMUNITIES

SEC. 4231. ASSISTANT SECRETARY OF THE INDIAN HEALTH SERVICE.

(a) REFERENCES.—Any reference in a law, regulation, document, paper, or other record of the United States to the Director of the Indian Health Service shall be deemed to be a reference to the Assistant Secretary of the Indian Health Service.

(b) EXECUTIVE SCHEDULE.—Section 5315 of title 5, United States Code, is amended, in the matter relating to the Assistant Secretaries of Health and Human Services, by striking ''(6)'' and inserting ''(7), 1 of whom shall be the Assistant Secretary of the Indian Health Service''.

(c) CONFORMING AMENDMENT.—Section 5316 of title 5, United States Code, is amended by striking ''Director, Indian Health Service, Department of Health and Human Services.''.

SEC. 4232. EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO INDIAN HEALTH CARE PROVIDERS.

Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a), by amending paragraph (9) to read as follows:

''(9) clinic services furnished by or under the direction of a physician, without regard to whether

the clinic itself is administered by a physician, including—

''(A) such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address; and

''(B) such services furnished outside the clinic by any Indian Health Service facility, a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638), or an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act;''; and

(2) in subsection (b), by inserting after ''Papa Ola Lokahi under section 8 of such Act'' the following: ''; the Federal medical assistance percentage shall also be 100 per centum with respect to amounts expended as medical assistance for services which are received by an Indian Health Service facility, a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638), or an urban In-

dian organization receiving funds under title V of the Indian Health Care Improvement Act''.

SEC. 4233. CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

Section 514 of the Indian Health Care Improvement Act (25 U.S.C. 1660d) is amended by striking subsection (b) and inserting the following:

''(b) REQUIREMENT.—The Secretary shall ensure that the Service and other agencies and offices of the Department and the Department of Veterans Affairs confer, to the maximum extent practicable, with urban Indian organizations in carrying out—

''(1) this Act; and

''(2) other provisions of law relating to Indian health care.''.

PART 4—PROVIDERS

SEC. 4241. AVAILABILITY OF NON-ENGLISH LANGUAGE SPEAKING PROVIDERS.

(a) IN GENERAL.—Section 1311(c)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(B)) is amended by inserting before the semicolon the following: ''and the ability of such provider to provide care in a language other than English either through the provider speaking such language or by the provider having a qualified interpreter for an individual

with limited English proficiency (as defined in section 3400 of such Act) who speaks such language available during office hours''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to any plan beginning on or prior to the date that is 1 year after the date of the enactment of this Act.

SEC. 4242. ACCESS TO ESSENTIAL COMMUNITY PROVIDERS.

(a) ESSENTIAL COMMUNITY PROVIDERS.—Section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(C)) is amended—

(1) by inserting ''(i)'' after ''(C)''; and

(2) by adding at the end the following new clauses:

''(ii) not later than January 1, 2023, increase the percentage of essential community providers as described in clause (i) included in its network by 10 percent annually (based on the level in the plan for 2016) until 90 percent of all federally qualified health centers and 75 percent of all other such essential community providers in the contract service area are in-network; and

''(iii) include at least one essential community provider in each of the essential community

provider categories described in section 156.235(a)(2)(ii)(B) of title 45, Code of Federal Regulations (as in effect on the date of enactment of the Health Equity and Accountability Act of 2022), in each county in the service area, where available;''.

(b) REPORTING REQUIREMENTS.—Section 1311(e)(3) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(e)(3)) is amended by adding at the end the following new subparagraph:

''(E) DATA ON ESSENTIAL COMMUNITY PROVIDERS.—The Secretary shall require qualified health plans to submit annually to the Secretary data on the percentage of essential community providers as described in clause (ii) of subsection (c)(1)(C), by county, that contract with each qualified health plan offered in that county and the percentage of such essential community providers, by category as described in clause (iii) of such subsection, that contract with each qualified health plan offered in that county. Such data shall be made available to the general public.''.

(c) ESSENTIAL COMMUNITY PROVIDER PROVISIONS APPLIED UNDER MEDICARE AND MEDICAID.—

(1) MEDICARE.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(F) the plan meets the requirements of clauses (ii) and (iii) of section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (relating to inclusion in networks of essential community providers).''.

(2) MEDICAID.—Section 1932(b)(5) of the Social Security Act (42 U.S.C. 1396u–2(b)(5)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) meets the requirements of clauses (ii) and (iii) of section 1311(c)(1)(C) of the Patient

Protection and Affordable Care Act (relating to inclusion in networks of essential community providers) with respect to services offered in the service area involved.''.

SEC. 4243. PROVIDER NETWORK ADEQUACY IN COMMUNITIES OF COLOR.

(a) IN GENERAL.—Section 1311(c)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(1)(B)), as amended by section 4241(a), is further amended—

(1) by inserting ''(i)'' after ''(B)''; and

(2) by adding at the end the following new clauses:

''(ii) meet such network adequacy standards as the Secretary may establish with regard to—

''(I) appointment wait time;

''(II) travel time and distance to health care provider facilities and providers by public and private transit;

''(III) hours of operation to accommodate individuals who cannot come to provider appointments during standard business hours;

"(IV) availability of health care options for patients; and

"(V) other network adequacy standards to ensure that care through these plans is accessible to diverse communities, including individuals with limited English proficiency as defined in section 3400 of such Act; and

"(iii) provide coverage for services for enrollees through out-of-network providers at no additional cost to the enrollees in cases where in-network providers are unable to comply with the standards established under subclause (III) or (IV) of clause (ii) for such services and the out-of-network providers can deliver such services in compliance with such standards;".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall not apply to plans beginning on or prior to the date that is 1 year after the date of the enactment of the Health Equity and Accountability Act of 2022.

PART 5—DENTAL

SEC. 4251. IMPROVING ACCESS TO DENTAL CARE.

(a) REPORTS TO CONGRESS.—

(1) GAO REPORTS.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress—

(A) a report on the Alaska Dental Health Aide Therapists program and the Dental Therapist and Advanced Dental Therapist programs in Minnesota, to assess the effectiveness of dental therapists in—

(i) improving access to timely dental care among communities of color;

(ii) providing high-quality care;

(iii) providing culturally competent care; and

(iv) providing accessible care to people with disabilities;

(B) a report on State variations in the use of dental hygienists and the effectiveness of expanding the scope of practice for dental hygienists in—

(i) improving access to timely dental care among communities of color;

(ii) providing high-quality care;

(iii) providing culturally competent care; and

(iv) providing accessible care to people with disabilities; and

(C) a report on the use of telehealth services to enhance services provided by dental hygienists and therapists, including recommendations for any modifications to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.) to better provide for telehealth consultations in conjunction with therapists' and hygienists' care.

(2) HRSA REPORT ON DENTAL SHORTAGE AREAS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall submit to Congress a report which details geographic dental access shortages and the preparedness of dental providers to offer culturally and linguistically appropriate, affordable, accessible, and timely services.

(b) EXPANSION OF DENTAL HEALTH AID THERAPISTS IN TRIBAL AND URBAN INDIAN COMMUNITIES.—

Section 119 of the Indian Health Care Improvement Act (25 U.S.C. 1616l) is amended—

(1) in subsection (d)—

(A) by striking paragraph (2) and inserting the following:

''(2) REQUIREMENT; EXCLUSION.—Subject to paragraphs (3) and (4), in establishing a national program under paragraph (1), the Secretary—

''(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b);

''(B) shall exclude dental health aide therapist services from services covered under such Program; and

''(C) shall include urban Indian organizations.''; and

(B) in paragraph (3), by striking ''or tribal organization'' each place it appears and inserting '', tribal organization, or urban Indian organization''; and

(2) in subsection (e), by striking ''or a tribal organization'' and inserting ''a tribal organization, or an urban Indian organization''.

(c) COVERAGE OF DENTAL SERVICES UNDER THE MEDICARE PROGRAM.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (GG), by striking ''and'' at the end;

(B) in subparagraph (HH), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(II) dental and oral health services (as defined in subsection (nnn));''.

(2) DENTAL AND ORAL HEALTH SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x),as amended by sections 2007(b) and 4221(a), is amended by adding at the end the following new subsection:

''Dental and Oral Health Services

''(nnn)(1) The term ' dental and oral health services' means services (as defined by the Secretary) that are necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions, including—

''(A) routine diagnostic and preventive care such as dental cleanings, exams, and x-rays;

''(B) basic dental services such as fillings and extractions;

''(C) major dental services such as root canals, crowns, and dentures;

''(D) emergency dental care; and

''(E) other necessary services related to dental and oral health (as defined by the Secretary).

''(2) For purposes of paragraph (1), such term shall include mobile and portable oral health services (as defined by the Secretary) that—

''(A) are provided for the purpose of overcoming mobility, transportation, and access barriers for individuals; and

''(B) satisfy the standards and certification requirements established under section 1902(a)(82)(B) for the State in which the services are provided.''.

(3) PAYMENT AND COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and'' before ''(DD)''; and

(B) by inserting before the semicolon at the end the following: ''and (EE) with respect to dental and oral health services (as defined in section 1861(nnn)), the amount paid shall be (i) in the case of such services that are preven-

tive, 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848, and (ii) in the case of all other such services, 80 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(4) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting '', (2)(II),'' after ''(including administration of the health risk assessment)''.

(5) DENTURES.—Section 1861(s)(8) of the Social Security Act (42 U.S.C. 1395x(s)(8)) is amended—

(A) by striking ''(other than dental)'' and inserting ''(including dentures)''; and

(B) by striking ''internal body''.

(6) REPEAL OF GROUND FOR EXCLUSION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y) is amended by striking paragraph (12).

(7) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2023.

(d) REQUIRING COVERAGE OF DENTAL SERVICES FOR UNDER THE MEDICAID PROGRAM.—

(1) MANDATORY COVERAGE.—

(A) IN GENERAL.—

(i) REQUIREMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended by inserting ", (10)" after "(5)".

(ii) EFFECTIVE DATE.—The amendment made by clause (i) shall apply with respect to medical assistance furnished in calendar quarters beginning on or after the date that is 1 year after the date of the enactment of this Act.

(B) BENCHMARK COVERAGE.—Section 1937(b)(5) of the Social Security Act (42 U.S.C. 1396u–7(b)(5)) is amended by striking the period and inserting , and, beginning with the first quarter beginning on or after the date of the enactment of the Health Equity and Accountability Act of 2022, coverage of dental and

oral health services (as defined in section 1905(kk)).

(2) DEFINITION OF SERVICES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4107, is further amended—

(A) in subsection (a)(10), by striking ''dental services'' and inserting ''dental and oral health services (as defined in subsection (kk)(1))''; and

(B) by adding at the end the following new subsection:

''(kk) DENTAL AND ORAL HEALTH SERVICES.—(1) For purposes of this title, the term 'dental and oral health services' means services necessary to prevent disease and promote oral health, restore oral structures to health and function, reduce oral pain, and treat emergency oral conditions. Such term includes the services specified in paragraph (2).

''(2) For purposes of paragraph (1), the services specified in this paragraph are the following:

''(A) Routine diagnostic and preventive care (such as dental cleanings, exams, and x-rays).

''(B) Basic dental services (such as fillings and extractions) and major dental services (such as root canals, crowns, and dentures).

''(C) Emergency dental care.

''(D) Temporomandibular (TMD) and orofacial pain disorder treatment.

''(E) Other necessary services related to dental and oral health (as specified by the Secretary).''.

''(3) For purposes of paragraph (1), such term shall not include dental care or services provided to individuals under the age of 21 under subsection (r)(3).''.

(3) CONFORMING AMENDMENTS.—

(A) STATE PLAN REQUIREMENTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(i) in paragraph (10)(A), in the matter preceding clause (i), by inserting ''(10),'' after ''(5),'';

(ii) in paragraph (86), by striking ''and'' at the end;

(iii) in paragraph (87), by striking the period at the end and inserting ''; and''; and

(iv) by inserting after paragraph (87) the following:

''(88) provide for—

''(A) informing, in writing, all individuals who have been determined to be eligible for

medical assistance of the availability of dental and oral health services (as defined in section 1905(kk));

"(B) conducting targeted outreach to pregnant women who have been determined to be eligible for medical assistance about the availability of medical assistance for such dental services and the importance of receiving dental care while pregnant; and

"(C) establishing and maintaining standards for and certification of mobile and portable oral health services (as described in section 1905(r)(3)(C)).".

(B) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a)(12) of the Social Security Act (42 U.S.C. 1396d(a)(12)) is amended by striking ", dentures,".

(4) MOBILE AND PORTABLE ORAL HEALTH SERVICES UNDER EPSDT.—Section 1905(r)(3) of the Social Security Act (42 U.S.C. 1396d(r)(3)) is amended—

(A) in subparagraph (A)(ii), by striking "; and" and inserting a semicolon;

(B) in subparagraph (B), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

''(C) which shall include mobile and portable oral health services (as defined by the Secretary) that—

''(i) are provided for the purpose of overcoming mobility, transportation, or access barriers for children; and

''(ii) satisfy the standards and certification requirements established under section 1902(a)(88)(C) for the State in which the services are provided.''.

(5) ENHANCED FMAP; MAINTENANCE OF EFFORT.—

(A) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by paragraph (2), is further amended—

(i) in subsection (b), by striking ''and (ii)'' and inserting ''(ii), and (ll)''; and

(ii) by adding at the end of the following new subsection:

''(ll) INCREASED FMAP FOR EXPENDITURES FOR DENTAL AND ORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Federal medical assistance percentage with respect to amounts expended

by such State for medical assistance consisting of dental and oral health services (as defined in subsection (kk)) furnished during the first calendar quarter beginning on or after the date that is 1 year after the date of the enactment of this subsection or during any subsequent quarter) to individuals 21 years of age or older shall be equal to, in the case of such services furnished—

"(A) during the 3-year period beginning on the first day of such first calendar year, 100 percent;

"(B) during the 1-year period immediately following the period described in subparagraph (A), 95 percent;

"(C) during each subsequent 1-year period (through the third such subsequent period), the percentage specified under this paragraph for the preceding 1-year period, reduced by 5 percentage points; and

"(D) during any quarter beginning after the 7-year period beginning on the first day described in subparagraph (A), 80 percent.

"(2) NO REDUCTION IN FMAP.—Paragraph (1) shall not apply with respect to amounts expended by a State if the Federal medical assistance percentage

otherwise applicable to such amounts without application of such paragraph would be higher than such percentage available to such amounts with application of such paragraph.''.

(6) EXCLUSION OF AMOUNTS ATTRIBUTABLE TO INCREASED FMAP FROM TERRITORIAL CAPS.—Section 1108 of the Social Security Act (42 U.S.C. 1308), as amended by section 4101(a), is amended—

(A) in subsection (f), in the matter preceding paragraph (1), by striking ''subsections (g), (h), and (i)''; and

(B) by adding at the end the following:

''(j) EXCLUSION FROM CAPS OF AMOUNTS ATTRIBUTABLE TO INCREASED FMAP FOR COVERAGE OF DENTAL AND ORAL SERVICES.—Any payment made to a territory for expenditures for medical assistance that are subject to an increase the Federal medical assistance percentage applicable to such expenditures under section 1905(ll) shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) to the extent that such payment exceeds the amount of the payment that would have been made to the territory for such expenditures without regard to such section.''.

(e) ORAL HEALTH SERVICES AS AN ESSENTIAL HEALTH BENEFIT.—Section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)), as amended by section 2013(a), is further amended—

(1) in paragraph (1)—

(A) in subparagraph (J), by striking ''oral and''; and

(B) by adding at the end the following:

''(L) Oral health services for children and adults.''; and

(2) by adding at the end the following:

''(6) ORAL HEALTH SERVICES.—For purposes of paragraph (1)(K), the term 'oral health services' means services (as defined by the Secretary) that are necessary to prevent any oral disease and promote oral health, restore oral structures to health and function, and treat emergency oral conditions.''.

(f) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR VETERANS IN RURAL AND OTHER UNDERSERVED COMMUNITIES.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Secretary of Veterans Affairs may carry out a demonstration program to establish programs to

train and employ alternative dental health care providers in order to increase access to dental health care services for veterans who are entitled to such services from the Department of Veterans Affairs and reside in rural and other underserved communities.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEFINED.—In this subsection, the term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

(g) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR MEMBERS OF THE ARMED FORCES AND DEPENDENTS LACKING READY ACCESS TO SUCH SERVICES.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Secretary of Defense may carry out a demonstration program to establish programs to train and employ alternative dental health care providers in order to increase access to dental health care services for members of the Armed Forces and their dependents who lack ready access to such services, including the following:

(A) Members and dependents who reside in rural areas or areas otherwise underserved by dental health care providers.

(B) Members of a reserve component of the Armed Forces in active status who are potentially deployable.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collabo-

ration and supervision when appropriate and feasible.

(3) DEFINITIONS.—In this subsection:

(A) ACTIVE STATUS.—The term ''active status'' has the meaning given that term in section 101(d) of title 10, United States Code.

(B) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS.—The term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

(h) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES FOR PRISONERS WITHIN THE CUSTODY OF THE BUREAU OF PRISONS.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Attorney General, acting through the Director of the Bureau of Prisons, may carry out a demonstration program to establish programs to train and employ alternative dental health care providers

in order to increase access to dental health services for prisoners within the custody of the Bureau of Prisons.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEFINED.—In this subsection, the term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

(i) DEMONSTRATION PROGRAM ON TRAINING AND EMPLOYMENT OF ALTERNATIVE DENTAL HEALTH CARE PROVIDERS FOR DENTAL HEALTH CARE SERVICES UNDER THE INDIAN HEALTH SERVICE.—

(1) DEMONSTRATION PROGRAM AUTHORIZED.—The Secretary of Health and Human Services, acting through the Indian Health Service, may carry out a demonstration program to establish programs to train and employ alternative dental health care providers in order to help eliminate oral health disparities and increase access to dental services through health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations.

(2) TELEHEALTH.—For purposes of alternative dental health care providers and other dental care providers who are licensed to provide clinical care, dental services provided under the demonstration program under this subsection may be administered by such providers through telehealth-enabled collaboration and supervision when appropriate and feasible.

(3) DEFINITIONS.—In this subsection:

(A) ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEFINED.—The term ''alternative dental health care providers'' has the meaning given that term in section 340G–1(a)(2) of the Public Health Service Act (42 U.S.C. 256g–1(a)(2)).

(B) INDIAN HEALTH CARE IMPROVEMENT ACT.—The terms ''Indian tribe'', ''tribal organization'', and ''Urban Indian organization'' have the meaning given the terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the demonstration program under this subsection.

SEC. 4252. ORAL HEALTH LITERACY AND AWARENESS CAMPAIGN.

The Public Health Service Act is amended by inserting after section 340G–1 of such Act (42 U.S.C. 256g–1) the following:

''SEC. 340G–2. ORAL HEALTH LITERACY AND AWARENESS.

''(a) CAMPAIGN.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a public education campaign (referred to in this subsection as the 'campaign') across all relevant programs of the Health Resources and Services Administration (including the health center program, oral health workforce programs, maternal and child health programs, the Ryan White HIV/AIDS Program, and rural

health programs) to increase oral health literacy and awareness.

''(b) STRATEGIES.—In carrying out the campaign, the Secretary shall identify oral health literacy and awareness strategies that are evidence-based and focused on oral health care education, including education on prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

''(c) FOCUS.—The Secretary shall design the campaign to communicate directly with specific populations, including children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives, and Native Hawaiians, in a culturally and linguistically appropriate manner.

''(d) OUTCOMES.—In carrying out the campaign, the Secretary shall include a process for measuring outcomes and effectiveness.

''(e) REPORT TO CONGRESS.—Not later than 3 years after the date of enactment of this section, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the outcomes and effectiveness of the campaign.

"(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $750,000 for each of fiscal years 2023 through 2027.".

Subtitle D—Advancing Health Equity Through Payment and Delivery Reform

SEC. 4301. SENSE OF CONGRESS.

It is the sense of Congress that—

(1) the sustainability of the health care system in the United States hinges on restructuring how health care is paid for, shifting away from paying for the volume of services provided to the value the services provide;

(2) high value care is care that provides higher quality care more efficiently, achieving greater health improvement and better health outcomes at lower cost (per patient and overall);

(3) a high value health care system must deliver timely, accessible, well-coordinated, high-quality, culturally centered, and language-appropriate care to everyone;

(4) eliminating health and health care disparities and achieving health equity must be central to

and required in efforts to achieve a high value health care system;

(5) eliminating such disparities and achieving such equity will require tailored interventions and targeted investments to address inequities in health and health care to make sure that health care delivery and payment efforts are responsive to and inclusive of the needs of communities of color and other communities experiencing disparities; and

(6) new models of value-based payment and care delivery should prioritize primary care and consider the holistic needs of and other factors with respect to the patient population, including with respect to behavioral health, oral health, end-of-life care, history of adverse childhood experiences and adverse community environments, social determinants of health, social risk factors, unmet social needs, and the burden of intergenerational racial and other inequities.

SEC. 4302. CENTERS FOR MEDICARE & MEDICAID SERVICES REPORTING AND VALUE BASED PROGRAMS.

(a) ADVANCING HEALTH EQUITY IN REPORTING AND VALUE BASED PAYMENT PROGRAMS.—

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services (in this

section referred to as the ''Administrator'') shall require that a clinician or other professional participating in any pay-for-reporting or value based payment program stratify clinical quality measures by disparity variables, including race, ethnicity, sex, primary language, disability status, sexual orientation, gender identity, and socioeconomic status. A clinician or other professional may use existing demographic data collection fields in certified electronic health record technology (as defined in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4))) to carry out such data stratification under the preceding sentence. Such stratified data will assist clinicians and other professionals in the identification of disparities obscured in aggregated data and assist with the provision of interventions that target reducing those disparities.

(2) CLINICIAN.—In assessing performance in any value-based payment program, the Administrator shall incorporate a clinician or other professional's performance in reducing disparities across race, ethnicity, sex, primary language, disability status, sexual orientation, gender identity, and socioeconomic status. Linking performance payments to the reduction of health care disparities across such

variables will assist in holding clinicians and other professionals accountable for providing quality care that can lead to decreased health inequities.

(3) REQUIREMENT OF ADOPTION OF CERT.—All entities, clinicians, or other professionals participating in the Quality Payment Program of the Centers for Medicare & Medicaid Services shall be required to adopt 2015 certified electronic health record technology (as so defined) as a condition of participating in such program.

(b) QUALITY IMPROVEMENT ACTIVITIES.—The Administrator, upon yearly review of the Quality Payment Program, shall add quality improvement activities that implement the Culturally and Linguistically Accessible Standards (CLAS) as Improvement Activities under the Quality Payment Program.

SEC. 4303. DEVELOPMENT AND TESTING OF DISPARITY REDUCING DELIVERY AND PAYMENT MODELS.

(a) IN GENERAL.—The Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (42 U.S.C. 1315a) (in this section referred to as the ''CMI'') shall establish a dedicated fund to identify, test, evaluate, and scale delivery and payment models under the applicable titles (as defined in subsection (a)(4)(B) of such section) that target health disparities

among racial and ethnic minorities, including models that support high-value nonmedical services that address socially determined barriers to health in all stages of the life cycle through end-of-life, including English proficiency status, low health and health care literacy, lack of access to health care planning, including end-of-life care planning, case management, transportation, enrollment assistance needs, stable and affordable housing, utility assistance, employment and career development, and nutrition and food security which will help to reduce disparities and impact the overall cost of care.

(b) AMENDMENT TO SOCIAL SECURITY ACT.—The second sentence of section 1115A(a)(1) of the Social Security Act (42 U.S.C. 1315a(a)(1)) is amended by inserting ''and improve health equity'' after ''expenditures''.

(c) PILOT PROGRAMS.—The CMI shall prioritize the testing of models under such section 1115A that include partnerships with entities, including community based organizations or other nonprofit entities, to help address socially determined barriers to health and health care.

(d) ALTERNATIVES.—Any model tested by the CMI under such 1115A shall include measures to assess and track the impact of the model on health disparities, using existing measures such as the Healthcare Disparities and Cultural Competency Measures endorsed by the entity

with a contract under section 1890(a) of the Social Security Act (42 U.S.C. 1395aaa(a)), and stratified by race, ethnicity, English proficiency, gender identity, sexual orientation, and disability status.

SEC. 4304. DIVERSITY IN CENTERS FOR MEDICARE AND MEDICAID CONSULTATION.

(a) IN GENERAL.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management, specifically such experts with expertise in—

(1) the health care needs of minority, rural, and underserved populations; and

(2) the financial needs of safety net, community based, rural, and critical access providers, including federally qualified health centers.

(b) OPEN DOOR FORUMS.—The CMI shall use open door forums or other mechanisms to seek external feedback from interested parties and incorporate that feedback into the development of models.

SEC. 4305. SUPPORTING SAFETY NET AND COMMUNITY-BASED PROVIDERS TO COMPETE IN VALUE-BASED PAYMENT SYSTEMS.

(a) IN GENERAL.—Any pay-for-performance or alternative payment model that is developed and tested by the

Center for Medicare and Medicaid Innovation established under section 1115A of the Social Security Act (42 U.S.C. 1315a), or any other agency of the Department of Health and Human Services with respect to the programs under titles XVIII, XIX, or XXI of such Act, shall be assessed for potential impact on safety net, community based, and critical access providers, including Federally qualified health centers.

(b) NEW MODELS.—The rollout of any such models shall include training and additional up front resources for community based and safety net providers to enable those providers to participate in the model.

Subtitle E—Health Empowerment Zones

SEC. 4401. DESIGNATION OF HEALTH EMPOWERMENT ZONES.

(a) IN GENERAL.—The Secretary may, at the request of an eligible community partnership described in subsection (b)(1), designate an eligible area described in subsection (b)(2) as a health empowerment zone for the purpose of eligibility for a grant under section 4402.

(b) ELIGIBILITY CRITERIA.—

(1) ELIGIBLE COMMUNITY PARTNERSHIP.—A community partnership is eligible to submit a request under this section if the partnership—

(A) demonstrates widespread public support from key individuals and entities in the eligible area, including members of the target community, State and local governments, nonprofit organizations including national and regional intermediaries with demonstrated capacity to serve low-income urban communities, and community and industry leaders, for designation of the eligible area as a health empowerment zone; and

(B) includes representatives of—

(i) a broad cross section of stakeholders and residents from communities in the eligible area experiencing disproportionate disparities in health status and health care; and

(ii) organizations, facilities, and institutions that have a history of working within and serving such communities.

(2) ELIGIBLE AREA.—An area is eligible to be designated as a health empowerment zone under this section if one or more communities in the area experience disproportionate disparities in health status and health care. In determining whether a community experiences such disparities, the Secretary shall

consider data collected by the Department of Health and Human Services focusing on the following areas:

(A) Access to affordable, high-quality health care services.

(B) The prevalence of disproportionate rates of certain illnesses or diseases including the following:

(i) Arthritis, osteoporosis, chronic back conditions, and other musculoskeletal diseases.

(ii) Cancer.

(iii) Chronic kidney disease.

(iv) Diabetes.

(v) Injury (intentional and unintentional).

(vi) Violence (intimate and non-intimate).

(vii) Maternal and paternal illnesses and diseases.

(viii) Infant mortality.

(ix) Mental illness and other disabilities.

(x) Substance use disorder treatment and prevention, including underage drinking.

(xi) Nutrition, obesity, and overweight conditions.

(xii) Heart disease.

(xiii) Hypertension.

(xiv) Cerebrovascular disease or stroke.

(xv) Tuberculosis.

(xvi) HIV/AIDS and other sexually transmitted infections.

(xvii) Viral hepatitis.

(xviii) Asthma.

(xix) Tooth decay and other oral health issues.

(C) Within the community, the historical and persistent presence of conditions that have been found to contribute to health disparities including any such conditions respecting any of the following:

(i) Poverty.

(ii) Educational status and the quality of community schools.

(iii) Income.

(iv) Access to high-quality affordable health care.

(v) Work and work environment.

(vi) Environmental conditions in the community, including with respect to clean water, clean air, and the presence or absence of pollutants.

(vii) Language and English proficiency.

(viii) Access to affordable healthy food.

(ix) Access to ethnically and culturally diverse health and human service providers and practitioners.

(x) Access to culturally and linguistically competent health and human services and health and human service providers.

(xi) Health-supporting infrastructure.

(xii) Health insurance that is adequate and affordable.

(xiii) Race, racism, and bigotry (conscious and unconscious).

(xiv) Sexual orientation.

(xv) Health and health care literacy.

(xvi) Place of residence (such as urban areas, rural areas, and reservations of Indian Tribes).

(xvii) Stress.

(c) PROCEDURE.—

(1) REQUEST.—A request under subsection (a) shall—

(A) describe the bounds of the area to be designated as a health empowerment zone and the process used to select those bounds;

(B) demonstrate that the partnership submitting the request is an eligible community partnership described in subsection (b)(1);

(C) demonstrate that the area is an eligible area described in subsection (b)(2);

(D) include a comprehensive assessment of disparities in health status and health care experience by one or more communities in the area;

(E) set forth—

(i) a vision and a set of values for the area; and

(ii) a comprehensive and holistic set of goals to be achieved in the area through designation as a health empowerment zone; and

(F) include a strategic plan and an action plan for achieving the goals described in subparagraph (E)(ii).

(2) APPROVAL.—Not later than 60 days after the receipt of a request for designation of an area as a health empowerment zone under this section, the Secretary shall approve or disapprove the request.

(d) MINIMUM NUMBER.—The Secretary—

(1) shall designate not more than 110 health empowerment zones under this section; and

(2) of such zones designated under paragraph (1), shall designate at least one health empowerment zone in each of the several States, the District of Columbia, and each territory or possession of the United States.

SEC. 4402. ASSISTANCE TO THOSE SEEKING DESIGNATION.

At the request of any organization or entity seeking to submit a request under section 4401(a), the Secretary shall provide technical assistance, and may award a grant, to assist such organization or entity—

(1) to form an eligible community partnership described in section 4401(b)(1);

(2) to complete a health assessment, including an assessment of health disparities under section 4401(c)(1)(D); or

(3) to prepare and submit a request, including a strategic plan, in accordance with section 4401.

SEC. 4403. BENEFITS OF DESIGNATION.

(a) PRIORITY.—In awarding a grant under subsection (b), a Federal official shall give priority to any applicant that—

(1) meets the eligibility criteria for the grant;

(2) proposes to use the grant for activities in a health empowerment zone; and

(3) demonstrates that such activities will directly and significantly further the goals of the strategic plan approved for such zone under section 4401.

(b) GRANTS FOR INITIAL IMPLEMENTATION OF STRATEGIC PLAN.—

(1) IN GENERAL.—Upon designating an eligible area as a health empowerment zone at the request of an eligible community partnership, the Secretary shall, subject to the availability of appropriations, make a grant to the community partnership for implementation of the strategic plan for such zone.

(2) GRANT PERIOD.—A grant under paragraph (1) for a health empowerment zone shall be for a period of 2 years and may be renewed, except that the total period of grants under paragraph (1) for such zone may not exceed 10 years.

(3) LIMITATION.—In awarding grants under this subsection, the Secretary shall not give less priority to an applicant or reduce the amount of a grant because the Secretary rendered technical assistance or made a grant to the same applicant under section 4401.

(4) REPORTING.—The Secretary shall establish metrics for measuring the progress of grantees under this subsection and, based on such metrics, require each such grantee to report to the Secretary not less than every 6 months on the progress in implementing the strategic plan for the health empowerment zone.

SEC. 4404. DEFINITION OF SECRETARY.

In this subtitle, the term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and the Deputy Assistant Secretary for Minority Health, and in cooperation with the Director of the Office of Community Services and the Director of the Na-

tional Institute on Minority Health and Health Disparities.

SEC. 4405. AUTHORIZATION OF APPROPRIATIONS.

To carry out this subtitle, there is authorized to be appropriated $100,000,000 for fiscal year 2023.

Subtitle F—Equitable Health Care For All

SEC. 4501. FINDINGS.

Congress finds the following:

(1) In 1966, Dr. Martin Luther King, Jr., said ''Of all the forms of inequality, injustice in health care is the most shocking and inhuman because it often results in physical death.''.

(2) Inequity in health care remains a persistent and devastating reality for many communities, and, in particular, communities of color.

(3) The provision of inequitable health care has complex causes, many stemming from systemic inequality in access to health care, housing, nutrition, economic opportunity, education, and other factors.

(4) Health care outcomes for Black communities in particular lag far behind those of the population as a whole.

(5) Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases,

said on April 7, 2020, the coronavirus outbreak is ''shining a bright light'' on ''unacceptable'' health disparities in the Black community.

(6) A contributing factor in health disparities is explicit and implicit bias in the delivery of health care, resulting in inferior care and poorer outcomes for some patients on the basis of factors that include race, national origin, sex (including sexual orientation or gender identity), disability, age, and religion.

(7) The National Academy of Medicine (formerly known as the ''Institute of Medicine'') issued a report in 2002 titled ''Unequal Treatment'', finding that racial and ethnic minorities receive lower-quality health care than Whites do, even when insurance status, income, age, and severity of condition is comparable.

(8) Just as Congress has sought to eliminate bias, both explicit and implicit, in employment, housing, and other parts of our society, the elimination of bias and the legacy of structural racism in health care is of paramount importance.

SEC. 4502. DATA COLLECTION AND REPORTING.

(a) REQUIRED REPORTING.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Director

for Civil Rights and Health Equity, the Director of the National Institutes of Health, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Agency for Healthcare Research and Quality, the Deputy Assistant Secretary for Minority Health, and the Director of the Centers for Disease Control and Prevention, shall by regulation require all health care providers and facilities that are required under other provisions of law to report data on specific health outcomes to the Department of Health and Human Services in aggregate form, to disaggregate such data by demographic characteristics, including by race, national origin, sex (including sexual orientation and gender identity), disability, and age, as well as any other factor that the Secretary of Health and Human Services determines would be useful for determining a pattern of provision of inequitable health care.

(2) PROPOSED REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall issue proposed regulations to carry out paragraph (1).

(b) REPOSITORY.—The Secretary of Health and Human Services shall—

(1) not later than 1 year after the date of enactment of this Act, establish a repository of the disaggregated data reported pursuant to subsection (a);

(2) subject to paragraph (3), make the data in such repository publicly available; and

(3) ensure that such repository does not contain any data that is individually identifiable.

SEC. 4503. REQUIRING EQUITABLE HEALTH CARE IN THE HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) EQUITABLE HEALTH CARE AS VALUE MEASUREMENT.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended by adding at the end the following new subclause:

''(XIII)(aa) Effective for payments beginning with fiscal year 2024, in expanding the number of measures under subclause (III), the Secretary shall adopt measures that relate to equitable health care furnished by hospitals in inpatient settings.

''(bb) In carrying out this subclause, the Secretary shall solicit input and recommendations from individuals and groups representing communities of color and other protected classes and ensure measures adopted pursuant to this subclause account for social determinants of health,

as defined in section 4506(e)(10) of the Health Equity and Accountability Act of 2022.

''(cc) For purposes of this subclause, the term 'equitable health care' refers to the principle that high-quality care should be provided to all individuals and health care treatment and services should not vary on account of the real or perceived race, national origin, sex (including sexual orientation and gender identity), disability, or age of an individual, as well as any other factor that the Secretary determines would be useful for determining a pattern of provision of inequitable health care.''.

(b) INCLUSION OF EQUITABLE HEALTH CARE MEASURES.—Section 1886(o)(2)(B) of the Social Security Act (42 U.S.C. 1395ww(o)(2)(B)) is amended by adding at the end the following new clause:

''(iv) INCLUSION OF EQUITABLE HEALTH CARE MEASURES.—Beginning in fiscal year 2024, measures selected under subparagraph (A) shall include the equitable health care measures described in subsection (b)(3)(B)(viii)(XIII).''.

SEC. 4504. PROVISION OF INEQUITABLE HEALTH CARE AS A BASIS FOR PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(18) PROVISION OF INEQUITABLE HEALTH CARE.—

"(A) IN GENERAL.—Subject to subparagraph (B), any health care provider that the Secretary determines has engaged in a pattern of providing inequitable health care (as defined in section 4506(e)(7) of the Health Equity and Accountability Act of 2022) on the basis of race, national origin, sex (including sexual orientation and gender identity), disability, or age of an individual.

"(B) EXCEPTION.—For purposes of carrying out subparagraph (A), the Secretary shall not exclude any health care provider from participation in the Medicare program under title XVIII of the Social Security Act or the Medicaid program under title XIX of such Act if the exclusion of such health care provider would result in increased difficulty in access to health

care services for underserved or low-income communities.''.

SEC. 4505. OFFICE FOR CIVIL RIGHTS AND HEALTH EQUITY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) NAME OF OFFICE.—Beginning on the date of enactment of this Act, the Office for Civil Rights of the Department of Health and Human Services shall be known as the ''Office for Civil Rights and Health Equity'' of the Department of Health and Human Services. Any reference to the Office for Civil Rights of the Department of Health and Human Services in any law, regulation, map, document, record, or other paper of the United States shall be deemed to be a reference to the Office for Civil Rights and Health Equity.

(b) HEAD OF OFFICE.—The head of the Office for Civil Rights and Health Equity shall be the Director for Civil Rights and Health Equity, to be appointed by the President. Any reference to the Director of the Office for Civil Rights of the Department of Health and Human Services in any law, regulation, map, document, record, or other paper of the United States shall be deemed to be a reference to the Director for Civil Rights and Health Equity.

SEC. 4506. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) PROHIBITING DISCRIMINATION.—

(1) IN GENERAL.—No health care provider may, on the basis, in whole or in part, of race, sex (including sexual orientation and gender identity), disability, age, or religion, subject an individual to the provision of inequitable health care.

(2) NOTICE OF PATIENT RIGHTS.—The Secretary shall provide to each patient a notice of a patient's rights under this section.

(b) ADMINISTRATIVE COMPLAINT AND CONCILIATION PROCESS.—

(1) COMPLAINTS AND ANSWERS.—

(A) IN GENERAL.—An aggrieved person may, not later than 1 year after an alleged violation of subsection (a) has occurred or concluded, file a complaint with the Director alleging provision of inequitable health care by a provider described in subsection (a).

(B) COMPLAINT.—A complaint submitted pursuant to subparagraph (A) shall be in writing and shall contain such information and be in such form as the Director requires.

(C) OATH OR AFFIRMATION.—The complaint and any answer made under this sub-

section shall be made under oath or affirmation, and may be reasonably and fairly modified at any time.

(2) RESPONSE TO COMPLAINTS.—

(A) IN GENERAL.—Upon the filing of a complaint under this subsection, the following procedures shall apply:

(i) COMPLAINANT NOTICE.—The Director shall serve notice upon the complainant acknowledging receipt of such filing and advising the complainant of the time limits and procedures provided under this section.

(ii) RESPONDENT NOTICE.—The Director shall, not later than 30 days after receipt of such filing—

(I) serve on the respondent a notice of the complaint, together with a copy of the original complaint; and

(II) advise the respondent of the procedural rights and obligations of respondents under this section.

(iii) ANSWER.—The respondent may file, not later than 60 days after receipt of

the notice from the Director, an answer to such complaint.

(iv) INVESTIGATIVE DUTIES.—The Director shall—

(I) make an investigation of the alleged provision of inequitable health care; and

(II) complete such investigation within 180 days (unless it is impracticable to complete such investigation within 180 days) after the filing of the complaint.

(B) INVESTIGATIONS.—

(i) PATTERN OR PRACTICE.—In the course of investigating the complaint, the Director may seek records of care provided to patients other than the complainant if necessary to demonstrate or disprove an allegation of provision of inequitable health care or to determine whether there is a pattern or practice of such care.

(ii) ACCOUNTING FOR SOCIAL DETERMINANTS OF HEALTH.—In investigating the complaint and reaching a determination on the validity of the complaint, the

Director shall account for social determinants of health and the effect of such social determinants on health care outcomes.

(iii) INABILITY TO COMPLETE INVESTIGATION.—If the Director is unable to complete (or finds it is impracticable to complete) the investigation within 180 days after the filing of the complaint (or, if the Secretary takes further action under paragraph (6)(B) with respect to a complaint, within 180 days after the commencement of such further action), the Director shall notify the complainant and respondent in writing of the reasons involved.

(iv) REPORT TO STATE LICENSING AUTHORITIES.—On concluding each investigation under this subparagraph, the Director shall provide to the appropriate State licensing authorities information specifying the results of the investigation.

(C) REPORT.—

(i) FINAL REPORT.—On completing each investigation under this paragraph,

the Director shall prepare a final investigative report.

(ii) MODIFICATION OF REPORT.—A final report under this subparagraph may be modified if additional evidence is later discovered.

(3) CONCILIATION.—

(A) IN GENERAL.—During the period beginning on the date on which a complaint is filed under this subsection and ending on the date of final disposition of such complaint (including during an investigation under paragraph (2)(B)), the Director shall, to the extent feasible, engage in conciliation with respect to such complaint.

(B) CONCILIATION AGREEMENT.—A conciliation agreement arising out of such conciliation shall be an agreement between the respondent and the complainant, and shall be subject to approval by the Director.

(C) RIGHTS PROTECTED.—The Director shall approve a conciliation agreement only if the agreement protects the rights of the complainant and other persons similarly situated.

(D) PUBLICLY AVAILABLE AGREEMENT.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall make available to the public a copy of a conciliation agreement entered into pursuant to this subsection unless the complainant and respondent otherwise agree, and the Secretary determines, that disclosure is not required to further the purposes of this subsection.

(ii) LIMITATION.—A conciliation agreement that is made available to the public pursuant to clause (i) may not disclose individually identifiable health information.

(4) FAILURE TO COMPLY WITH CONCILIATION AGREEMENT.—Whenever the Director has reasonable cause to believe that a respondent has breached a conciliation agreement, the Director shall refer the matter to the Attorney General to consider filing a civil action to enforce such agreement.

(5) WRITTEN CONSENT FOR DISCLOSURE OF INFORMATION.—Nothing said or done in the course of conciliation under this subsection may be made public, or used as evidence in a subsequent pro-

ceeding under this subsection, without the written consent of the parties to the conciliation.

(6) PROMPT JUDICIAL ACTION.—

(A) IN GENERAL.—If the Director determines at any time following the filing of a complaint under this subsection that prompt judicial action is necessary to carry out the purposes of this subsection, the Director may recommend that the Attorney General promptly commence a civil action under subsection (d).

(B) IMMEDIATE SUIT.—If the Director determines at any time following the filing of a complaint under this subsection that the public interest would be served by allowing the complainant to bring a civil action under subsection (c) in a State or Federal court immediately, the Director shall certify that the administrative process has concluded and that the complainant may file such a suit immediately.

(7) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director shall make publicly available a report detailing the activities of the Office for Civil Rights and Health Equity under this subsection, including—

(A) the number of complaints filed and the basis on which the complaints were filed;

(B) the number of investigations undertaken as a result of such complaints; and

(C) the disposition of all such investigations.

(c) ENFORCEMENT BY PRIVATE PERSONS.—

(1) IN GENERAL.—

(A) CIVIL ACTION.—

(i) IN SUIT.—A complainant under subsection (b) may commence a civil action to obtain appropriate relief with respect to an alleged violation of subsection (a), or for breach of a conciliation agreement under subsection (b), in an appropriate district court of the United States or State court—

(I) not sooner than the earliest of—

(aa) the date a conciliation agreement is reached under subsection (b);

(bb) the date of a final disposition of a complaint under subsection (b); or

(cc) 180 days after the first day of the alleged violation; and

(II) not later than 2 years after the final day of the alleged violation.

(ii) STATUTE OF LIMITATIONS.—The computation of such 2-year period shall not include any time during which an administrative proceeding (including investigation or conciliation) under subsection (b) was pending with respect to a complaint under such subsection.

(B) BARRING SUIT.—If the Director has obtained a conciliation agreement under subsection (b) regarding an alleged violation of subsection (a), no action may be filed under this paragraph by the complainant involved with respect to the alleged violation except for the purpose of enforcing the terms of such an agreement.

(2) RELIEF WHICH MAY BE GRANTED.—

(A) IN GENERAL.—In a civil action under paragraph (1), if the court finds that a violation of subsection (a) or breach of a conciliation agreement has occurred, the court may award to the plaintiff actual and punitive damages,

and may grant as relief, as the court determines to be appropriate, any permanent or temporary injunction, temporary restraining order, or other order (including an order enjoining the defendant from engaging in a practice violating subsection (a) or ordering such affirmative action as may be appropriate).

(B) FEES AND COSTS.—In a civil action under paragraph (1), the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee and costs. The United States shall be liable for such fees and costs to the same extent as a private person.

(3) INTERVENTION BY ATTORNEY GENERAL.—Upon timely application, the Attorney General may intervene in a civil action under paragraph (1), if the Attorney General certifies that the case is of general public importance.

(d) ENFORCEMENT BY THE ATTORNEY GENERAL.—

(1) COMMENCEMENT OF ACTIONS.—

(A) PATTERN OR PRACTICE CASES.—The Attorney General may commence a civil action in any appropriate district court of the United States if the Attorney General has reasonable

cause to believe that any health care provider covered by subsection (a)—

(i) is engaged in a pattern or practice that violates such subsection; or

(ii) is engaged in a violation of such subsection that raises an issue of significant public importance.

(B) CASES BY REFERRAL.—The Director may determine, based on a pattern of complaints, a pattern of violations, a review of data reported by a health care provider covered by subsection (a), or any other means, that there is reasonable cause to believe a health care provider is engaged in a pattern or practice that violates subsection (a). If the Director makes such a determination, the Director shall refer the related findings to the Attorney General. If the Attorney General finds that such reasonable cause exists, the Attorney General may commence a civil action in any appropriate district court of the United States.

(2) ENFORCEMENT OF SUBPOENAS.—The Attorney General, on behalf of the Director, or another party at whose request a subpoena is issued under this subsection, may enforce such subpoena in ap-

propriate proceedings in the district court of the United States for the district in which the person to whom the subpoena was addressed resides, was served, or transacts business.

(3) RELIEF WHICH MAY BE GRANTED IN CIVIL ACTIONS.—

(A) IN GENERAL.—In a civil action under 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

(II) in an amount not exceeding $1,000,000, for any subsequent violation.

(B) FEES AND COSTS.—In a civil action under this subsection, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee and costs. The United States shall be liable for such fees and costs to the extent provided by section 2412 of title 28, United States Code.

(4) INTERVENTION IN CIVIL ACTIONS.—Upon timely application, any person may intervene in a civil action commenced by the Attorney General under paragraphs (1) and (2) if the action involves an alleged violation of subsection (a) with respect to which such person is an aggrieved person (including a person who is a complainant under subsection (b)) or a conciliation agreement to which such person is a party.

(e) DEFINITIONS.—In this section:

(1) AGGRIEVED PERSON.—The term ''aggrieved person'' means—

(A) a person who believes that the person was or will be injured in violation of subsection (a); or

(B) the personal representative or estate of a deceased person who was injured in violation of subsection (a).

(2) DIRECTOR.—The term ''Director'' means the Director for Civil Rights and Health Equity of the Department of Health and Human Services.

(3) DISABILITY.—The term ''disability'' has the meaning given such term in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102).

(4) CONCILIATION.—The term ''conciliation'' means the attempted resolution of issues raised by a complaint, or by the investigation of such complaint, through informal negotiations involving the complainant, the respondent, and the Secretary.

(5) CONCILIATION AGREEMENT.—The term ''conciliation agreement'' means a written agreement setting forth the resolution of the issues in conciliation.

(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ''individually identifiable health information'' means any information, including demographic information collected from an individual—

(A) that is created or received by a health care provider covered by subsection (a), health plan, employer, or health care clearinghouse;

(B) that relates to the past, present, or future physical or mental health or condition of, the provision of health care to, or the past, present, or future payment for the provision of health care to, the individual; and

(C)(i) that identifies the individual; or

(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(7) PROVISION OF INEQUITABLE HEALTH CARE.—The term ''provision of inequitable health care'' means the provision of any health care service, by a health care provider in a manner that—

(A) fails to meet a high-quality care standard, meaning the health care provider fails to—

(i) avoid harm to patients as a result of the health services that are intended to help the patient;

(ii) provide health services based on scientific knowledge to all and to all patients who benefit;

(iii) refrain from providing services to patients not likely to benefit;

(iv) provide care that is responsive to patient preferences, needs, and values; and

(v) avoids waits or delays in care; and

(B) is discriminatory in intent or effect based at least in part on a basis specified in subsection (a).

(8) RESPONDENT.—The term ''respondent'' means the person or other entity accused in a complaint of a violation of subsection (a).

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(10) SOCIAL DETERMINANTS OF HEALTH.—The term ''social determinants of health'' means conditions in the environments in which individuals live, work, attend school, and worship, that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as repealing or limiting the effect of title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), section 504 of

the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.).

SEC. 4507. FEDERAL HEALTH EQUITY COMMISSION.

(a) ESTABLISHMENT OF COMMISSION.—

(1) IN GENERAL.—There is established the Federal Health Equity Commission (in this section referred to as the ''Commission'').

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Commission shall be composed of—

(i) 8 voting members appointed under subparagraph (B); and

(ii) the nonvoting, ex officio members listed in subparagraph (C).

(B) VOTING MEMBERS.—Not more than 4 of the members described in subparagraph (A)(i) shall at any one time be of the same political party. Such members shall have recognized expertise in and personal experience with racial and ethnic health inequities, health care needs of vulnerable and marginalized populations, and health equity as a vehicle for improving health status and health outcomes. Such members shall be appointed to the Commission as follows:

(i) 4 members of the Commission shall be appointed by the President.

(ii) 2 members of the Commission shall be appointed by the President pro tempore of the Senate, upon the recommendations of the majority leader and the minority leader of the Senate. Each member appointed to the Commission under this clause shall be appointed from a different political party.

(iii) 2 members of the Commission shall be appointed by the Speaker of the House of Representatives upon the recommendations of the majority leader and the minority leader of the House of Representatives. Each member appointed to the Commission under this clause shall be appointed from a different political party.

(C) EX OFFICIO MEMBER.—The Commission shall have the following nonvoting, ex officio members:

(i) The Director for Civil Rights and Health Equity of the Department of Health and Human Services.

(ii) The Deputy Assistant Secretary for Minority Health of the Department of Health and Human Services.

(iii) The Director of the National Institute on Minority Health and Health Disparities.

(iv) The Chairperson of the Advisory Committee on Minority Health established under section 1707(c) of the Public Health Service Act (42 U.S.C. 300u–6(c)).

(3) TERMS.—The term of office of each member appointed under paragraph (2)(B) of the Commission shall be 6 years.

(4) CHAIRPERSON; VICE CHAIRPERSON.—

(A) CHAIRPERSON.—The President shall, with the concurrence of a majority of the members of the Commission appointed under paragraph (2)(B), designate a Chairperson from among the members of the Commission appointed under such paragraph.

(B) VICE CHAIRPERSON.—

(i) DESIGNATION.—The Speaker of the House of Representatives shall, in consultation with the majority leaders and the minority leaders of the Senate and the

House of Representatives and with the concurrence of a majority of the members of the Commission appointed under paragraph (2)(B), designate a Vice Chairperson from among the members of the Commission appointed under such paragraph. The Vice Chairperson may not be a member of the same political party as the Chairperson.

(ii) DUTY.—The Vice Chairperson shall act in place of the Chairperson in the absence of the Chairperson.

(5) REMOVAL OF MEMBERS.—The President may remove a member of the Commission only for neglect of duty or malfeasance in office.

(6) QUORUM.—A majority of members of the Commission appointed under paragraph (2)(B) shall constitute a quorum of the Commission, but a lesser number of members may hold hearings.

(b) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) monitor and report on the implementation of this Act; and

(B) investigate, monitor, and report on progress towards health equity and the elimination of health disparities.

(2) ANNUAL REPORT.—The Commission shall—

(A) submit to the President and Congress at least one report annually on health equity and health disparities; and

(B) include in such report—

(i) a description of actions taken by the Department of Health and Human Services and any other Federal agency related to health equity or health disparities; and

(ii) recommendations on ensuring equitable health care and eliminating health disparities.

(c) POWERS.—

(1) HEARINGS.—

(A) IN GENERAL.—The Commission or, at the direction of the Commission, any subcommittee or member of the Commission, may, for the purpose of carrying out this section, as the Commission or the subcommittee or member considers advisable—

(i) hold such hearings, meet and act at such times and places, take such testimony, receive such evidence, and administer such oaths; and

(ii) require, by subpoena or otherwise, the attendance and testimony of such witnesses and the production of such books, records, correspondence, memoranda, papers, documents, tapes, and materials.

(B) LIMITATION ON HEARINGS.—The Commission may hold a hearing under subparagraph (A)(i) only if the hearing is approved—

(i) by a majority of the members of the Commission appointed under subsection (a)(2)(B); or

(ii) by a majority of such members present at a meeting when a quorum is present.

(2) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

(A) ISSUANCE.—A subpoena issued under paragraph (1) shall—

(i) bear the signature of the Chairperson of the Commission; and

(ii) be served by any person or class of persons designated by the Chairperson for that purpose.

(B) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under paragraph (1), the United States district court for the district in which the subpoenaed person resides, is served, or may be found may issue an order requiring the person to appear at any designated place to testify or to produce documentary or other evidence.

(C) NONCOMPLIANCE.—Any failure to obey the order of the court may be punished by the court as a contempt of court.

(3) WITNESS ALLOWANCES AND FEES.—

(A) IN GENERAL.—Section 1821 of title 28, United States Code, shall apply to a witness requested or subpoenaed to appear at a hearing of the Commission.

(B) EXPENSES.—The per diem and mileage allowances for a witness shall be paid from funds available to pay the expenses of the Commission.

(4) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and

under the same conditions as other agencies of the Federal Government.

(5) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(d) ADMINISTRATIVE PROVISIONS.—

(1) STAFF.—

(A) DIRECTOR.—There shall be a full-time staff director for the Commission who shall—

(i) serve as the administrative head of the Commission; and

(ii) be appointed by the Chairperson with the concurrence of the Vice Chairperson.

(B) OTHER PERSONNEL.—The Commission may—

(i) appoint such other personnel as it considers advisable, subject to the provisions of title 5, United States Code, governing 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.

(B) FEDERAL EMPLOYEES.—Each member of the Commission who is an officer or employee of the Federal Government shall serve without compensation in addition to the compensation received for the services of the mem-

ber as an office or employee of the Federal Government.

(C) TRAVEL EXPENSES.—A member of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Commission.

(3) COOPERATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this Act. Upon request of the Chairman of the Commission, the head of such department or agency shall furnish such information to the Commission.

(e) PERMANENT COMMISSION.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal year 2022 and each fiscal year thereafter such sums as may be necessary to carry out the duties of the Commission.

SEC. 4508. GRANTS FOR HOSPITALS TO PROMOTE EQUITABLE HEALTH CARE AND OUTCOMES.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall award grants to hospitals to promote equitable health care treatment and services, and reduce disparities in care and outcomes.

(b) CONSULTATION.—In establishing the criteria for grants under this section and evaluating applications for such grants, the Secretary shall consult with the Director for Civil Rights and Health Equity of the Department of Health and Human Services.

(c) USE OF FUNDS.—A hospital shall use funds received from a grant under this section to establish or expand programs to provide equitable health care to all patients and to ensure equitable health care outcomes. Such uses may include—

(1) providing explicit and implicit bias training to medical providers and staff;

(2) providing translation or interpretation services for patients;

(3) recruiting and training a diverse workforce;

(4) tracking data related to care and outcomes; and

(5) training on cultural sensitivity.

(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to hospitals that have received disproportionate share hospital payments under section 1886(r) of the Social Security Act (42 U.S.C. 1395ww(r)) or section 1923 of such Act (42 U.S.C. 1396r–4) with respect to fiscal year 2021.

(e) SUPPLEMENT, NOT SUPPLANT.—Grants awarded under this section shall be used to supplement, not supplant, any nongovernment efforts, or other Federal, State, or local funds provided to a recipient.

(f) EQUITABLE HEALTH CARE DEFINED.—The term ''equitable health care'' has the meaning given such term in section 1886(b)(3)(B)(viii)(XIII)(cc) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)(XIII)(cc)), as added by section 4503(a).

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2022 through 2027.

Subtitle G—Investing in Equity

SEC. 4601. DEFINITIONS.

In this subtitle:

(1) ADVISORY COUNCIL.—The term ''Advisory Council'' means the Pay for Equity Council convened under section 4603.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) STRATEGY.—The term ''Strategy'' means the Pay for Equity Strategy set forth under section 4602.

SEC. 4602. STRATEGY TO INCENTIVIZE HEALTH EQUITY.

(a) IN GENERAL.—The Secretary, in consultation with the heads of other appropriate Federal agencies, shall develop jointly with the Advisory Council and submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, and make publicly available on the internet website of the Department of Health and Human Services, a Pay for Equity Strategy.

(b) CONTENTS.—The Strategy shall establish goals for Federal programs, including those authorized under titles XVIII and XIX of the Social Security Act, to incentivize health equity, which may include at least—

(1) incorporating measures of equity into all payment models by 2025;

(2) tying a percentage of reimbursement in value-based payment models to equity measure performance by 2028; and

(3) increasing the number of safety net providers participating in value based payment by a set percentage by 2030.

(c) DUTIES OF THE SECRETARY.—The Secretary, in carrying out subsection (a), shall oversee the following:

(1) Collecting and making publicly available information submitted by the Advisory Council.

(2) Coordinating and assessing existing Federal Government programs and activities to assess capacity to meet equity goals.

(3) Providing technical assistance, as appropriate, such as disseminating identified best practices and information sharing based on reports developed as a result of this subtitle.

(d) INITIAL STRATEGY; UPDATES.—The Secretary shall—

(1) not later than 18 months after the date of enactment of this Act, develop, publish, and submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives the strategy outlined in subsection (a); and

(2) biennially update, publish, and submit to Congress an updated strategy to—

(A) reflect new developments, challenges, opportunities, and solutions; and

(B) review progress and, based on the results of such review, recommend priority actions for improving the implementation of such recommendations, as appropriate.

(e) PROCESS FOR PUBLIC INPUT.—The Secretary shall establish a process for public input to inform the development of, and updates to, the Strategy, including a process for the public to submit recommendations to the Advisory Council and an opportunity for public comment on the proposed Strategy.

SEC. 4603. PAY FOR EQUITY ADVISORY COUNCIL.

(a) CONVENING.—The Secretary shall convene a Pay for Equity Advisory Council to advise and provide recommendations, including identified best practices, to the Secretary on the Pay for Equity Strategy.

(b) MEMBERSHIP.—

(1) IN GENERAL.—The members of the Advisory Council shall consist of—

(A) the appointed members under paragraph (2); and

(B) the Federal members under paragraph (3).

(2) APPOINTED MEMBERS.—In addition to the Federal members under paragraph (3), the Secretary shall appoint not more than 15 voting members of the Advisory Council who are not representatives of Federal departments or agencies and who shall include at least 1 representative of each of the following:

(A) Beneficiaries of Medicare and Medicaid.

(B) Safety net health care providers.

(C) Value-based payment experts.

(D) Other members with expertise and lived experience the Secretary deems appropriate.

(3) FEDERAL MEMBERS.—The Federal members of the Advisory Council, who shall be nonvoting members, shall consist of the following:

(A) The Administrator of the Centers for Medicare & Medicaid Services (or the Administrator's designee).

(B) The Administrator of the Health Resources and Services Administration.

(4) DIVERSE REPRESENTATION.—The Secretary shall ensure that the membership of the Advi-

sory Council reflects the diversity of individuals impacted by Federal health payment programs.

(c) MEETINGS.—The Advisory Council shall meet quarterly during the 1-year period beginning on the date of enactment of this Act and at least 3 times during each year thereafter. Meetings of the Advisory Council shall be open to the public.

TITLE V—IMPROVING HEALTH OUTCOMES FOR WOMEN, CHILDREN, AND FAMILIES

Subtitle A—In General

SEC. 5001. GRANTS TO PROMOTE HEALTH FOR UNDERSERVED COMMUNITIES.

Part Q of title III of the Public Health Service Act (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

"SEC. 399Z–3. GRANTS TO PROMOTE HEALTH FOR UNDERSERVED COMMUNITIES.

''(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities—

''(1) to promote health for medically underserved communities, with preference given to

projects that benefit racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer, nonbinary, gender-nonconforming, or questioning communities; and

''(2) to strengthen health outreach initiatives in medically underserved communities, including linguistically isolated populations.

''(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support the activities of community health workers, including such activities—

''(1) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

''(2) to educate and provide outreach in a community setting regarding health problems prevalent among medically underserved communities, and especially among racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer, nonbinary, gender-nonconforming, or questioning communities;

"(3) to educate and provide experiential learning opportunities and target risk factors and healthy behaviors that impede or contribute to achieving positive health outcomes, including—

"(A) healthy nutrition;

"(B) physical activity;

"(C) overweight or obesity;

"(D) tobacco use, including the use of e-cigarettes and vaping;

"(E) alcohol and substance use;

"(F) injury and violence;

"(G) sexual health;

"(H) mental health;

"(I) musculoskeletal health and arthritis;

"(J) prenatal and postnatal care;

"(K) dental and oral health;

"(L) understanding informed consent;

"(M) stigma; and

"(N) environmental hazards;

"(4) to promote community wellness and awareness; and

"(5) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to in-

crease access to quality health care services, including preventive health services.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

''(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

''(A) describe the activities for which assistance under this section is sought;

''(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant awarded, such program provides in-language training and supervision to community health workers to enable such workers to provide authorized program activities in (at least) the most commonly used languages within a particular geographic region;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

"(D) contain an assurance that each community health worker program receiving funds under the grant will provide culturally competent services in the linguistic context most appropriate for the individuals served by the program;

"(E) contain a plan to document and disseminate project descriptions and results to other States and organizations as identified by the Secretary; and

"(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

"(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

"(ii) providing other services, as the Secretary determines to be appropriate, which may include transportation and translation services.

"(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to those applicants—

"(1) who propose to target geographic areas that—

"(A)(i) have a high percentage of residents who are uninsured or underinsured (if the targeted geographic area is located in a State that has elected to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to individuals described in such section);

"(ii) have a high percentage of underinsured residents in a particular geographic area (if the targeted geographic area is located in a State that has not so elected); or

"(iii) have a high number of households experiencing extreme poverty; and

"(B) have a high percentage of families for whom English is not their primary language or including smaller limited English-proficient communities within the region that are not otherwise reached by linguistically appropriate health services;

"(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) with documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, including minority-serving institutions. Nothing in this section shall be construed to require such collaboration.

''(f) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for ensuring the quality of the training and supervision of community health workers under the programs funded under this section and for ensuring the cost effectiveness of such programs.

''(g) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications and shall determine whether such programs are in compliance with the guidelines established under subsection (f).

''(h) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications with respect to planning, developing, and operating programs under the grant.

''(i) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served.

''(C) An evaluation of—

''(i) the effectiveness of these programs;

''(ii) the cost of these programs; and

''(iii) the impact of these programs on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(j) DEFINITIONS.—In this section:

"(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

"(A) by serving as a liaison between communities and health care agencies;

"(B) by providing guidance and social assistance to community residents;

"(C) by enhancing community residents' ability to effectively communicate with health care providers;

"(D) by providing culturally and linguistically appropriate health or nutrition education;

"(E) by advocating for individual and community health, including dental, oral, mental, and environmental health, or nutrition needs;

"(F) by taking into consideration the needs of the communities served, including the prevalence rates of risk factors that impede achieving positive healthy outcomes among pregnant, birthing, and postpartum people and children, especially among racial and ethnic minority pregnant, birthing, and postpartum people and children; and

"(G) by providing referral and followup services.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization that serves a population.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(A) a unit of State, territorial, local, or Tribal government (including a federally recognized Tribe or Alaska Native village); or

"(B) a community-based organization.

"(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community—

"(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3);

"(B) a significant portion of which is a health professional shortage area as designated under section 332; and

"(C) that includes populations that are linguistically isolated, such as geographic areas with a shortage of health professionals able to provide linguistically appropriate services.

''(5) SUPPORT.—The term 'support' means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2023 through 2027.''.

Subtitle B—Pregnancy Screening

SEC. 5101. PREGNANCY INTENTION SCREENING INITIATIVE DEMONSTRATION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V–7. PREGNANCY INTENTION SCREENING INITIATIVE DEMONSTRATION PROGRAM.

''(a) PROGRAM ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to facilitate the clinical adoption of pregnancy intention screening initiatives by health care and social services providers.

''(b) GRANTS.—The Secretary may carry out the demonstration program through awarding grants to eligi-

ble entities to implement pregnancy intention screening initiatives, collect data, and evaluate such initiatives.

''(c) ELIGIBLE ENTITIES.—To be eligible to seek a grant under this section, an entity shall—

''(1) provide non-directive, comprehensive, medically accurate information; and

''(2) be a community-based organization, voluntary health organization, public health department, community health center, or other interested public or private primary, behavioral, or other health care or social service provider or organization.

''(d) PREGNANCY INTENTION SCREENING INITIATIVE.—For purposes of this section, the term 'pregnancy intention screening initiative' means any initiative by an eligible entity to routinely screen people with respect to their pregnancy intentions and goals to either prevent unintended pregnancies or improve the likelihood of healthy pregnancies, in order to better provide health care that meets the contraceptive or pre-pregnancy needs and goals of such people.

''(e) EVALUATION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, by grant or contract, and after consultation as described in paragraph (2),

conduct an evaluation of the demonstration program, with respect to pregnancy intention screening initiatives, conducted under this section. Such evaluation shall include:

''(A) Assessment of the implementation of pregnancy intention screening protocols among a diverse group of patients and providers, including collecting data on the experiences and outcomes for diverse patient populations in a variety of clinical settings.

''(B) Analysis of outcome measures that will facilitate effective and widespread adoption of such protocols by health care providers for inquiring about and responding to pregnancy goals of people with both contraceptive and pre-pregnancy care.

''(C) Consideration of health inequities among the population served.

''(D) Assessment of the equitable and voluntary application of such initiatives to minority and medically underserved communities.

''(E) Assessment of the training, capacity, and ongoing technical assistance needed for providers to effectively implement such pregnancy intention screening protocols.

"(F) Assessment of whether referral systems for selected protocols follow evidence-based standards that ensure access to comprehensive health services and appropriate follow-up care.

"(G) Measuring through rigorous methods the effect of such initiatives on key health outcomes.

"(2) CONSULTATION WITH INDEPENDENT, EXPERT ADVISORY PANEL.—In conducting the evaluation under paragraph (1), the Director of the Centers for Disease Control and Prevention shall consult with physicians, physician assistants, advanced practice registered nurses, nurse midwives, and other health care providers who specialize in women's health, and other experts in public health, clinical practice, program evaluation, and research.

"(3) REPORT.—Not later than one year after the last day of the demonstration program under this section, the Director of the Centers for Disease Control and Prevention shall—

"(A) submit to Congress a report on the results of the evaluation conducted under paragraph (1); and

"(B) make the report publicly available.

"(f) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.

''(2) LIMITATION.—Not more than 20 percent of funds appropriated to carry out this section pursuant to paragraph (1) for a fiscal year may be used for purposes of the evaluation under subsection (e).''.

SEC. 5102. BIRTH DEFECTS PREVENTION, RISK REDUCTION, AND AWARENESS.

(a) IN GENERAL.—The Secretary shall establish and implement a birth defects prevention and public awareness program, consisting of the activities described in subsections (c) and (d).

(b) DEFINITIONS.—In this section:

(1) MATERNAL.—The term ''maternal'' refers to people who are pregnant or breastfeeding.

(2) PREGNANCY AND BREASTFEEDING INFORMATION SERVICES.—The term ''pregnancy and breastfeeding information services'' includes only—

(A) information services to provide accurate, evidence-based, clinical information regarding maternal exposures during pregnancy or breastfeeding that may be associated with

birth defects, health risks to a breastfed infant, or other health risks, such as exposures to medications, chemicals, infections, foodborne pathogens, illnesses, nutrition, lifestyle, or climate- and weather-related factors;

(B) the provision of accurate, evidence-based information weighing risks of exposures during breastfeeding against the benefits of breastfeeding; and

(C) the provision of information described in subparagraph (A) or (B) through counselors, websites, fact sheets, telephonic or electronic communication, community outreach efforts, or other appropriate means.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention.

(c) NATIONWIDE MEDIA CAMPAIGN.—In carrying out subsection (a), the Secretary shall conduct or support a nationwide media campaign to increase awareness among health care providers and at-risk populations about pregnancy and breastfeeding information services.

(d) GRANTS FOR PREGNANCY AND BREASTFEEDING INFORMATION SERVICES.—

(1) IN GENERAL.—In carrying out subsection (a), the Secretary shall award grants to State or regional agencies or organizations for any of the following:

(A) INFORMATION SERVICES.—The provision of, or campaigns to increase awareness about, pregnancy and breastfeeding information services.

(B) SURVEILLANCE AND RESEARCH.—The conduct or support of—

(i) surveillance of or research on—

(I) maternal exposures and maternal health conditions that may influence the risk of birth defects, prematurity, or other adverse pregnancy outcomes; and

(II) maternal exposures that may influence health risks to a breastfed infant; or

(ii) networking to facilitate surveillance or research described in this subparagraph.

(2) PREFERENCE FOR CERTAIN STATES.—The Secretary, in making any grant under this subsection, shall give preference to States, otherwise

equally qualified, that have pregnancy and breastfeeding information services in place.

(3) MATCHING FUNDS.—The Secretary may only award a grant under this subsection to a State or regional agency or organization that agrees, with respect to the costs to be incurred in carrying out the grant activities, to make available (directly or through donations from public or private entities) non-Federal funds toward such costs in an amount equal to not less than 25 percent of the amount of the grant.

(4) COORDINATION.—The Secretary shall ensure that activities funded through a grant under this subsection are coordinated, to the maximum extent practicable, with other birth defects prevention and environmental health activities of the Federal Government, including with respect to pediatric environmental health specialty units and children's environmental health centers.

(e) EVALUATION.—The Secretary shall provide for an evaluation of pregnancy and breastfeeding information services carried out by States to identify efficient and effective models of—

(1) providing information;

(2) raising awareness and increasing knowledge about birth defects prevention measures and targeting education to at-risk groups;

(3) modifying risk behaviors; or

(4) other outcome measures as determined appropriate by the Secretary.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated—

(1) $5,000,000 for fiscal year 2023;

(2) $6,000,000 for fiscal year 2024;

(3) $7,000,000 for fiscal year 2025;

(4) $8,000,000 for fiscal year 2026; and

(5) $9,000,000 for fiscal year 2027.

Subtitle C—Pregnancy-Related Care

SEC. 5201. MOTHERS AND OFFSPRING MORTALITY AND MORBIDITY AWARENESS.

(a) IMPROVING FEDERAL EFFORTS WITH RESPECT TO PREVENTION OF MATERNAL MORTALITY.—

(1) TECHNICAL ASSISTANCE FOR STATES WITH RESPECT TO REPORTING MATERNAL MORTALITY.—Not later than one year after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), in consultation with the Admin-

istrator of the Health Resources and Services Administration, shall provide technical assistance to States that elect to report comprehensive data on maternal mortality and factors relating to such mortality (including oral and mental health), intimate partner violence, and breastfeeding health information, for the purpose of encouraging uniformity in the reporting of such data and to encourage the sharing of such data among the respective States.

(2) BEST PRACTICES RELATING TO PREVENTION OF MATERNAL MORTALITY.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act—

(i) the Director, in consultation with relevant patient and provider groups, shall issue best practices to State maternal mortality review committees on how best to identify and review maternal mortality cases, taking into account any data made available by States relating to maternal mortality, including data on oral, mental, and breastfeeding health, and utilization of any emergency services; and

(ii) the Director, working in collaboration with the Health Resources and Serv-

ices Administration, shall issue best practices to hospitals, State professional society groups, and perinatal quality collaboratives on how best to prevent maternal mortality.

(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this paragraph, there is authorized to be appropriated $5,000,000 for each of fiscal years 2023 through 2027.

(3) ALLIANCE FOR INNOVATION ON MATERNAL HEALTH GRANT PROGRAM.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services, acting through the Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration (referred to in this paragraph as the ''Secretary''), shall establish a grant program to be known as the Alliance for Innovation on Maternal Health Grant Program (referred to in this subsection as ''AIM'') under which the Secretary shall award grants to eligible entities for the purpose of—

(i) directing widespread adoption and implementation of maternal safety bundles through collaborative State-based teams; and

(ii) collecting and analyzing process, structure, and outcome data to drive continuous improvement in the implementation of such safety bundles by such State-based teams with the ultimate goal of eliminating preventable maternal mortality and severe maternal morbidity in the United States.

(B) ELIGIBLE ENTITIES.—In order to be eligible for a grant under subparagraph (A), an entity shall—

(i) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(ii) demonstrate in such application that the entity is an interdisciplinary, multi-stakeholder, national organization with a national data-driven maternal safety and quality improvement initiative based on implementation approaches that have

been proven to improve maternal safety and outcomes in the United States.

(C) USE OF FUNDS.—An eligible entity that receives a grant under subparagraph (A) shall use such grant funds—

(i) to develop and implement, through a robust, multi-stakeholder process, maternal safety bundles to assist States, perinatal quality collaboratives, and health care systems in aligning national, State, and hospital-level quality improvement efforts to improve maternal health outcomes, specifically the reduction of maternal mortality and severe maternal morbidity;

(ii) to ensure, in developing and implementing maternal safety bundles under clause (i), that such maternal safety bundles—

(I) satisfy the quality improvement needs of a State, perinatal quality collaborative, or health care system by factoring in the results and findings of relevant data reviews, such as reviews conducted by a State maternal mortality review committee; and

(II) address topics which may include—

(aa) information on evidence-based practices to improve the quality and safety of maternal health care in hospitals and other health care settings of a State or health care system, including by addressing topics commonly associated with health complications or risks related to prenatal care, labor care, birthing, and postpartum care;

(bb) best practices for improving maternal health care based on data findings and reviews conducted by a State maternal mortality review committee that address topics of relevance to common complications or health risks related to prenatal care, labor care, birthing, and postpartum care;

(cc) information on addressing determinants of health that

impact maternal health outcomes for people before, during, and after pregnancy;

(dd) obstetric hemorrhage;

(ee) obstetric and postpartum care for people with substance use disorders, including opioid use disorder;

(ff) maternal cardiovascular system;

(gg) maternal mental health;

(hh) postpartum care basics for maternal safety;

(ii) reduction of peripartum racial and ethnic inequities;

(jj) reduction of primary caesarean birth;

(kk) severe hypertension in pregnancy;

(ll) severe maternal morbidity reviews;

(mm) support after a severe maternal morbidity event;

(nn) thromboembolism;

(oo) optimization of support for breastfeeding;

(pp) maternal oral health; and

(qq) intimate partner violence; and

(iii) to provide ongoing technical assistance at the national and State levels to support implementation of maternal safety bundles under clause (i).

(D) MATERNAL SAFETY BUNDLE DEFINED.—For purposes of this paragraph, the term ''maternal safety bundle'' means standardized, evidence-informed processes for maternal health care.

(E) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this paragraph, there is authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.

(4) FUNDING FOR STATE-BASED PERINATAL QUALITY COLLABORATIVES DEVELOPMENT AND SUSTAINABILITY.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Sec-

retary of Health and Human Services (referred to in this paragraph as the ''Secretary''), acting through the Division of Reproductive Health of the Centers for Disease Control and Prevention, shall establish a grant program to be known as the State-Based Perinatal Quality Collaborative grant program under which the Secretary awards grants to eligible entities for the purpose of development and sustainability of perinatal quality collaboratives in every State, the District of Columbia, and eligible territories, in order to measurably improve perinatal care and perinatal health outcomes for pregnant and postpartum people and their infants.

(B) GRANT AMOUNTS.—Grants awarded under this paragraph shall be in amounts not to exceed $250,000 per year, for the duration of the grant period.

(C) STATE-BASED PERINATAL QUALITY COLLABORATIVE DEFINED.—For purposes of this paragraph, the term ''State-based perinatal quality collaborative'' means a network of teams that—

(i) is multidisciplinary in nature and includes the full range of perinatal and maternity care providers;

(ii) works to improve measurable outcomes for maternal and infant health by advancing evidence-informed clinical practices using quality improvement principles;

(iii) works with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, including patients and families, to spread best practices and optimize resources to improve perinatal care and outcomes;

(iv) employs strategies that include the use of the collaborative learning model to provide opportunities for hospitals and clinical teams to collaborate on improvement strategies, rapid-response data to provide timely feedback to hospital and other clinical teams to track progress, and quality improvement science to provide support and coaching to hospital and clinical teams;

(v) has the goal of improving population-level outcomes in maternal and infant health; and

(vi) has the goal of improving outcomes of all birthing people, through the coordination, integration, and collaboration across birth settings.

(D) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this paragraph, there is authorized to be appropriated $14,000,000 per year for each of fiscal years 2023 through 2027.

(5) EXPANSION OF MEDICAID AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM PEOPLE.—

(A) REQUIRING COVERAGE OF ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM PEOPLE.—

(i) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as previously amended by this Act, is amended—

(I) in subsection (a)(4), by inserting ‘‘and ; (G) oral health services for pregnant and postpartum people

(as defined in subsection (mm))'' before the semicolon at the end; and

(II) by adding at the end the following new subsection:

''(mm) ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM PEOPLE.—

''(1) IN GENERAL.—For purposes of this title, the term 'oral health services for pregnant and postpartum people' means dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions that are furnished to a person during pregnancy (or during the 1-year period beginning on the last day of the pregnancy).

''(2) COVERAGE REQUIREMENTS.—To satisfy the requirement to provide oral health services for pregnant and postpartum people, a State shall provide coverage for preventive, diagnostic, periodontal, and restorative care consistent with recommendations for perinatal oral health care and dental care during pregnancy from the American Academy of Pediatric Dentistry and the American College of Obstetricians and Gynecologists.''.

(ii) CHIP.—Section 2103(c)(6)(A) of the Social Security Act (42 U.S.C.

1397cc(c)(6)(A)) is amended by inserting ''or a targeted low-income pregnant person'' after ''targeted low-income child''.

(B) EXTENDING MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM PEOPLE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(i) in subsection (e)—

(I) in paragraph (5)—

(aa) by inserting ''(including oral health services for pregnant and postpartum people (as defined in section 1905(mm)))'' after ''postpartum medical assistance under the plan''; and

(bb) by striking ''60-day'' and inserting ''1-year''; and

(II) in paragraph (6), by striking ''60-day'' and inserting ''1-year''; and

(ii) in subsection (l)(1)(A), by striking ''60-day'' and inserting ''1-year''.

(C) EXTENDING CHIP COVERAGE FOR PREGNANT AND POSTPARTUM PEOPLE.—Section 2112(d)(2)(A) of the Social Security Act

(42 U.S.C. 1397ll(d)(2)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(D) CONFORMING AMENDMENTS.—

(i) Section 1902(e)(16) of the Social Security Act (42 U.S.C. 1396a(e)(16)) is amended—

(I) in subparagraph (A), by striking ''may provide'' and all that follows through the period and inserting the following: ''may provide that the State will provide the medical assistance described in subparagraph (B) to an individual who, while pregnant, is eligible for and has received medical assistance under the State plan approved under this title (or a waiver of such plan), including during a period of retroactive eligibility under subsection (a)(34) and through the end of the month in which the 1-year period beginning on the last day of the individual's pregnancy ends.''; and

(II) in subparagraph (B), by striking ''12-month'' each place it appears and inserting ''1-year''.

(ii) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended, in the fifth sentence, by striking ''60-day'' and inserting ''1-year''.

(E) MAINTENANCE OF EFFORT.—

(i) MEDICAID.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

''(5) During the period that begins on the date of enactment of this paragraph and ends on the date that is 5 years after such date of enactment, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect, with respect to people who are eligible for medical assistance under the State plan or under a waiver of such plan on the basis of being pregnant or having been pregnant, eligibility standards, methodologies, or procedures under the State plan or waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver that are in effect on the date of enactment of this paragraph.''.

(ii) CHIP.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d))

is amended by adding at the end the following new paragraph:

''(4) ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT PEOPLE.—During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide assistance to people on the basis of being pregnant (including pregnancy-related assistance provided to targeted low-income pregnant people (as defined in section 2112(d)), pregnancy-related assistance provided to people who are eligible for such assistance through application of section 1902(v)(4)(A) under section 2107(e)(1), or any other assistance under the State child health plan (or a waiver of such plan) which is provided to people on the basis of being pregnant) shall not have in effect, with respect to such people, eligibility standards, methodologies, or procedures under such plan (or waiver) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.''.

(F) INFORMATION ON BENEFITS.—The Secretary of Health and Human Services shall make publicly available on the internet website of the Department of Health and Human Services, information regarding benefits available to pregnant and postpartum people and under the Medicaid program and the Children's Health Insurance Program, including information on—

(i) benefits that States are required to provide to pregnant and postpartum people under such programs;

(ii) optional benefits that States may provide to pregnant and postpartum people under such programs; and

(iii) the availability of different kinds of benefits for pregnant and postpartum people, including oral health and mental health benefits, under such programs.

(G) FEDERAL FUNDING FOR COST OF EXTENDED MEDICAID AND CHIP COVERAGE FOR POSTPARTUM PEOPLE.—

(i) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as previously amended by this Act, is further amended—

(I) in subsection (b), by striking ''and (ll)'' and inserting ''(ll), and (nn)''; and

(II) by adding at the end the following:

''(nn) INCREASED FMAP FOR EXTENDED MEDICAL ASSISTANCE FOR POSTPARTUM PEOPLE.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State, with respect to amounts expended by such State for medical assistance for a person who is eligible for such assistance on the basis of being pregnant or having been pregnant that is provided during the 305-day period that begins on the 60th day after the last day of their pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(1) 100 percent for the first 20 calendar quarters during which this subsection is in effect; and

''(2) 90 percent for calendar quarters thereafter.''.

(ii) CHIP.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

"(13) ENHANCED PAYMENT FOR EXTENDED ASSISTANCE PROVIDED TO PREGNANT PEOPLE.—Notwithstanding subsection (b), the enhanced FMAP, with respect to payments under subsection (a) for expenditures under the State child health plan (or a waiver of such plan) for assistance provided under the plan (or waiver) to a person who is eligible for such assistance on the basis of being pregnant (including pregnancy-related assistance provided to a targeted low-income pregnant person (as defined in section 2112(d)), pregnancy-related assistance provided to a person who is eligible for such assistance through application of section 1902(v)(4)(A) under section 2107(e)(1), or any other assistance under the plan (or waiver) provided to a person who is eligible for such assistance on the basis of being pregnant) during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

"(A) 100 percent for the first 20 calendar quarters during which this paragraph is in effect; and

"(B) 90 percent for calendar quarters thereafter.".

(H) GUIDANCE ON STATE OPTIONS FOR MEDICAID COVERAGE OF DOULA SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the States concerning options for Medicaid coverage and payment for support services provided by doulas.

(I) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by this paragraph shall take effect on the first day of the first calendar quarter that begins on or after the date that is one year after the date of enactment of this Act.

(ii) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act that the Secretary of Health and Human Services determines requires State

legislation in order for the respective plan to meet any requirement imposed by amendments made by this paragraph, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(6) REGIONAL CENTERS OF EXCELLENCE.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5101, is further amended by adding at the end the following new section:

"SEC. 399V–8. REGIONAL CENTERS OF EXCELLENCE ADDRESSING IMPLICIT BIAS AND CULTURAL COMPETENCY IN PATIENT-PROVIDER INTERACTIONS EDUCATION.

''(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall award cooperative agreements for the establishment or support of regional centers of excellence addressing implicit bias, cultural competency, and respectful care practices in patient-provider interactions education for the purpose of enhancing and improving how health care professionals are educated in implicit bias and delivering culturally competent health care.

''(b) ELIGIBILITY.—To be eligible to receive a cooperative agreement under subsection (a), an entity shall—

''(1) be a public or other nonprofit entity specified by the Secretary that provides educational and training opportunities for students and health care professionals, which may be a health system, teaching hospital, community health center, medical school, school of public health, school of nursing, dental school, social work school, school of professional psychology, or any other health professional school or program at an institution of higher education (as defined in section 101 of the Higher Edu-

cation Act of 1965) focused on the prevention, treatment, or recovery of health conditions that contribute to maternal mortality and the prevention of maternal mortality and severe maternal morbidity;

''(2) demonstrate community engagement and participation, such as through partnerships with home visiting and case management programs;

''(3) demonstrate engagement with groups engaged in the implementation of health care professional training in implicit bias and delivering culturally competent care, such as departments of public health, perinatal quality collaboratives, hospital systems, and health care professional groups, in order to obtain input on resources needed for effective implementation strategies; and

''(4) provide to the Secretary such information, at such time and in such manner, as the Secretary may require.

''(c) DIVERSITY.—In awarding a cooperative agreement under subsection (a), the Secretary shall take into account any regional differences among eligible entities and make an effort to ensure geographic diversity among award recipients.

''(d) DISSEMINATION OF INFORMATION.—

''(1) PUBLIC AVAILABILITY.—The Secretary shall make publicly available on the internet website of the Department of Health and Human Services information submitted to the Secretary under subsection (b)(4).

''(2) EVALUATION.—The Secretary shall evaluate each regional center of excellence established or supported pursuant to subsection (a) and disseminate the findings resulting from each such evaluation to the appropriate public and private entities.

''(3) DISTRIBUTION.—The Secretary shall share evaluations and overall findings with State departments of health and other relevant State level offices to inform State and local best practices.

''(e) MATERNAL MORTALITY DEFINED.—In this section, the term 'maternal mortality' means death of a person that occurs during pregnancy or within the one-year period following the end of such pregnancy.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2023 through 2027.''.

(7) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR PEOPLE, INFANTS, AND CHILDREN.—Sec-

tion 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

(A) by striking the clause designation and heading and all that follows through ''A State'' and inserting the following:

''(ii) PREGNANT AND POSTPARTUM PEOPLE.—

''(I) BREASTFEEDING PEOPLE.—A State'';

(B) in subclause (I) (as so designated), by striking ''1 year'' and all that follows through ''earlier'' and inserting ''2 years postpartum''; and

(C) by adding at the end the following:

''(II) POSTPARTUM PEOPLE.—A State may elect to certify a postpartum person for a period of 2 years.''.

(8) DEFINITIONS.—In this subsection:

(A) MATERNAL MORTALITY.—The term ''maternal mortality'' means death of a person that occurs during pregnancy or within the one-year period following the end of such pregnancy.

(B) PREGNANCY RELATED DEATH.—The term ''pregnancy related death'' includes the death of a person during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(C) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' includes unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a person's health.

(b) INCREASE IN TAX ON CERTAIN TOBACCO PRODUCTS AND IMPOSITION OF TAX ON NICOTINE.—

(1) INCREASING TAX ON CIGARETTES.—

(A) SMALL CIGARETTES.—Section 5701(b)(1) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

(B) LARGE CIGARETTES.—Section 5701(b)(2) of such Code is amended by striking ''$105.69'' and inserting ''$211.39''.

(2) TAX PARITY FOR SMALL CIGARS.—Section 5701(a)(1) of such Code is amended by striking ''$50.33'' and inserting ''$100.66''.

(3) TAX PARITY FOR LARGE CIGARS.—Section 5701(a)(2) of such Code is amended by striking ''52.75 percent'' and all that follows through the period and inserting ''$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.06 cents per cigar.''.

(4) TAX PARITY FOR SMOKELESS TOBACCO.—

(A) Section 5701(e) of such Code is amended—

(i) in paragraph (1), by striking ''$1.51'' and inserting ''$26.84'',

(ii) in paragraph (2), by striking ''50.33 cents'' and inserting ''$10.70'', and

(iii) by adding at the end the following new paragraph:

''(3) SMOKELESS TOBACCO SOLD IN DISCRETE SINGLE-USE UNITS.—On discrete single-use units, $100 per thousand.''.

(B) Section 5702(m) of such Code is amended—

(i) in paragraph (1), by striking ''or chewing tobacco'' and inserting '', chewing tobacco, or discrete single-use unit'',

(ii) in paragraphs (2) and (3), by inserting ''and that is not a discrete single-use unit'' before the period at the end of each such paragraph, and

(iii) by adding at the end the following new paragraph:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing tobacco that—

''(A) is not intended to be smoked, and

''(B) is in the form of a lozenge, tablet, pill, pouch, dissolvable strip, or other discrete single-use or single-dose unit.''.

(5) TAX PARITY FOR PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking ''$2.8311 cents'' and inserting ''$49.56''.

(6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''$24.78'' and inserting ''$49.56''.

(7) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO AND CERTAIN PROCESSED TOBACCO.—Section 5702(o) of such Code is amended by inserting '',

and includes processed tobacco that is removed for delivery or delivered to a person other than a person with a permit provided under section 5713, but does not include removals of processed tobacco for exportation'' after ''wrappers thereof''.

(8) IMPOSITION OF TAX ON NICOTINE FOR USE IN VAPING, ETC.—

(A) IN GENERAL.—Section 5701 of such Code is amended by redesignating subsection (h) as subsection (i) and by inserting after subsection (g) the following new subsection:

''(h) NICOTINE.—On taxable nicotine, manufactured in or imported into the United States, there shall be imposed a tax equal to the dollar amount specified in section 5701(b)(1) per 1,810 milligrams of nicotine (and a proportionate tax at the like rate on any fractional part thereof).''.

(B) TAXABLE NICOTINE.—Section 5702 of such Code is amended by adding at the end the following new subsection:

''(q) TAXABLE NICOTINE.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the term 'taxable nicotine' means any nicotine which has been extracted, concentrated, or synthesized.

''(2) EXCEPTION FOR PRODUCTS APPROVED BY FOOD AND DRUG ADMINISTRATION.—Such term shall not include any nicotine if the manufacturer or importer thereof demonstrates to the satisfaction of the Secretary of Health and Human Services that such nicotine will be used in—

''(A) a drug—

''(i) that is approved under section 505 of the Federal Food, Drug, and Cosmetic Act or licensed under section 351 of the Public Health Service Act, or

''(ii) for which an investigational use exemption has been authorized under section 505(i) of the Federal Food, Drug, and Cosmetic Act or under section 351(a) of the Public Health Service Act, or

''(B) a combination product (as described in section 503(g) of the Federal Food, Drug, and Cosmetic Act), the constituent parts of which were approved or cleared under section 505, 510(k), or 515 of such Act.

''(3) COORDINATION WITH TAXATION OF OTHER TOBACCO PRODUCTS.—Tobacco products meeting the definition of cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco in

this section shall be classified and taxed as such despite any concentration of the nicotine inherent in those products or any addition of nicotine to those products during the manufacturing process.

''(4) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as is necessary or appropriate to carry out the purposes of this subsection, including regulations or other guidance for coordinating the taxation of tobacco products and taxable nicotine to protect revenue and prevent double taxation.''.

(C) TAXABLE NICOTINE TREATED AS A TOBACCO PRODUCT.—Section 5702(c) of such Code is amended by striking ''and roll-your-own tobacco'' and inserting ''roll-your-own tobacco, and taxable nicotine''.

(D) MANUFACTURER OF TAXABLE NICOTINE.—Section 5702 of such Code, as amended by subparagraph (B), is amended by adding at the end the following new subsection:

''(r) MANUFACTURER OF TAXABLE NICOTINE.—

''(1) IN GENERAL.—Any person who extracts, concentrates, or synthesizes nicotine shall be treated as a manufacturer of taxable nicotine (and as manufacturing such taxable nicotine).

''(2) APPLICATION OF RULES RELATED TO MANUFACTURERS OF TOBACCO PRODUCTS.—Any reference to a manufacturer of tobacco products, or to manufacturing tobacco products, shall be treated as including a reference to a manufacturer of taxable nicotine, or to manufacturing taxable nicotine, respectively.''.

(9) REPEAL OF SPECIAL RULES FOR DETERMINING PRICE OF CIGARS.—Section 5702 of such Code is amended by striking subsection (l).

(10) FLOOR STOCKS TAXES.—

(A) IMPOSITION OF TAX.—On covered tobacco products, and cigarette papers and tubes, manufactured in or imported into the United States which are removed before the tax increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(i) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(ii) the prior tax (if any) imposed under section 5701 of such Code on such article.

(B) COVERED TOBACCO PRODUCTS.—For purposes of this paragraph, the term ''covered tobacco products'' means any tobacco product other than—

(i) cigars described in section 5701(a)(2) of the Internal Revenue Code of 1986,

(ii) discrete single-use units (as defined in section 5702(m)(4) of such Code, as amended by this subsection), and

(iii) taxable nicotine (as defined in section 5702(q) of such Code, as amended by this subsection).

(C) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by subparagraph (A) an amount equal to the lesser of $1,000 or the amount of such taxes. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 person for purposes of this subparagraph.

(D) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(i) LIABILITY FOR TAX.—The person referred to in subparagraph (A) shall be liable for the tax imposed by such subparagraph.

(ii) METHOD OF PAYMENT.—The tax imposed by subparagraph (A) shall be paid in such manner as the Secretary may provide.

(E) ARTICLES IN FOREIGN TRADE ZONES.—

(i) IN GENERAL.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.) or any other provision of law, any covered tobacco products, or cigarette papers and tubes, which are located in a foreign trade zone on the tax increase date, shall be subject to the tax imposed by subparagraph (A) if—

(I) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a re-

quest made under the 1st proviso of section 3(a) of such Act, or

(II) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(F) TAX INCREASE DATE.—For purposes of this paragraph, the term ''tax increase date'' means the first day of the first calendar quarter described in paragraph (11)(A).

(G) CERTAIN OTHER DEFINITIONS.—Terms used in this paragraph which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the same meaning as when used in such section.

(11) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the amendments made by this subsection shall apply to articles removed in calendar quarters beginning after the date of the enactment of this Act.

(B) DELAYED EFFECTIVE DATE FOR CERTAIN PRODUCTS.—The amendments made by

paragraphs (3), (4)(A)(iii), (4)(B), and (8) shall apply to articles removed in calendar quarters beginning after the date which is 180 days after the date of the enactment of this Act.

(12) TRANSITION RULE FOR PERMIT AND BOND REQUIREMENTS.—A person which is lawfully engaged in business as a manufacturer or importer of taxable nicotine (within the meaning of subchapter A of chapter 52 of the Internal Revenue Code of 1986, as amended by this subsection) on the date of the enactment of this Act, first becomes subject to the requirements of subchapter B of chapter 52 of such Code by reason of the amendments made by this subsection, and submits an application under such subchapter B to engage in such business not later than 90 days after the date of the enactment of this Act, shall not be denied the right to carry on such business by reason of such requirements before final action on such application.

SEC. 5202. MOMMIES.

(a) GAO STUDY AND REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to

Congress a report on the gaps in coverage with respect to—

(A) pregnant individuals enrolled under a State plan (or waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.); and

(B) postpartum individuals enrolled under a State plan (or waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) who received assistance under either such program during their pregnancy.

(2) CONTENT OF REPORT.—The report required under this paragraph shall include the following:

(A) Information about the abilities and successes of State Medicaid agencies in determining whether pregnant and postpartum individuals are eligible under another insurance affordability program, and in transitioning any such individuals who are so eligible to coverage

under such a program at the end of their period of eligibility for medical assistance, pursuant to section 435.1200 of the title 42, Code of Federal Regulations (as in effect on September 1, 2018).

(B) Information on factors contributing to gaps in coverage that disproportionately impact underserved populations, including low-income individuals, Black, Indigenous, and other individuals of color, individuals who reside in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) or individuals who are members of a medically underserved population (as defined by section 330(b)(3) of such Act (42 U.S.C. 254b(b)(3)(A))).

(C) Recommendations for addressing and reducing such gaps in coverage.

(D) Such other information as the Comptroller General deems necessary.

(3) DATA DISAGGREGATION.—To the greatest extent possible, the Comptroller General shall disaggregate data presented in the report, including

by age, gender identity, race, ethnicity, income level, and other demographic factors.

(b) MATERNITY CARE HOME DEMONSTRATION PROJECT.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting the following new section after section 1947:

"SEC. 1948. MATERNITY CARE HOME DEMONSTRATION PROJECT.

''(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this section, the Secretary shall establish a demonstration project (in this section referred to as the 'demonstration project') under which the Secretary shall provide grants to States to enter into arrangements with eligible entities to implement or expand a maternity care home model for eligible individuals.

''(b) GOALS OF DEMONSTRATION PROJECT.—The goals of the demonstration project are the following:

''(1) To improve—

''(A) maternity and infant care outcomes;

''(B) birth equity;

''(C) health equity for—

''(i) Black, Indigenous, and other people of color;

"(ii) lesbian, gay, bisexual, transgender, queer, non-binary, and gender nonconfirming individuals;

"(iii) people with disabilities; and

"(iv) other underserved populations;

"(D) communication by maternity, infant care, and social services providers;

"(E) integration of perinatal support services, including community health workers, doulas, social workers, public health nurses, peer lactation counselors, lactation consultants, childbirth educators, peer mental health workers, and others, into health care entities and organizations;

"(F) care coordination between maternity, infant care, oral health services, and social services providers within the community;

"(G) the quality and safety of maternity and infant care;

"(H) the experience of individuals receiving maternity care, including by increasing the ability of an individual to develop and follow their own birthing plans; and

"(I) access to adequate prenatal and postpartum care, including—

"(i) prenatal care that is initiated in a timely manner;

"(ii) not fewer than 5 post-pregnancy visits to a maternity care provider; and

"(iii) interpregnancy care.

"(2) To provide coordinated, evidence-based, respectful, culturally and linguistically appropriate, and person-centered maternity care management.

"(3) To decrease—

"(A) severe and preventable maternal morbidity and maternal mortality;

"(B) overall health care spending;

"(C) unnecessary emergency department visits;

"(D) inequities in maternal and infant care outcomes, including racial, economic, disability, gender-based, and geographical inequities;

"(E) racial, gender, economic, and other discrimination among health care professionals;

"(F) racism, discrimination, disrespect, and abuse in maternity care settings;

"(G) the rate of cesarean deliveries for low-risk pregnancies;

"(H) the rate of pre-term births and infants born with low birth weight; and

''(I) the rate of avoidable maternal and newborn hospitalizations and admissions to intensive care units.

''(c) CONSULTATION.—In designing and implementing the demonstration project the Secretary shall consult with stakeholders, including—

''(1) States;

''(2) organizations representing relevant health care professionals, including oral health services professionals;

''(3) organizations, particularly reproductive justice and birth justice organizations led by people of color, that represent consumers of maternal health care, including consumers of maternal health care who are disproportionately impacted by poor maternal health outcomes;

''(4) representatives with experience implementing other maternity care home models, including representatives from the Center for Medicare and Medicaid Innovation;

''(5) community-based health care professionals, including doulas, lactation consultants, and other stakeholders;

''(6) experts in promoting health equity and combating racial bias in health care settings; and

''(7) Black, Indigenous, and other maternal health care consumers of color who have experienced severe maternal morbidity.

''(d) APPLICATION AND SELECTION OF STATES.—

''(1) IN GENERAL.—A State seeking to participate in the demonstration project shall submit an application to the Secretary at such time and in such manner as the Secretary shall require.

''(2) SELECTION OF STATES.—

''(A) IN GENERAL.—The Secretary shall select at least 10 States to participate in the demonstration project.

''(B) SELECTION REQUIREMENTS.—In selecting States to participate in the demonstration project, the Secretary shall—

''(i) ensure that there is geographic and regional diversity in the areas in which activities will be carried out under the project;

''(ii) ensure that States with significant inequities in maternal and infant health outcomes, including severe maternal morbidity, and other inequities based on race, income, or access to maternity care, are included; and

"(iii) ensure that at least 1 territory is included.

"(e) GRANTS.—

"(1) IN GENERAL.—From amounts appropriated under subsection (l), the Secretary shall award 1 grant for each year of the demonstration project to each State that is selected to participate in the demonstration project.

"(2) USE OF GRANT FUNDS.—A State may use funds received under this section to—

"(A) award grants or make payments to eligible entities as part of an arrangement described in subsection (f)(2);

"(B) provide financial incentives to health care professionals, including community-based health care workers and community-based doulas, who participate in the State's maternity care home model;

"(C) provide adequate training for health care professionals, including community-based health care workers, doulas, and care coordinators, who participate in the State's maternity care home model, which may include training for cultural humility and antiracism, racial bias, health equity, reproductive and birth justice,

trauma-informed care, home visiting skills, and respectful communication and listening skills, particularly in regards to maternal health;

"(D) pay for personnel and administrative expenses associated with designing, implementing, and operating the State's maternity care home model;

"(E) pay for items and services that are furnished under the State's maternity care home model and for which payment is otherwise unavailable under this title;

"(F) pay for services and materials to ensure culturally and linguistically appropriate communication, including—

"(i) language services such as interpreters and translation of written materials; and

"(ii) development of culturally and linguistically appropriate materials; and auxiliary aids and services; and

"(G) pay for other costs related to the State's maternity care home model, as determined by the Secretary.

"(3) GRANT FOR NATIONAL INDEPENDENT EVALUATOR.—

"(A) IN GENERAL.—From the amounts appropriated under subsection (l), prior to awarding any grants under paragraph (1), the Secretary shall enter into a contract with a national external entity to create a single, uniform process to—

"(i) ensure that States that receive grants under paragraph (1) comply with the requirements of this section; and

"(ii) evaluate the outcomes of the demonstration project in each participating State.

"(B) ANNUAL REPORT.—The contract described in subparagraph (A) shall require the national external entity to submit to the Secretary—

"(i) a yearly evaluation report for each year of the demonstration project; and

"(ii) a final impact report after the demonstration project has concluded.

"(C) SECRETARY'S AUTHORITY.—Nothing in this paragraph shall prevent the Secretary from making a determination that a State is not in compliance with the requirements of this

section without the national external entity making such a determination.

''(f) PARTNERSHIP WITH ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—As a condition of receiving a grant under this section, a State shall enter into an arrangement with one or more eligible entities that meets the requirements of paragraph (2).

''(2) ARRANGEMENTS WITH ELIGIBLE ENTITIES.—Under an arrangement between a State and an eligible entity under this subsection, the eligible entity shall perform the following functions, with respect to eligible individuals enrolled with the entity under the State's maternity care home model—

''(A) provide culturally and linguistically appropriate congruent care, which may include prenatal care, family planning services, medical care, mental and behavioral care, postpartum care, and oral health services to such eligible individuals through a team of health care professionals, which may include obstetrician-gynecologists, maternal-fetal medicine specialists, family physicians, primary care providers, oral health providers, physician assistants, advanced practice registered nurses such as nurse practitioners and certified nurse midwives, certified

midwives, certified professional midwives, physical therapists, social workers, traditional and community-based doulas, lactation consultants, childbirth educators, community health workers, peer mental health supporters, and other health care professionals;

''(B) conduct a risk assessment of each such eligible individual to determine if their pregnancy is high or low risk, and establish a tailored pregnancy care plan, which takes into consideration the individual's own preferences and pregnancy care and birthing plans and determines the appropriate support services to reduce the individual's medical, social, and environmental risk factors, for each such eligible individual based on the results of such risk assessment;

''(C) assign each such eligible individual to a culturally and linguistically appropriate care coordinator, which may be a nurse, social worker, traditional or community-based doula, community health worker, midwife, or other health care provider, who is responsible for ensuring that such eligible individual receives the nec-

essary medical care and connections to essential support services;

"(D) provide, or arrange for the provision of, essential support services, such as services that address—

"(i) food access, nutrition, and exercise;

"(ii) smoking cessation;

"(iii) substance use disorder and addiction treatment;

"(iv) anxiety, depression, trauma, and other mental and behavioral health issues;

"(v) breast feeding, chestfeeding, or other infant feeding options supports, initiation, continuation, and duration;

"(vi) stable, affordable, safe, and healthy housing;

"(vii) transportation;

"(viii) intimate partner violence;

"(ix) community and police violence;

"(x) home visiting services;

"(xi) childbirth and newborn care education;

"(xii) oral health education;

"(xiii) continuous labor support;

"(xiv) group prenatal care;

"(xv) family planning and contraceptive care and supplies; and

"(xvi) affordable child care;

"(E) as appropriate, facilitate connections to a usual primary care provider, which may be a reproductive health care provider;

"(F) refer to guidelines and opinions of medical associations when determining whether an elective delivery should be performed on an eligible individual before 39 weeks of gestation;

"(G) provide such eligible individual with evidence-based and culturally and linguistically appropriate education and resources to identify potential warning signs of pregnancy and postpartum complications and when and how to obtain medical attention;

"(H) provide, or arrange for the provision of, culturally and linguistically appropriate pregnancy and postpartum health services, including family planning counseling and services, to eligible individuals;

"(I) track and report postpartum health and birth outcomes of such eligible individuals and their children;

"(J) ensure that care is person-centered, culturally and linguistically appropriate, and patient-led, including by engaging eligible individuals in their own care, including through communication and education; and

"(K) ensure adequate training for appropriately serving the population of individuals eligible for medical assistance under the State plan (or waiver of such plan), including through reproductive justice, birth justice, birth equity, and anti-racist frameworks, home visiting skills, and knowledge of social services.

"(g) TERM OF DEMONSTRATION PROJECT.—The Secretary shall conduct the demonstration project for a period of 5 years.

"(h) REPORT.—Not later than 18 months after the date of the enactment of this section and annually thereafter for each year of the demonstration project term, the Secretary shall submit a report to Congress on the results of the demonstration project, including—

"(1) the results of the final report of the national external entity required under subsection (e)(3)(B)(ii); and

"(2) recommendations on whether the model studied in the demonstration project should be con-

tinued or more widely adopted, including by private health plans.

''(i) WAIVER AUTHORITY.—To the extent that the Secretary determines necessary in order to carry out the demonstration project, the Secretary may waive section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability).

''(j) TECHNICAL ASSISTANCE.—The Secretary shall establish a process to provide technical assistance to States that are awarded grants under this section and to eligible entities and other providers participating in a State maternity care home model funded by such a grant.

''(k) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an entity or organization that provides medically accurate, comprehensive maternity services to individuals who are eligible for medical assistance under a State plan under this title or a waiver of such a plan, and may include:

''(A) A freestanding birth center.

''(B) An entity or organization receiving assistance under section 330 of the Public Health Service Act.

''(C) A federally qualified health center.

''(D) A rural health clinic.

''(E) A health facility operated by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means a pregnant individual or a formerly pregnant individual during the 1-year period beginning on the last day of the pregnancy, or such longer period beginning on such day as a State may elect, who is—

''(A) enrolled in a State plan under this title, a waiver of such a plan, or a State child health plan under title XXI; and

''(B) a patient of an eligible entity which has entered into an arrangement with a State under subsection (g).

''(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, for each of fiscal years 2023 through 2030, such sums as may be necessary to carry out this section.''.

(c) REAPPLICATION OF MEDICARE PAYMENT RATE FLOOR TO PRIMARY CARE SERVICES FURNISHED UNDER MEDICAID AND INCLUSION OF ADDITIONAL PROVIDERS.—

(1) REAPPLICATION OF PAYMENT FLOOR; ADDITIONAL PROVIDERS.—

(A) IN GENERAL.—Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended—

(i) in subparagraph (B), by striking ''; and'' and inserting a semicolon;

(ii) in subparagraph (C), by striking the semicolon and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(D) payment for primary care services (as defined in subsection (jj)(1)) furnished in the period that begins on the first day of the first month that begins after the date of enactment of this subparagraph by a provider described in subsection (jj)(2)—

''(i) at a rate that is not less than 100 percent of the payment rate that applies to such services and the provider of such services under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the

year were the conversion factor under such section for 2009);

"(ii) in the case of items and services that are not items and services provided under such part, at a rate to be established by the Secretary; and

"(iii) in the case of items and services that are furnished in rural areas (as defined in section 1886(d)(2)(D)), health professional shortage areas (as defined in section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))), or medically underserved areas (according to a designation under section 330(b)(3)(A) of the Public Health Service Act (42 U.S.C. 254b(b)(3)(A))), at the rate otherwise applicable to such items or services under clause (i) or (ii) increased, at the Secretary's discretion, by not more than 25 percent;".

(B) CONFORMING AMENDMENTS.—

(i) Section 1902(a)(13)(C) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)) is amended by striking

''subsection (jj)'' and inserting ''subsection (jj)(1)''.

(ii) Section 1905(dd) of the Social Security Act (42 U.S.C. 1396d(dd)) is amended—

(I) by striking ''Notwithstanding'' and inserting the following: ''(1) IN GENERAL.—Notwithstanding'';

(II) by striking ''section 1902(a)(13)(C)'' and inserting ''subparagraph (C) of section 1902(a)(13)'';

(III) by inserting ''or for services described in subparagraph (D) of section 1902(a)(13) furnished during an additional period specified in paragraph (2),'' after ''2015,'';

(IV) by striking ''under such section'' and inserting ''under subparagraph (C) or (D) of section 1902(a)(13), as applicable''; and

(V) by adding at the end the following:

''(2) ADDITIONAL PERIODS.—For purposes of paragraph (1), the following are additional periods:

''(A) The period that begins on the first day of the first month that begins after the date of enactment of the this paragraph.''.

(2) IMPROVED TARGETING OF PRIMARY CARE.—Section 1902(jj) of the Social Security Act (42 U.S.C. 1396a(jj)) is amended—

(A) by redesignating paragraphs (1) and (2) as clauses (i) and (ii), respectively, and realigning the left margins accordingly;

(B) by striking ''For purposes of subsection (a)(13)(C)'' and inserting the following: ''(1) IN GENERAL.—

''(A) DEFINITION.—For purposes of subparagraphs (C) and (D) of subsection (a)(13)''; and

(C) by inserting after clause (ii) (as so redesignated) the following:

''(B) EXCLUSIONS.—Such term does not include any services described in subparagraph (A) or (B) of paragraph (1) if such services are provided in an emergency department of a hospital.

''(2) ADDITIONAL PROVIDERS.—For purposes of subparagraph (D) of subsection (a)(13), a pro-

vider described in this paragraph is any of the following:

"(A) A physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine, or obstetrics and gynecology.

"(B) An advanced practice clinician, as defined by the Secretary, that works under the supervision of—

"(i) a physician that satisfies the criteria specified in subparagraph (A);

"(ii) a nurse practitioner or a physician assistant (as such terms are defined in section 1861(aa)(5)(A)) who is working in accordance with State law; or

"(iii) or a certified nurse-midwife (as defined in section 1861(gg)) or a certified professional midwife who is working in accordance with State law.

"(C) A rural health clinic, federally qualified health center, health center that receives funding under title X of the Public Health Service Act, or other health clinic that receives reimbursement on a fee schedule applicable to a physician.

''(D) An advanced practice clinician supervised by a physician described in subparagraph (A), another advanced practice clinician, or a certified nurse-midwife.

''(E) A midwife who is working in accordance with State law.''.

(3) ENSURING PAYMENT BY MANAGED CARE ENTITIES.—

(A) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(i) in clause (xii), by striking ''and'' after the semicolon;

(ii) by realigning the left margin of clause (xiii) so as to align with the left margin of clause (xii) and by striking the period at the end of clause (xiii) and inserting ''; and''; and

(iii) by inserting after clause (xiii) the following:

''(xiv) such contract provides that (I) payments to providers specified in section 1902(a)(13)(D) for primary care services (as defined in section 1902(jj)) that are furnished during a year or period (as specified in section 1902(a)(13)(D) and section

1905(dd)) are at least equal to the amounts set forth and required by the Secretary by regulation; (II) the entity shall, upon request, provide documentation to the State, sufficient to enable the State and the Secretary to ensure compliance with subclause (I); and (III) the Secretary shall approve payments described in subclause (I) that are furnished through an agreed upon capitation, partial capitation, or other value-based payment arrangement if the capitation, partial capitation, or other value-based payment arrangement is based on a reasonable methodology and the entity provides documentation to the State sufficient to enable the State and the Secretary to ensure compliance with subclause (I).''.

(B) CONFORMING AMENDMENT.—Section 1932(f) of the Social Security Act (42 U.S.C. 1396u–2(f)) is amended—

(i) by striking ''section 1902(a)(13)(C)'' and inserting ''subsections (C) and (D) of section 1902(a)(13)''; and

(ii) by inserting '', and clause (xiv) of section 1903(m)(2)(A)'' before the period.

(d) MACPAC REPORT AND CMS GUIDANCE ON INCREASING ACCESS TO DOULA SERVICES FOR MEDICAID BENEFICIARIES.—

(1) MACPAC REPORT.—

(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Medicaid and CHIP Payment and Access Commission (referred to in this subsection as ''MACPAC'') shall publish a report on the coverage of doula services under State Medicaid programs, which shall at a minimum include the following:

(i) Information about coverage for doula services under State Medicaid programs that currently provide coverage for such care, including the type of doula services offered (such as prenatal, labor and delivery, postpartum support, and also community-based and traditional doula services).

(ii) An analysis of barriers to covering doula services under State Medicaid programs.

(iii) An identification of effective 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-

sumers of maternal health care, including those that are disproportionately impacted by poor maternal health outcomes;

(iii) organizations and individuals representing doulas, including community-based doula programs and those who serve underserved communities, including communities of color, and communities facing linguistic or cultural barriers;

(iv) organizations representing health care providers; and

(v) Black, Indigenous, and other maternal health care consumers of color who have experienced severe maternal morbidity.

(2) CMS GUIDANCE.—

(A) IN GENERAL.—Not later than 1 year after the date that MACPAC publishes the report required under paragraph (1)(A), the Administrator of the Centers for Medicare & Medicaid Services shall issue guidance to States on increasing access to doula services under Medicaid. Such guidance shall at a minimum include—

(i) options for States to provide medical assistance for doula services under State Medicaid programs;

(ii) best practices for ensuring that doulas, including community-based doulas, receive reimbursement for doula services provided under a State Medicaid program, at a level that allows doulas to earn a living wage that accounts for their time and costs associated with providing care and community-based doula program administration; and

(iii) best practices for increasing access to doula services, including services provided by community-based doulas, under State Medicaid programs.

(B) STAKEHOLDER CONSULTATION.—In developing the guidance required under subparagraph (A), the Administrator of the Centers for Medicare & Medicaid Services shall consult with MACPAC and other relevant stakeholders, including—

(i) State Medicaid officials;

(ii) organizations representing consumers of maternal health care, including

those that are disproportionately impacted by poor maternal health outcomes;

(iii) organizations representing doulas, including community-based doulas and those who serve underserved communities, such as communities of color and communities facing linguistic or cultural barriers; and

(iv) organizations representing medical professionals.

(e) GAO REPORT ON STATE MEDICAID PROGRAMS' USE OF TELEHEALTH TO INCREASE ACCESS TO MATERNITY CARE.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to Congress on State Medicaid programs' use of telehealth to increase access to maternity care. Such report shall include the following:

(1) The number of State Medicaid programs that utilize telehealth that increases access to maternity care.

(2) With respect to State Medicaid programs that utilize telehealth that increases access to maternity care, information about—

(A) common characteristics of such programs' approaches to utilizing telehealth that increases access to maternity care;

(B) differences in States' approaches to utilizing telehealth to improve access to maternity care, and the resulting differences in State maternal health outcomes, as determined by factors described in subsection (C); and

(C) when compared to patients who receive maternity care in-person, what is known about—

(i) the demographic characteristics, such as race, ethnicity, sex, sexual orientation, gender identity, disability status, age, and preferred language of the individuals enrolled in such programs who use telehealth to access maternity care;

(ii) health outcomes for such individuals, including frequency of mortality and severe morbidity, as compared to individuals with similar characteristics who did not use telehealth to access maternity care;

(iii) the services provided to individuals through telehealth, including family

planning services, mental health care services, and oral health services;

(iv) the devices and equipment provided to individuals for remote patient monitoring and telehealth, including blood pressure monitors and blood glucose monitors;

(v) the quality of maternity care provided through telehealth, including whether maternity care provided through telehealth is culturally and linguistically appropriate;

(vi) the level of patient satisfaction with maternity care provided through telehealth to individuals enrolled in State Medicaid programs;

(vii) the impact of utilizing telehealth to increase access to maternity care on spending, cost savings, access to care, and utilization of care under State Medicaid programs; and

(viii) the accessibility and effectiveness of telehealth for maternity care during the COVID–19 pandemic.

(3) An identification and analysis of the barriers to using telehealth to increase access to maternity care under State Medicaid programs.

(4) Recommendations for such legislative and administrative actions related to increasing access to telehealth maternity services under Medicaid as the Comptroller General deems appropriate.

SEC. 5203. JUSTICE FOR INCARCERATED MOMS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the respect and proper care that birthing people deserve is inclusive; and

(2) regardless of race, ethnicity, gender identity, sexual orientation, religion, marital status, familial status, socioeconomic status, immigration status, incarceration status, or disability, all deserve dignity.

(b) ENDING THE SHACKLING OF PREGNANT INDIVIDUALS.—

(1) IN GENERAL.—For each fiscal year that begins on or after the date that is 180 days after the date of enactment of this Act, for each State that receives a grant under subpart 1 of part E of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10151 et seq.) (commonly

referred to as the ''Edward Byrne Memorial Justice Assistance Grant Program'') and that does not have in effect throughout the State for such fiscal year laws restricting the use of restraints on pregnant individuals in correctional facilities that provide rights, procedures, requirements, effects, and penalties that are substantially similar to those set forth in section 4322 of title 18, United States Code, the amount of such grant that would otherwise be allocated to such State under such subpart for the fiscal year shall be decreased by 25 percent.

(2) REALLOCATION.—Amounts not allocated to a State for failure to comply with paragraph (1) shall be reallocated in accordance with subpart 1 of part E of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10151 et seq.) to States that have complied with such paragraph.

(c) CREATING MODEL PROGRAMS FOR THE CARE OF INCARCERATED INDIVIDUALS IN THE PRENATAL AND POSTPARTUM PERIODS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Attorney General, acting through the Director of the Bureau of Prisons (in this subsection referred to as the ''Director''), shall establish, in not fewer than 6 Bureau of

Prisons facilities, programs to optimize maternal health outcomes for pregnant and postpartum individuals incarcerated in such facilities. The Attorney General shall establish such programs in consultation with stakeholders such as—

(A) Federal Public Defenders and Executive Directors of Community Defender Organizations;

(B) relevant community-based organizations, particularly organizations that represent incarcerated and formerly incarcerated individuals and organizations that seek to improve maternal health outcomes for pregnant and postpartum individuals from racial and ethnic minority groups;

(C) relevant organizations representing patients, with a particular focus on patients from racial and ethnic minority groups;

(D) organizations representing maternity care providers and maternal health care education programs;

(E) perinatal health workers; and

(F) researchers and policy experts in fields related to maternal health care for incarcerated individuals.

(2) START DATE.—Each facility selected under paragraph (1) shall begin the programs to optimize maternal health outcomes for pregnant and postpartum individuals incarcerated in such facilities not later than 18 months after the date of enactment of this Act.

(3) FACILITY PRIORITY.—In carrying out paragraph (1), the Director, in consultation with the stakeholders described in paragraph (1), shall give priority to a facility based on—

(A) the number of pregnant and postpartum individuals incarcerated in such facility and, among such individuals, the number of pregnant and postpartum individuals from racial and ethnic minority groups; and

(B) the extent to which the leaders of such facility have demonstrated a commitment to developing exemplary programs for pregnant and postpartum individuals incarcerated in such facility.

(4) PROGRAM DURATION.—The programs established under this subsection shall be carried out for a 5-year period.

(5) PROGRAMS.—Bureau of Prisons facilities selected by the Director shall establish programs for

pregnant and postpartum incarcerated individuals, and such programs may—

(A) provide access to perinatal health workers from pregnancy through the postpartum period;

(B) provide access to healthy foods and counseling on nutrition, recommended activity levels, and safety measures throughout pregnancy;

(C) train correctional officers to ensure that pregnant incarcerated individuals receive safe and respectful treatment;

(D) train medical personnel to ensure that pregnant incarcerated individuals receive trauma-informed, culturally congruent care that promotes the health and safety of the pregnant individuals;

(E) provide counseling and treatment for individuals who have suffered from—

(i) diagnosed mental or behavioral health conditions, including trauma and substance use disorders;

(ii) trauma or violence, including domestic violence;

(iii) human immunodeficiency virus;

(iv) sexual abuse;

(v) pregnancy or infant loss; or

(vi) chronic conditions;

(F) provide evidence-based pregnancy and childbirth education, parenting support, and other relevant forms of health literacy;

(G) provide clinical education opportunities to maternity care providers in training to expand pathways into maternal health care careers serving incarcerated individuals;

(H) offer opportunities for postpartum individuals to maintain contact with the individual's newborn child to promote bonding, including enhanced visitation policies, access to prison nursery programs, or breastfeeding support;

(I) provide reentry assistance, particularly to—

(i) ensure access to health insurance coverage and transfer of health records to community providers if an incarcerated individual exits the criminal justice system during such individual's pregnancy or in the postpartum period; and

(ii) connect individuals exiting the criminal justice system during pregnancy

or in the postpartum period to community-based resources, such as referrals to health care providers, substance use disorder treatments, and social services that address social determinants of maternal health; or

(J) establish partnerships with local public entities, private community entities, community-based organizations, Indian Tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), and urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) to establish or expand pretrial diversion programs as an alternative to incarceration for pregnant and postpartum individuals, including—

(i) evidence-based childbirth education or parenting classes;

(ii) prenatal health coordination;

(iii) family and individual counseling;

(iv) evidence-based screenings, education, and, as needed, treatment for men-

tal and behavioral health conditions, including drug and alcohol treatments;

(v) family case management services;

(vi) domestic violence education and prevention;

(vii) physical and sexual abuse counseling; and

(viii) programs to address social determinants of health such as employment, housing, education, transportation, and nutrition.

(6) IMPLEMENTATION AND REPORTING.—A facility selected under paragraph (1) shall be responsible for—

(A) implementing programs, which may include the programs described in paragraph (5); and

(B) not later than 3 years after the date of enactment of this Act, and not later than 6 years after the date of enactment of this Act, reporting results of the programs to the Director, including information describing—

(i) relevant quantitative indicators of success in improving the standard of care and health outcomes for pregnant and

postpartum incarcerated individuals in the facility, including data stratified by race, ethnicity, sex, gender, age, geography, disability status, the category of the criminal charge against such individual, rates of pregnancy-related deaths, pregnancy-associated deaths, cases of infant mortality and morbidity, rates of pre-term births and low-birthweight births, cases of severe maternal morbidity, cases of violence against pregnant or postpartum individuals, diagnoses of maternal mental or behavioral health conditions, and other such information as appropriate;

(ii) relevant qualitative and quantitative evaluations from pregnant and postpartum incarcerated individuals who participated in such programs, including measures of patient-reported experience of care; and

(iii) strategies to sustain such programs after fiscal year 2028 and expand such programs to other facilities.

(7) REPORT.—Not later than 6 years after the date of enactment of this Act, the Director shall

submit to the Attorney General and Congress a report describing the results of the programs carried out under this subsection.

(8) OVERSIGHT.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall award a contract to an independent organization or independent organizations to conduct oversight of the programs described in paragraph (5).

(9) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $10,000,000 for each of fiscal years 2024 through 2028.

(d) GRANT PROGRAM TO IMPROVE MATERNAL HEALTH OUTCOMES FOR INDIVIDUALS IN STATE AND LOCAL CORRECTIONAL FACILITIES.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Attorney General, acting through the Director of the Bureau of Justice Assistance (in this subsection referred to as the ''Director''), shall award Justice for Incarcerated Moms grants to States to establish or expand programs in State and local correctional facilities for pregnant and postpartum incarcerated individuals.

The Attorney General shall award such grants in consultation with stakeholders such as—

(A) Federal Public Defenders and Executive Directors of Community Defender Organizations;

(B) relevant community-based organizations, particularly organizations that represent incarcerated and formerly incarcerated individuals and organizations that seek to improve maternal health outcomes for pregnant and postpartum individuals from racial and ethnic minority groups;

(C) relevant organizations representing patients, with a particular focus on patients from racial and ethnic minority groups;

(D) organizations representing maternity care providers and maternal health care education programs;

(E) perinatal health workers; and

(F) researchers and policy experts in fields related to maternal health care for incarcerated individuals.

(2) APPLICATIONS.—Each State desiring a grant under this subsection shall submit to the Director an application at such time, in such manner,

and containing such information as the Director may require.

(3) USE OF FUNDS.—A State that is awarded a grant under this subsection shall use such grant to establish or expand programs for pregnant and postpartum incarcerated individuals, and such programs may—

(A) provide access to perinatal health workers from pregnancy through the postpartum period;

(B) provide access to healthy foods and counseling on nutrition, recommended activity levels, and safety measures throughout pregnancy;

(C) train correctional officers to ensure that pregnant incarcerated individuals receive safe and respectful treatment;

(D) train medical personnel to ensure that pregnant incarcerated individuals receive trauma-informed, culturally congruent care that promotes the health and safety of the pregnant individuals;

(E) provide counseling and treatment for individuals who have suffered from—

(i) diagnosed mental or behavioral health conditions, including trauma and substance use disorders;

(ii) trauma or violence, including domestic violence;

(iii) human immunodeficiency virus;

(iv) sexual abuse;

(v) pregnancy or infant loss; or

(vi) chronic conditions;

(F) provide evidence-based pregnancy and childbirth education, parenting support, and other relevant forms of health literacy;

(G) provide clinical education opportunities to maternity care providers in training to expand pathways into maternal health care careers serving incarcerated individuals;

(H) offer opportunities for postpartum individuals to maintain contact with the individual's newborn child to promote bonding, including enhanced visitation policies, access to prison nursery programs, or breastfeeding support;

(I) provide reentry assistance, particularly to—

(i) ensure access to health insurance coverage and transfer of health records to

community providers if an incarcerated individual exits the criminal justice system during such individual's pregnancy or in the postpartum period; and

(ii) connect individuals exiting the criminal justice system during pregnancy or in the postpartum period to community-based resources, such as referrals to health care providers, substance use disorder treatments, and social services that address social determinants of maternal health; or

(J) establish partnerships with local public entities, private community entities, community-based organizations, Indian Tribes and tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), and urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) to establish or expand pretrial diversion programs as an alternative to incarceration for pregnant and postpartum individuals, including—

(i) evidence-based childbirth education or parenting classes;

(ii) prenatal health coordination;

(iii) family and individual counseling;

(iv) evidence-based screenings, education, and, as needed, treatment for mental and behavioral health conditions, including drug and alcohol treatments;

(v) family case management services;

(vi) domestic violence education and prevention;

(vii) physical and sexual abuse counseling; and

(viii) programs to address social determinants of health such as employment, housing, education, transportation, and nutrition.

(4) PRIORITY.—In awarding grants under this subsection, the Director shall give priority to applicants based on—

(A) the number of pregnant and postpartum individuals incarcerated in the State and, among such individuals, the number of pregnant and postpartum individuals from racial and ethnic minority groups; and

(B) the extent to which the State has demonstrated a commitment to developing exemplary programs for pregnant and postpartum individuals incarcerated in the correctional facilities in such State.

(5) GRANT DURATION.—A grant awarded under this subsection shall be for a 5-year period.

(6) IMPLEMENTING AND REPORTING.—A State that receives a grant under this subsection shall be responsible for—

(A) implementing the program funded by the grant; and

(B) not later than 3 years after the date of enactment of this Act, and not later than 6 years after the date of enactment of this Act, reporting results of such program to the Attorney General, including information describing—

(i) relevant quantitative indicators of the program's success in improving the standard of care and health outcomes for pregnant and postpartum incarcerated individuals in the facility, including data stratified by race, ethnicity, sex, gender, age, geography, disability status, category of the criminal charge against such indi-

vidual, incidence rates of pregnancy-related deaths, pregnancy-associated deaths, cases of infant mortality and morbidity, rates of pre-term births and low-birthweight births, cases of severe maternal morbidity, cases of violence against pregnant or postpartum individuals, diagnoses of maternal mental or behavioral health conditions, and other such information as appropriate;

(ii) relevant qualitative and quantitative evaluations from pregnant and postpartum incarcerated individuals who participated in such programs, including measures of patient-reported experience of care; and

(iii) strategies to sustain such programs beyond the duration of the grant and expand such programs to other facilities.

(7) REPORT.—Not later than 6 years after the date of enactment of this Act, the Attorney General shall submit to Congress a report describing the results of programs carried out using grants under this subsection.

(8) OVERSIGHT.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall award a contract to an independent organization or independent organizations to conduct oversight of the programs described in paragraph (3).

(9) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $10,000,000 for each of fiscal years 2024 through 2028.

(e) GAO REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on adverse maternal and infant health outcomes among incarcerated individuals and infants born to such individuals, with a particular focus on racial and ethnic inequities in maternal and infant health outcomes for incarcerated individuals.

(2) CONTENTS OF REPORT.—The report described in this subsection shall include—

(A) to the extent practicable—

(i) the number of pregnant individuals who are incarcerated in Bureau of Prisons facilities;

(ii) the number of incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities, who have experienced a pregnancy-related death, pregnancy-associated death, or the death of an infant in the most recent 10 years of available data;

(iii) the number of cases of severe maternal morbidity among incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities, in the most recent 10 years of available data;

(iv) the number of pre-term and low-birthweight births of infants born to incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities, in the most recent 10 years of available data; and

(v) statistics on the racial and ethnic inequities in maternal and infant health outcomes and severe maternal morbidity rates among incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities;

(B) in the case that the Comptroller General of the United States is unable to determine the information required in clauses (i) through (v) of subparagraph (A), an assessment of the barriers to determining such information and recommendations for improvements in tracking maternal health outcomes among incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities;

(C) a discussion of causes of adverse maternal health outcomes that are unique to incarcerated individuals, including those incarcerated in Federal, State, and local correctional facilities;

(D) a discussion of causes of adverse maternal health outcomes and severe maternal morbidity that are unique to incarcerated individuals from racial and ethnic minority groups;

(E) recommendations to reduce maternal mortality and severe maternal morbidity among incarcerated individuals and to address racial and ethnic inequities in maternal health outcomes for incarcerated individuals in Bureau of Prisons facilities and State and local correctional facilities; and

(F) such other information as may be appropriate to reduce the occurrence of adverse maternal health outcomes among incarcerated individuals and to address racial and ethnic inequities in maternal health outcomes for such individuals.

(f) MACPAC REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Medicaid and CHIP Payment and Access Commission (referred to in this subsection as ''MACPAC'') shall publish a report on the implications of pregnant and postpartum incarcerated individuals being ineligible for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) that contains the information described in paragraph (2).

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph includes—

(A) information on the effect of ineligibility for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on maternal health outcomes for pregnant and postpartum incarcerated individ-

uals, concentrating on the effects of such ineligibility for pregnant and postpartum individuals from racial and ethnic minority groups; and

(B) the potential implications on maternal health outcomes resulting from suspending eligibility for medical assistance under a State plan under such title of such Act when a pregnant or postpartum individual is incarcerated.

(g) DEFINITIONS.—In this section:

(1) CULTURALLY CONGRUENT.—The term ''culturally congruent'' means that the care, maternity care, health care services, provider, or non-clinical support made available is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of

Midwives, nurse practitioner, or clinical nurse specialist; and

(B) has a focus on maternal or perinatal health.

(3) MATERNAL MORTALITY.—The term ''maternal mortality'' means a death occurring during or within a one-year period after pregnancy that is caused by pregnancy-related or childbirth complications, including a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications.

(4) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(6) PREGNANCY-ASSOCIATED DEATH.—The term ''pregnancy-associated death'' means a death of a pregnant or postpartum individual, by any cause,

that occurs during, or within 1 year following, the individual's pregnancy, regardless of the outcome, duration, or site of the pregnancy.

(7) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related death'' means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(8) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(9) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(10) SOCIAL DETERMINANTS OF MATERNAL HEALTH.—The term ''social determinants of mater-

nal health'' means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include poverty, employment, food security, support for and access to lactation and other infant feeding options, housing stability, and related factors;

(B) neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

(D) household factors, which may include ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors;

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) health care access factors, including health insurance coverage, access to culturally congruent health care services, providers, and non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

(11) STATE.—The term ''State'' means any State of the United States, the District of Columbia, or any territory or possession of the United States.

SEC. 5204. IMPACT TO SAVE MOMS ACT.

(a) PERINATAL CARE ALTERNATIVE PAYMENT MODEL DEMONSTRATION PROJECT.—

(1) IN GENERAL.—For the period of fiscal years 2023 through 2027, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish and implement, in accordance with the requirements of this subsection, a demonstration project, to be known as the Perinatal

Care Alternative Payment Model Demonstration Project (referred to in this subsection as the ''Demonstration Project''), for purposes of allowing States to test payment models under their State plans under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.) with respect to maternity care provided to pregnant and postpartum individuals enrolled in such State plans and State child health plans.

(2) COORDINATION.—In establishing the Demonstration Project, the Secretary shall coordinate with stakeholders such as—

(A) State Medicaid programs;

(B) relevant organizations representing maternal health care providers;

(C) relevant organizations representing patients, with a particular focus on individuals from demographic groups with disproportionate rates of adverse maternal health outcomes;

(D) relevant community-based organizations, particularly organizations that seek to improve maternal health outcomes for individuals from demographic groups with dispropor-

tionate rates of adverse maternal health outcomes;

(E) non-clinical perinatal health workers such as doulas, community health workers, peer supporters, certified lactation consultants, nutritionists and dieticians, social workers, home visitors, and navigators;

(F) relevant health insurance issuers;

(G) hospitals, health systems, freestanding birth centers (as such term is defined in paragraph (3)(B) of section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l))), Federally-qualified health centers (as such term is defined in paragraph (2)(B) of such section), and rural health clinics (as such term is defined in section 1861(aa) of such Act (42 U.S.C. 1395x(aa)));

(H) researchers and policy experts in fields related to maternity care payment models; and

(I) any other stakeholders as the Secretary determines appropriate, with a particular focus on stakeholders from demographic groups with disproportionate rates of adverse maternal health outcomes.

(3) CONSIDERATIONS.—In establishing the Demonstration Project, the Secretary shall consider each of the following:

(A) Findings from any evaluations of the Strong Start for Mothers and Newborns initiative carried out by the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, and the Administration on Children and Families.

(B) Any alternative payment model that—

(i) is designed to improve maternal health outcomes for racial and ethnic groups with disproportionate rates of adverse maternal health outcomes;

(ii) includes methods for stratifying patients by pregnancy risk level and, as appropriate, adjusting payments under such model to take into account pregnancy risk level;

(iii) establishes evidence-based quality metrics for such payments;

(iv) includes consideration of non-hospital birth settings such as freestanding birth centers (as so defined);

(v) includes consideration of social determinants of health that are relevant to maternal health outcomes such as housing, transportation, nutrition, and other nonclinical factors that influence maternal health outcomes; or

(vi) includes diverse maternity care teams that include—

(I) maternity care providers, including obstetrician-gynecologists, family physicians, physician assistants, midwives who meet, at a minimum, the international definition of the term ''midwife'' and global standards for midwifery education (as established by the International Confederation of Midwives), and nurse practitioners—

(aa) from racially, ethnically, and professionally diverse backgrounds;

(bb) with experience practicing in racially and ethnically diverse communities; or

(cc) who have undergone trainings on racism, implicit bias, and explicit bias; and

(II) non-clinical perinatal health workers such as doulas, community health workers, peer supporters, certified lactation consultants, nutritionists and dieticians, social workers, home visitors, and navigators.

(4) ELIGIBILITY.—To be eligible to participate in the Demonstration Project, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) EVALUATION.—The Secretary shall conduct an evaluation of the Demonstration Project to determine the impact of the Demonstration Project on—

(A) maternal health outcomes, with data stratified by race, ethnicity, socioeconomic indicators, and any other factors as the Secretary determines appropriate;

(B) spending on maternity care by States participating in the Demonstration Project;

(C) to the extent practicable, subjective measures of patient experience; and

(D) any other areas of assessment that the Secretary determines relevant.

(6) REPORT.—Not later than one year after the completion or termination date of the Demonstration Project, the Secretary shall submit to the Committee on Energy and Commerce, the Committee on Ways and Means, and the Committee on Education and Labor of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate, and make publicly available, a report containing—

(A) the results of any evaluation conducted under paragraph (5); and

(B) a recommendation regarding whether the Demonstration Project should be continued after fiscal year 2026 and expanded on a national basis.

(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this subsection.

(8) DEFINITIONS.—In this subsection:

(A) ALTERNATIVE PAYMENT MODEL.—The term ''alternative payment model'' has the meaning given such term in section

1833(z)(3)(C) of the Social Security Act (42 U.S.C. 1395l(z)(3)(C)).

(B) PERINATAL.—The term ''perinatal'' means the period beginning on the day a person becomes pregnant and ending on the last day of the 1-year period beginning on the last day of such person's pregnancy.

(b) MACPAC REPORT.—

(1) IN GENERAL.—Not later than two years after the date of the enactment of this section, the Medicaid and CHIP Payment and Access Commission shall publish a report on issues relating to the continuity of coverage under State plans under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.) for pregnant and postpartum individuals. Such report shall, at a minimum, include the following:

(A) An assessment of any existing policies under such State plans and such State child health plans regarding presumptive eligibility for pregnant individuals while their application for enrollment in such a State plan or such a State child health plan is being processed.

(B) An assessment of any existing policies under such State plans and such State child health plans regarding measures to ensure continuity of coverage under such a State plan or such a State child health plan for pregnant and postpartum individuals, including such individuals who need to change their health insurance coverage during their pregnancy or the postpartum period following their pregnancy.

(C) An assessment of any existing policies under such State plans and such State child health plans regarding measures to automatically reenroll individuals who are eligible to enroll under such a State plan or such a State child health plan as a parent.

(D) If determined appropriate by the Commission, any recommendations for the Department of Health and Human Services, or such State plans and such State child health plans, to ensure continuity of coverage under such a State plan or such a State child health plan for pregnant and postpartum people.

(2) POSTPARTUM DEFINED.—In this subsection, the term ''postpartum'' means the 1-year

period beginning on the last day of a person's pregnancy.

SEC. 5205. PROTECTING MOMS AND BABIES AGAINST CLIMATE CHANGE.

(a) GRANT PROGRAM TO PROTECT VULNERABLE MOTHERS AND BABIES FROM CLIMATE CHANGE RISKS.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a grant program (in this subsection referred to as the ''Program'') to protect vulnerable individuals from risks associated with climate change.

(2) GRANT AUTHORITY.—In carrying out the Program, the Secretary may award, on a competitive basis, grants to 10 covered entities.

(3) APPLICATIONS.—To be eligible for a grant under the Program, a covered entity shall submit to the Secretary an application at such time, in such form, and containing such information as the Secretary may require, which shall include, at a minimum, a description of the following:

(A) Plans for the use of grant funds awarded under the Program and how patients

and stakeholder organizations were involved in the development of such plans.

(B) How such grant funds will be targeted to geographic areas that have disproportionately high levels of risks associated with climate change for vulnerable individuals.

(C) How such grant funds will be used to address racial and ethnic inequities in—

(i) adverse maternal and infant health outcomes; and

(ii) exposure to risks associated with climate change for vulnerable individuals.

(D) Strategies to prevent an initiative assisted with such grant funds from causing—

(i) adverse environmental impacts;

(ii) displacement of residents and businesses;

(iii) rent and housing price increases; or

(iv) disproportionate adverse impacts on racial and ethnic minority groups and other underserved populations.

(4) SELECTION OF GRANT RECIPIENTS.—

(A) TIMING.—Not later than 270 days after the date of the enactment of this Act, the

Secretary shall select the recipients of grants under the Program.

(B) CONSULTATION.—In selecting covered entities for grants under the Program, the Secretary shall consult with—

(i) representatives of stakeholder organizations;

(ii) the Administrator of the Environmental Protection Agency;

(iii) the Administrator of the National Oceanic and Atmospheric Administration; and

(iv) from the Department of Health and Human Services—

(I) the Deputy Assistant Secretary for Minority Health;

(II) the Administrator of the Centers for Medicare & Medicaid Services;

(III) the Administrator of the Health Resources and Services Administration;

(IV) the Director of the National Institutes of Health; and

(V) the Director of the Centers for Disease Control and Prevention.

(C) PRIORITY.—In selecting a covered entity to be awarded a grant under the Program, the Secretary shall give priority to covered entities that serve a county—

(i) designated, or located in an area designated, as a nonattainment area pursuant to section 107 of the Clean Air Act (42 U.S.C. 7407) for any air pollutant for which air quality criteria have been issued under section 108(a) of such Act (42 U.S.C. 7408(a));

(ii) with a level of vulnerability of moderate-to-high or higher, according to the Social Vulnerability Index of the Centers for Disease Control and Prevention; or

(iii) with temperatures that pose a risk to human health, as determined by the Secretary, in consultation with the Administrator of the National Oceanic and Atmospheric Administration and the Chair of the United States Global Change Research Program, based on the best available science.

(D) LIMITATION.—A recipient of grant funds under the Program may not use such grant funds to serve a county that is served by any other recipient of a grant under the Program.

(5) USE OF FUNDS.—A covered entity awarded grant funds under the Program may only use such grant funds for the following:

(A) Initiatives to identify risks associated with climate change for vulnerable individuals and to provide services and support to such individuals that address such risks, which may include—

(i) training for health care providers, doulas, and other employees in hospitals, birth centers, midwifery practices, and other health care practices that provide prenatal or labor and delivery services to vulnerable individuals on the identification of, and patient counseling relating to, risks associated with climate change for vulnerable individuals;

(ii) hiring, training, or providing resources to community health workers and perinatal health workers who can help

identify risks associated with climate change for vulnerable individuals, provide patient counseling about such risks, and carry out the distribution of relevant services and support;

(iii) enhancing the monitoring of risks associated with climate change for vulnerable individuals, including by—

(I) collecting data on such risks in specific census tracts, neighborhoods, or other geographic areas; and

(II) sharing such data with local health care providers, doulas, and other employees in hospitals, birth centers, midwifery practices, and other health care practices that provide prenatal or labor and delivery services to local vulnerable individuals; and

(iv) providing vulnerable individuals—

(I) air conditioning units, residential weatherization support, filtration systems, household appliances, or related items;

(II) direct financial assistance; and

(III) services and support, including housing and transportation assistance, to prepare for or recover from extreme weather events, which may include floods, hurricanes, wildfires, droughts, and related events.

(B) Initiatives to mitigate levels of and exposure to risks associated with climate change for vulnerable individuals, which shall be based on the best available science and which may include initiatives to—

(i) develop, maintain, or expand urban or community forestry initiatives and tree canopy coverage initiatives;

(ii) improve infrastructure, including buildings and paved surfaces;

(iii) develop or improve community outreach networks to provide culturally and linguistically appropriate information and notifications about risks associated with climate change for vulnerable individuals; and

(iv) provide enhanced services to racial and ethnic minority groups and other underserved populations.

(6) LENGTH OF AWARD.—A grant under this subsection shall be disbursed over 4 fiscal years.

(7) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to a covered entity awarded a grant under the Program to support the development, implementation, and evaluation of activities funded with such grant.

(8) REPORTS TO SECRETARY.—

(A) ANNUAL REPORT.—For each fiscal year during which a covered entity is disbursed grant funds under the Program, such covered entity shall submit to the Secretary a report that summarizes the activities carried out by such covered entity with such grant funds during such fiscal year, which shall include a description of the following:

(i) The involvement of stakeholder organizations in the implementation of initiatives assisted with such grant funds.

(ii) Relevant health and environmental data, disaggregated, to the extent prac-

ticable, by race, ethnicity, gender, and pregnancy status.

(iii) Qualitative feedback received from vulnerable individuals with respect to initiatives assisted with such grant funds.

(iv) Criteria used in selecting the geographic areas assisted with such grant funds.

(v) Efforts to address racial and ethnic inequities in adverse maternal and infant health outcomes and in exposure to risks associated with climate change for vulnerable individuals.

(vi) Any negative and unintended impacts of initiatives assisted with such grant funds, including—

(I) adverse environmental impacts;

(II) displacement of residents and businesses;

(III) rent and housing price increases; and

(IV) disproportionate adverse impacts on racial and ethnic minority

groups and other underserved populations.

(vii) How the covered entity will address and prevent any impacts described in clause (vi).

(B) PUBLICATION.—Not later than 30 days after the date on which a report is submitted under subparagraph (A), the Secretary shall publish such report on a public website of the Department of Health and Human Services.

(9) REPORT TO CONGRESS.—Not later than the date that is 5 years after the date on which the Program is established, the Secretary shall submit to Congress and publish on a public website of the Department of Health and Human Services a report on the results of the Program, including the following:

(A) Summaries of the annual reports submitted under paragraph (8).

(B) Evaluations of the initiatives assisted with grant funds under the Program.

(C) An assessment of the effectiveness of the Program in—

(i) identifying risks associated with climate change for vulnerable individuals;

(ii) providing services and support to such individuals;

(iii) mitigating levels of and exposure to such risks; and

(iv) addressing racial and ethnic inequities in adverse maternal and infant health outcomes and in exposure to such risks.

(D) A description of how the Program could be expanded, including—

(i) monitoring efforts or data collection that would be required to identify areas with high levels of risks associated with climate change for vulnerable individuals;

(ii) how such areas could be identified using the strategy developed under subsection (d); and

(iii) recommendations for additional funding.

(10) COVERED ENTITY DEFINED.—In this subsection, the term ''covered entity'' means a consortium of organizations serving a county that—

(A) shall include a community-based organization; and

(B) may include—

(i) another stakeholder organization;

(ii) the government of such county;

(iii) the governments of one or more municipalities within such county;

(iv) a State or local public health department or emergency management agency;

(v) a local health care practice, which may include a licensed and accredited hospital, birth center, midwifery practice, or other health care practice that provides prenatal or labor and delivery services to vulnerable individuals;

(vi) an Indian tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304));

(vii) an Urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)); and

(viii) an institution of higher education.

(11) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $100,000,000 for fiscal years 2023 through 2026.

(b) GRANT PROGRAM FOR EDUCATION AND TRAINING AT HEALTH PROFESSION SCHOOLS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a grant program (in this subsection referred to as the ''Program'') to provide funds to health profession schools to support the development and integration of education and training programs for identifying and addressing risks associated with climate change for vulnerable individuals.

(2) GRANT AUTHORITY.—In carrying out the Program, the Secretary may award, on a competitive basis, grants to health profession schools.

(3) APPLICATION.—To be eligible for a grant under the Program, a health profession school shall submit to the Secretary an application at such time, in such form, and containing such information as the Secretary may require, which shall include, at a minimum, a description of the following:

(A) How such health profession school will engage with vulnerable individuals, and stake-

holder organizations representing such individuals, in developing and implementing the education and training programs supported by grant funds awarded under the Program.

(B) How such health profession school will ensure that such education and training programs will address racial and ethnic inequities in exposure to, and the effects of, risks associated with climate change for vulnerable individuals.

(4) USE OF FUNDS.—A health profession school awarded a grant under the Program shall use the grant funds to develop, and integrate into the curriculum and continuing education of such health profession school, education and training on each of the following:

(A) Identifying risks associated with climate change for vulnerable individuals and individuals with the intent to become pregnant.

(B) How risks associated with climate change affect vulnerable individuals and individuals with the intent to become pregnant.

(C) Racial and ethnic inequities in exposure to, and the effects of, risks associated with

climate change for vulnerable individuals and individuals with the intent to become pregnant.

(D) Patient counseling and mitigation strategies relating to risks associated with climate change for vulnerable individuals.

(E) Relevant services and support for vulnerable individuals relating to risks associated with climate change and strategies for ensuring vulnerable individuals have access to such services and support.

(F) Implicit and explicit bias, racism, and discrimination.

(G) Related topics identified by such health profession school based on the engagement of such health profession school with vulnerable individuals and stakeholder organizations representing such individuals.

(5) PARTNERSHIPS.—In carrying out activities with grant funds, a health profession school awarded a grant under the Program may partner with one or more of the following:

(A) A State or local public health department.

(B) A health care professional membership organization.

(C) A stakeholder organization.

(D) A health profession school.

(E) An institution of higher education.

(6) REPORTS TO SECRETARY.—

(A) ANNUAL REPORT.—For each fiscal year during which a health profession school is disbursed grant funds under the Program, such health profession school shall submit to the Secretary a report that describes the activities carried out with such grant funds during such fiscal year.

(B) FINAL REPORT.—Not later than the date that is 1 year after the end of the last fiscal year during which a health profession school is disbursed grant funds under the Program, the health profession school shall submit to the Secretary a final report that summarizes the activities carried out with such grant funds.

(7) REPORT TO CONGRESS.—Not later than the date that is 6 years after the date on which the Program is established, the Secretary shall submit to Congress and publish on a public website of the Department of Health and Human Services a report that includes the following:

(A) A summary of the reports submitted under paragraph (6).

(B) Recommendations to improve education and training programs at health profession schools with respect to identifying and addressing risks associated with climate change for vulnerable individuals.

(8) HEALTH PROFESSION SCHOOL DEFINED.—In this subsection, the term ''health profession school'' means an accredited—

(A) medical school;

(B) school of nursing;

(C) midwifery program;

(D) physician assistant education program;

(E) teaching hospital;

(F) residency or fellowship program; or

(G) other school or program determined appropriate by the Secretary.

(9) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for fiscal years 2023 through 2026.

(c) NIH CONSORTIUM ON BIRTH AND CLIMATE 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'').

(2) DUTIES.—

(A) IN GENERAL.—The Consortium shall coordinate, across the institutes, centers, and offices of the National Institutes of Health, research on the risks associated with climate change for vulnerable individuals.

(B) REQUIRED ACTIVITIES.—In carrying out subparagraph (A), the Consortium shall—

(i) establish research priorities, including 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,

with a particular focus on risks among racial and ethnic minority groups and other underserved populations;

(ii) identify gaps in available data related to such risks;

(iii) identify gaps in, and opportunities for, research collaborations;

(iv) identify funding opportunities for community-based organizations and researchers from racially, ethnically, and geographically diverse backgrounds; and

(v) publish annual reports on the work and findings of the Consortium on a public website of the National Institutes of Health.

(3) MEMBERSHIP.—The Director of NIH shall appoint to the Consortium representatives of such institutes, centers, and offices of the National Institutes of Health as the Director of NIH considers appropriate, including, at a minimum, representatives of—

(A) the National Institute of Environmental Health Sciences;

(B) the National Institute on Minority Health and Health Disparities;

(C) the Eunice Kennedy Shriver National Institute of Child Health and Human Development;

(D) the National Institute of Nursing Research; and

(E) the Office of Research on Women's Health.

(4) CHAIRPERSON.—The Chairperson of the Consortium shall be designated by the Director of NIH and selected from among the representatives appointed under paragraph (3).

(5) CONSULTATION.—In carrying out the duties described in paragraph (2), the Consortium shall consult with—

(A) the heads of relevant Federal agencies, including—

(i) the Environmental Protection Agency;

(ii) the National Oceanic and Atmospheric Administration;

(iii) the Occupational Safety and Health Administration; and

(iv) from the Department of Health and Human Services—

(I) the Office of Minority Health in the Office of the Secretary;

(II) the Centers for Medicare & Medicaid Services;

(III) the Health Resources and Services Administration;

(IV) the Centers for Disease Control and Prevention;

(V) the Indian Health Service; and

(VI) the Administration for Children and Families; and

(B) representatives of—

(i) stakeholder organizations;

(ii) health care providers and professional membership organizations with expertise in maternal health or environmental justice;

(iii) State and local public health departments;

(iv) licensed and accredited hospitals, birth centers, midwifery practices, or other health care practices that provide prenatal

or labor and delivery services to vulnerable individuals; and

(v) institutions of higher education, including such institutions that are minority-serving institutions or have expertise in maternal health or environmental justice.

(d) STRATEGY FOR IDENTIFYING CLIMATE CHANGE RISK ZONES FOR VULNERABLE MOTHERS AND BABIES.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop a strategy (in this subsection referred to as the ''Strategy'') for designating areas that the Secretary determines to have a high risk of adverse maternal and infant health outcomes among vulnerable individuals as a result of risks associated with climate change.

(2) STRATEGY REQUIREMENTS.—

(A) IN GENERAL.—In developing the Strategy, the Secretary shall establish a process to identify areas where vulnerable individuals are exposed to a high risk of adverse maternal and infant health outcomes as a result of risks associated with climate change in conjunction with other factors that can impact such health outcomes, including—

(i) the incidence of diseases associated with air pollution, extreme heat, and other environmental factors;

(ii) the availability and accessibility of maternal and infant health care providers;

(iii) English-language proficiency among people of reproductive age;

(iv) the health insurance status of people of reproductive age;

(v) the number of people of reproductive age who are members of racial or ethnic groups with disproportionately high rates of adverse maternal and infant health outcomes;

(vi) the socioeconomic status of people of reproductive age, including with respect to—

(I) poverty;

(II) unemployment;

(III) household income; and

(IV) educational attainment; and

(vii) access to quality housing, transportation, and nutrition.

(B) RESOURCES.—In developing the Strategy, the Secretary shall identify, and incorporate a description of, the following:

(i) Existing mapping tools or Federal programs that identify—

(I) risks associated with climate change for vulnerable individuals; and

(II) other factors that can influence maternal and infant health outcomes, including the factors described in subparagraph (A).

(ii) Environmental, health, socioeconomic, and demographic data relevant to identifying risks associated with climate change for vulnerable individuals.

(iii) Existing monitoring networks that collect data described in clause (ii), and any gaps in such networks.

(iv) Federal, State, and local stakeholders involved in maintaining monitoring networks identified under clause (iii), and how such stakeholders are coordinating their monitoring efforts.

(v) Additional monitoring networks, and enhancements to existing monitoring

networks, that would be required to address gaps identified under clause (iii), including at the subcounty and census tract level.

(vi) Funding amounts required to establish the monitoring networks identified under clause (v) and recommendations for Federal, State, and local coordination with respect to such networks.

(vii) Potential uses for data collected and generated as a result of the Strategy, including how such data may be used in determining recipients of grants under the program established by subsection (a) or other similar programs.

(viii) Other information the Secretary considers relevant for the development of the Strategy.

(3) COORDINATION AND CONSULTATION.—In developing the Strategy, the Secretary shall—

(A) coordinate with the Administrator of the Environmental Protection Agency and the Administrator of the National Oceanic and Atmospheric Administration; and

(B) consult with—

(i) stakeholder organizations;

(ii) health care providers and professional membership organizations with expertise in maternal health or environmental justice;

(iii) State and local public health departments;

(iv) licensed and accredited hospitals, birth centers, midwifery practices, or other health care providers that provide prenatal or labor and delivery services to vulnerable individuals; and

(v) institutions of higher education, including such institutions that are minority-serving institutions or have expertise in maternal health or environmental justice.

(4) NOTICE AND COMMENT.—At least 240 days before the date on which the Strategy is published in accordance with paragraph (5), the Secretary shall provide—

(A) notice of the Strategy on a public website of the Department of Health and Human Services; and

(B) an opportunity for public comment of at least 90 days.

(5) PUBLICATION.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall publish on a public website of the Department of Health and Human Services—

(A) the Strategy;

(B) the public comments received under paragraph (4); and

(C) the responses of the Secretary to such public comments.

(e) DEFINITIONS.—In this section, the following definitions apply:

(1) ADVERSE MATERNAL AND INFANT HEALTH OUTCOMES.—The term ''adverse maternal and infant health outcomes'' includes the outcomes of preterm birth, low birth weight, stillbirth, infant or maternal mortality, and severe maternal morbidity.

(2) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(3) MINORITY-SERVING INSTITUTION.—The term ''minority-serving institution'' means an entity specified in any of paragraphs (1) through (7) of section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

(4) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

(5) RISKS ASSOCIATED WITH CLIMATE CHANGE.—The term ''risks associated with climate change'' includes risks associated with extreme heat, air pollution, extreme weather events, and other environmental issues associated with climate change that can result in adverse maternal and infant health outcomes.

(6) STAKEHOLDER ORGANIZATION.—The term ''stakeholder organization'' means—

(A) a community-based organization with expertise in providing assistance to vulnerable individuals;

(B) a nonprofit organization with expertise in maternal or infant health or environmental justice; and

(C) a patient advocacy organization representing vulnerable individuals.

(7) VULNERABLE INDIVIDUAL.—The term ''vulnerable individual'' means—

(A) an individual who is pregnant;

(B) an individual who was pregnant during any portion of the preceding 1-year period; and

(C) an individual under 3 years of age.

SEC. 5206. TECH TO SAVE MOMS.

(a) DEFINITIONS.—In this section:

(1) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(2) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(3) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(4) SOCIAL DETERMINANTS OF MATERNAL HEALTH.—The term ''social determinants of maternal health'' means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include poverty, employment, food security, support for and access to lactation and other infant feeding options, housing stability, and related factors;

(B) neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

(D) household factors, which may include ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors;

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) health care access factors, including health insurance coverage, access to culturally congruent health care services, providers, and non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

(b) INTEGRATED TELEHEALTH MODELS IN MATERNITY CARE SERVICES.—

(1) IN GENERAL.—Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following:

''(xxviii) Focusing on title XIX, providing for the adoption of and use of telehealth tools that allow for screening, monitoring, and management of common health complications with respect to an individual receiving medical assistance during such individual's pregnancy and for not more than a 1-year period beginning on the last day of the pregnancy.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 1 year after the date of the enactment of this section.

(c) GRANTS TO EXPAND THE USE OF TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY MODELS FOR PREGNANT AND POSTPARTUM INDIVIDUALS.—Title III of the Public Health Service Act is amended by inserting after section 330N (42 U.S.C. 254c–20) the following new section:

"SEC. 330N–1. EXPANDING CAPACITY FOR MATERNAL HEALTH OUTCOMES.

''(a) ESTABLISHMENT.—Beginning not later than 1 year after the date of enactment of this section, the Secretary shall award grants to eligible entities to evaluate, develop, and expand the use of technology-enabled collaborative learning and capacity building models and improve maternal health outcomes—

''(1) in health professional shortage areas;

''(2) in areas with high rates of maternal mortality and severe maternal morbidity;

''(3) in areas with significant racial and ethnic inequities in maternal health outcomes; and

''(4) for medically underserved populations and American Indians and Alaska Natives, including Indian Tribes, Tribal organizations, and Urban Indian organizations.

''(b) USE OF FUNDS.—

''(1) REQUIRED USES.—Recipients of grants under this section shall use the grants to—

''(A) train maternal health care providers, students, and other similar professionals through models that include—

''(i) methods to increase safety and health care quality;

''(ii) training to increase awareness of, and eliminate implicit bias, racism, and discrimination in, the provision of health care;

''(iii) best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders;

''(iv) training on best practices in maternity care for pregnant and postpartum individuals during the COVID–19 public health emergency or future public health emergencies;

''(v) methods to screen for social determinants of maternal health risks in the prenatal and postpartum periods; and

''(vi) the use of remote patient monitoring tools for pregnancy-related com-

plications described in section 1115A(b)(2)(B)(xxviii) of the Social Security Act;

''(B) evaluate and collect information on the effect of such models on—

''(i) access to, and quality of, care;

''(ii) outcomes with respect to the health of an individual; and

''(iii) the experience of individuals who receive pregnancy-related health care;

''(C) develop qualitative and quantitative measures to identify best practices for the expansion and use of such models;

''(D) study the effect of such models on patient outcomes and maternity care providers; and

''(E) conduct any other activity, as determined by the Secretary.

''(2) PERMISSIBLE USES.—Recipients of grants under this section may use grants to support—

''(A) the use and expansion of technology-enabled collaborative learning and capacity building models, including hardware and software that—

''(i) enable distance learning and technical support; and

''(ii) support the secure exchange of electronic health information; and

''(B) maternity care providers, students, and other similar professionals in the provision of maternity care through such models.

''(c) APPLICATION.—

''(1) IN GENERAL.—An eligible entity seeking a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(2) ASSURANCE.—An application under paragraph (1) shall include an assurance that such entity shall collect information on, and assess the effect of, the use of technology-enabled collaborative learning and capacity building models, including with respect to—

''(A) maternal health outcomes;

''(B) access to maternal health care services;

''(C) quality of maternal health care; and

"(D) retention of maternity care providers serving areas and populations described in subsection (a).

"(d) LIMITATIONS.—

"(1) NUMBER.—The Secretary may not award more than 1 grant under this section to an eligible entity.

"(2) DURATION.—A grant awarded under this section shall be for a 5-year period.

"(e) ACCESS TO BROADBAND.—In administering grants under this section, the Secretary may coordinate with other agencies to ensure that funding opportunities are available to support access to reliable, high-speed internet for grantees.

"(f) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly or by contract) technical assistance to eligible entities, including recipients of grants under subsection (a), on the development, use, and sustainability of technology-enabled collaborative learning and capacity building models to expand access to maternal health care services provided by such entities, including—

"(1) in health professional shortage areas;

"(2) in areas with high rates of maternal mortality and severe maternal morbidity or significant

racial and ethnic inequities in maternal health outcomes; and

''(3) for medically underserved populations or American Indians and Alaska Natives.

''(g) RESEARCH AND EVALUATION.—The Secretary, in consultation with experts, shall develop a strategic plan to research and evaluate the evidence for such models.

''(h) REPORTING.—

''(1) ELIGIBLE ENTITIES.—An eligible entity that receives a grant under subsection (a) shall submit to the Secretary a report, at such time, in such manner, and containing such information as the Secretary may require.

''(2) SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall submit to the Congress, and make available on the website of the Department of Health and Human Services, a report that includes—

''(A) a description of grants awarded under subsection (a) and the purpose and amounts of such grants;

''(B) a summary of—

''(i) the evaluations conducted under subsection (b)(1)(B);

''(ii) any technical assistance provided under subsection (f); and

''(iii) the activities conducted under subsection (a); and

''(C) a description of any significant findings with respect to—

''(i) patient outcomes; and

''(ii) best practices for expanding, using, or evaluating technology-enabled collaborative learning and capacity building models.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $6,000,000 for each of fiscal years 2023 through 2027.

''(j) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—

''(A) IN GENERAL.—The term 'eligible entity' means an entity that provides, or supports the provision of, maternal health care services or other evidence-based services for pregnant and postpartum individuals—

''(i) in health professional shortage areas;

''(ii) in areas with high rates of adverse maternal health outcomes or signifi-

cant racial and ethnic inequities in maternal health outcomes; or

"(iii) who are—

"(I) members of medically underserved populations; or

"(II) American Indians and Alaska Natives, including Indian Tribes, Tribal organizations, and Urban Indian organizations.

"(B) INCLUSIONS.—An eligible entity may include entities that lead, or are capable of leading, a technology-enabled collaborative learning and capacity building model.

"(2) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means a health professional shortage area designated under section 332.

"(3) INDIAN TRIBE.—The term 'Indian Tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act.

"(4) MATERNAL MORTALITY.—The term 'maternal mortality' means a death occurring during or within the 1-year period after pregnancy caused by pregnancy-related or childbirth complications, in-

cluding a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy or childbirth complications.

''(5) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given such term in section 330(b)(3).

''(6) POSTPARTUM.—The term 'postpartum' means the 1-year period beginning on the last date of an individual's pregnancy.

''(7) SEVERE MATERNAL MORBIDITY.—The term 'severe maternal morbidity' means a health condition, including a mental health or substance use disorder, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

''(8) TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODEL.—The term 'technology-enabled collaborative learning and capacity building model' means a distance health education model that connects health care professionals, and other specialists, through simultaneous interactive videoconferencing for the purpose of fa-

cilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

''(9) TRIBAL ORGANIZATION.—The term 'Tribal organization' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act.

''(10) URBAN INDIAN ORGANIZATION.—The term 'Urban Indian organization' has the meaning given such term in section 4 of the Indian Health Care Improvement Act.''.

(d) GRANTS TO PROMOTE EQUITY IN MATERNAL HEALTH OUTCOMES THROUGH DIGITAL TOOLS.—

(1) IN GENERAL.—Beginning not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall make grants to eligible entities to reduce racial and ethnic inequities in maternal health outcomes by increasing access to digital tools related to maternal health care.

(2) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) PRIORITIZATION.—In awarding grants under this subsection, the Secretary shall prioritize an eligible entity—

(A) in an area with high rates of adverse maternal health outcomes or significant racial and ethnic inequities in maternal health outcomes;

(B) in a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e); and

(C) that promotes technology that addresses racial and ethnic inequities in maternal health outcomes.

(4) LIMITATIONS.—

(A) NUMBER.—The Secretary may award not more than 1 grant under this subsection to an eligible entity.

(B) DURATION.—A grant awarded under this subsection shall be for a 5-year period.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to an eligible entity on the development, use, evaluation, and post-grant sustainability of digital tools for purposes of promoting equity in maternal health outcomes.

(6) REPORTING.—

(A) ELIGIBLE ENTITIES.—An eligible entity that receives a grant under paragraph (1) shall submit to the Secretary a report, at such time, in such manner, and containing such information as the Secretary may require.

(B) SECRETARY.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report that includes—

(i) an evaluation on the effectiveness of grants awarded under this subsection to improve health outcomes for pregnant and postpartum individuals from racial and ethnic minority groups;

(ii) recommendations on new grant programs that promote the use of technology to improve such maternal health outcomes; and

(iii) recommendations with respect to—

(I) technology-based privacy and security safeguards in maternal health care;

(II) reimbursement rates for maternal telehealth services;

(III) the use of digital tools to analyze large data sets to identify potential pregnancy-related complications;

(IV) barriers that prevent maternity care providers from providing telehealth services across States;

(V) the use of consumer digital tools such as mobile phone applications, patient portals, and wearable technologies to improve maternal health outcomes;

(VI) barriers that prevent access to telehealth services, including a lack of access to reliable, high-speed internet or electronic devices;

(VII) barriers to data sharing between the Special Supplemental Nutrition Program for Women, Infants, and Children program and maternity care providers, and recommendations for addressing such barriers; and

(VIII) lessons learned from expanded access to telehealth related to

maternity care during the COVID–19 public health emergency.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $6,000,000 for each of fiscal years 2023 through 2027.

(e) REPORT ON THE USE OF TECHNOLOGY IN MATERNITY CARE.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (referred to in this section as the ''National Academies'') under which the National Academies shall conduct a study on the use of technology and patient monitoring devices in maternity care.

(2) CONTENT.—The agreement entered into pursuant to paragraph (1) shall provide for the study of the following:

(A) The use of innovative technology (including artificial intelligence) in maternal health care, including the extent to which such technology has affected racial or ethnic biases in maternal health care.

(B) The use of patient monitoring devices (including pulse oximeter devices) in maternal health care, including the extent to which such devices have affected racial or ethnic biases in maternal health care.

(C) Best practices for reducing and preventing racial or ethnic biases in the use of innovative technology and patient monitoring devices in maternity care.

(D) Best practices in the use of innovative technology and patient monitoring devices for pregnant and postpartum individuals from racial and ethnic minority groups.

(E) Best practices with respect to privacy and security safeguards in such use.

(3) REPORT.—Not later than 24 months after the date of enactment of this Act, the National Academies shall complete the study under this subsection, and transmit a report the results of such study to Congress.

SEC. 5207. SOCIAL DETERMINANTS FOR MOMS.

(a) TASK FORCE TO DEVELOP A STRATEGY TO ADDRESS SOCIAL DETERMINANTS OF MATERNAL HEALTH.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall convene a task force (in this subsection referred to as the ''Task Force'') to develop a strategy to coordinate efforts between Federal agencies to address social determinants of maternal health with respect to pregnant and postpartum individuals.

(2) EX OFFICIO MEMBERS.—The ex officio members of the Task Force shall consist of the following:

(A) The Secretary of Health and Human Services (or a designee thereof).

(B) The Secretary of Housing and Urban Development (or a designee thereof).

(C) The Secretary of Transportation (or a designee thereof).

(D) The Secretary of Agriculture (or a designee thereof).

(E) The Secretary of Labor (or a designee thereof).

(F) The Administrator of the Environmental Protection Agency (or a designee thereof).

(G) The Assistant Secretary for the Administration for Children and Families (or a designee thereof).

(H) The Administrator of the Centers for Medicare & Medicaid Services (or a designee thereof).

(I) The Director of the Indian Health Service (or a designee thereof).

(J) The Director of the National Institutes of Health (or a designee thereof).

(K) The Administrator of the Health Resources and Services Administration (or a designee thereof).

(L) The Deputy Assistant Secretary for Minority Health of the Department of Health and Human Services (or a designee thereof).

(M) The Deputy Assistant Secretary for Women's Health of the Department of Health and Human Services (or a designee thereof).

(N) The Director of the Centers for Disease Control and Prevention (or a designee thereof).

(O) The Director of the Office on Violence Against Women of the Department of Justice (or a designee thereof).

(3) APPOINTED MEMBERS.—In addition to the ex officio members of the Task Force, the Secretary of Health and Human Services shall appoint the following members of the Task Force:

(A) At least two representatives of patients, to include—

(i) a representative of patients who have suffered from severe maternal morbidity; or

(ii) a representative of patients who is a family member of an individual who suffered a pregnancy-related death.

(B) At least two leaders of community-based organizations that address maternal mortality and severe maternal morbidity with a specific focus on racial and ethnic inequities. In appointing such leaders under this subparagraph, the Secretary of Health and Human Services shall give priority to individuals who are leaders of organizations led by individuals from racial and ethnic minority groups.

(C) At least two perinatal health workers.

(D) A professionally diverse panel of maternity 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 paragraph (1);

(B) recommendations on funding amounts 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.

(b) HOUSING FOR MOMS GRANT PROGRAM.—

(1) DEFINITIONS.—In this subsection:

(A) ELIGIBLE ENTITY.—The term ''eligible entity'' means—

(i) a community-based organization;

(ii) a State or local governmental entity, including a State or local public health department;

(iii) an Indian tribe or Tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)); or

(iv) an Urban Indian organization (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Housing and Urban Development.

(2) ESTABLISHMENT.—The Secretary shall establish a Housing for Moms grant program to make grants to eligible entities to increase access to safe, stable, affordable, and adequate housing for pregnant and postpartum individuals and their families.

(3) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may provide.

(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to an eligible entity that—

(A) is a community-based organization or will partner with a community-based organization to implement initiatives to increase access to safe, stable, affordable, and adequate housing for pregnant and postpartum individuals and their families;

(B) is operating in an area with high rates of adverse maternal health outcomes or significant racial or ethnic inequities in maternal health outcomes, to the extent such data are available; and

(C) is operating in an area with a high poverty rate or a significant number of individuals who lack consistent access to safe, stable, affordable, and adequate housing.

(5) USE OF FUNDS.—An eligible entity that receives a grant under this subsection shall use funds from the grant for the purposes of—

(A) identifying and conducting outreach to pregnant and postpartum individuals who are low-income and lack consistent access to safe, stable, affordable, and adequate housing;

(B) providing safe, stable, affordable, and adequate housing options to such individuals;

(C) connecting such individuals with local organizations offering safe, stable, affordable, and adequate housing options;

(D) providing application assistance to such individuals seeking to enroll in programs offering safe, stable, affordable, and adequate housing options;

(E) providing direct financial assistance to such individuals for the purposes of maintaining safe, stable, and adequate housing for the duration of the individual's pregnancy and postpartum periods; and

(F) working with relevant stakeholders to ensure that local housing and homeless shelter infrastructure is supportive to pregnant and postpartum individuals, including through—

(i) health-promoting housing codes;

(ii) enforcement of housing codes;

(iii) proactive rental inspection programs;

(iv) code enforcement officer training; and

(v) partnerships between regional offices of the Department of Housing and Urban Development and community-based organizations to ensure housing laws are understood and violations are discovered.

(6) REPORTING.—

(A) ELIGIBLE ENTITIES.—The Secretary shall require each eligible entity receiving a grant under this subsection to annually submit to the Secretary and make publicly available a report on the status of activities conducted using the grant.

(B) SECRETARY.—Not later than the end of each fiscal year in which grants are made under this subsection, the Secretary shall submit to Congress and make publicly available a report that—

(i) summarizes the reports received under subparagraph (A);

(ii) evaluates the effectiveness of grants awarded under this subsection in increasing access to safe, stable, affordable, and adequate housing for pregnant and postpartum individuals and their families; and

(iii) makes recommendations with respect to ensuring activities described paragraph (5) continue after grant amounts made available under this subsection are expended.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $10,000,000 for fiscal year 2023, which shall remain available until expended.

(c) DEPARTMENT OF TRANSPORTATION.—

(1) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Transportation shall submit to Congress and make publicly available a report containing—

(A) an assessment of transportation barriers preventing individuals from attending prenatal and postpartum appointments, accessing maternal health care services, or accessing services and resources related to social determinants of maternal health;

(B) recommendations on how to overcome the barriers assessed under subparagraph (A); and

(C) an assessment of transportation safety risks for pregnant individuals and recommendations on how to mitigate those risks.

(2) CONSIDERATIONS.—In carrying out paragraph (1), the Secretary of Transportation shall give special consideration to solutions for—

(A) pregnant and postpartum individuals living in a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e);

(B) pregnant and postpartum individuals living in areas with high maternal mortality or severe morbidity rates or significant racial or ethnic inequities in maternal health outcomes; and

(C) pregnant and postpartum individuals with a disability that impacts mobility.

(d) DEPARTMENT OF AGRICULTURE.—

(1) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN.—

(A) EXTENSION OF POSTPARTUM PERIOD.—Section 17(b)(10) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(10)) is amended by striking ''six'' and inserting ''24''.

(B) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report that evaluates the effect of the amendment made by subparagraph (A) on—

(i) maternal and infant health outcomes, including racial and ethnic inequities with respect to those outcomes;

(ii) breastfeeding rates among postpartum individuals;

(iii) qualitative evaluations of family experiences under the special supplemental nutrition program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

(iv) other relevant information as determined by the Secretary.

(2) GRANT PROGRAM FOR HEALTHY FOOD AND CLEAN WATER FOR PREGNANT AND POSTPARTUM INDIVIDUALS.—

(A) IN GENERAL.—The Secretary shall establish a program (referred to in this paragraph as the ''program'') to award grants, on a com-

petitive basis, to eligible entities to carry out the activities described in subparagraph (D).

(B) APPLICATION.—To be eligible for a grant under the program, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary determines appropriate.

(C) PRIORITY.—In awarding grants under the program, the Secretary shall give priority to an eligible entity that—

(i) is, or will partner with, an eligible entity described in paragraph (3)(A)(i); and

(ii) is operating in an area with a high rate of—

(I) adverse maternal health outcomes; or

(II) significant racial or ethnic inequities in maternal health outcomes.

(D) USE OF FUNDS.—An eligible entity shall use a grant awarded under the program to deliver healthy food, infant formula, clean water, or diapers to pregnant and postpartum

individuals located in areas that are food deserts, as determined by the Secretary using data from the Food Access Research Atlas of the Department of Agriculture.

(E) REPORTS.—

(i) ELIGIBLE ENTITIES.—Not later than 1 year after the date on which an eligible entity receives a grant under the program, and annually thereafter, the eligible entity shall submit to the Secretary a report on the status of activities conducted using the grant, which shall contain such information as the Secretary may require.

(ii) SECRETARY.—

(I) IN GENERAL.—Not later than 2 years after the date on which the first grant is awarded under the program, the Secretary shall submit to Congress a report that includes—

(aa) a summary of the reports submitted by eligible entities under clause (i);

(bb) an assessment of the extent to which food distributed using grants awarded under the

program was purchased from local and regional food systems;

(cc) an evaluation of the effect of the program on maternal and infant health outcomes, including racial and ethnic inequities with respect to those outcomes; and

(dd) recommendations with respect to ensuring the activities described in subparagraph (D) continue after the grant period funding those activities expires.

(II) PUBLICATION.—The Secretary shall make the report submitted under subclause (I) publicly available on the website of the Department of Agriculture.

(F) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the program $5,000,000 for the period of fiscal years 2022 through 2024.

(3) DEFINITIONS.—In this subsection:

(A) ELIGIBLE ENTITY.—The term ''eligible entity'' means—

(i) a community based organization;

(ii) a State or local governmental entity, including a State or local public health department;

(iii) an Indian Tribe or Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)); and

(iv) an Urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Agriculture.

(e) ENVIRONMENTAL STUDY THROUGH NATIONAL ACADEMIES.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Administrator of the Environmental Protection Agency shall seek to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (referred to in this subsection as the ''National Academies'') under which the National Academies agree to conduct a study on the impacts of, with respect to maternal and infant health incomes, water and

air quality, exposure to extreme temperatures, environmental chemicals, environmental risks in the workplace and the home, and pollution levels.

(2) STUDY REQUIREMENTS.—The agreement under paragraph (1) shall direct the National Academies to make recommendations for—

(A) improving environmental conditions to improve maternal and infant health outcomes; and

(B) reducing or eliminating racial and ethnic inequities in those outcomes.

(3) REPORT.—The agreement under paragraph (1) shall direct the National Academies to complete the study under this subsection, and submit to Congress and make publicly available a report on the results of the study, not later than 1 year after the date of enactment of this Act.

(f) CHILD CARE ACCESS.—

(1) GRANT PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall award grants to eligible organizations to carry out programs to provide pregnant and postpartum individuals with free and accessible drop-in child care services during prenatal and postpartum appointments.

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) ELIGIBLE ORGANIZATIONS.—

(A) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an organization shall be an organization that—

(i) provides child care services; and

(ii) can carry out a program providing pregnant and postpartum individuals with free and accessible drop-in child care services during prenatal and postpartum appointments.

(B) PRIORITIZATION.—In selecting grant recipients under this subsection, the Secretary shall give priority to eligible organizations that operate in an area that has, to the extent data with respect to such an area are available—

(i) high rates of adverse maternal health outcomes; or

(ii) significant racial or ethnic inequities in maternal health outcomes.

(4) TIMING.—The Secretary shall commence the grant program under paragraph (1) not later than 1 year after the date of enactment of this Act.

(5) REPORTING.—

(A) GRANTEES.—Each recipient of a grant under this subsection shall annually submit to the Secretary and make publicly available a report on the status of activities conducted using the grant. Each such report shall include—

(i) an analysis of the effect of the funded program on prenatal and postpartum appointment attendance rates;

(ii) summaries of qualitative assessments of the funded program from—

(I) pregnant and postpartum individuals participating in the program; and

(II) the families of such individuals; and

(iii) such additional information as the Secretary may require.

(B) SECRETARY.—Not later than the end of fiscal year 2024, the Secretary shall submit to the Congress, and make publicly available, a report containing each of the following:

(i) A summary of the reports received under subparagraph (A).

(ii) An assessment of the effects, if any, of the funded programs on maternal health outcomes, with a specific focus on racial and ethnic inequities in such outcomes.

(iii) A description of actions the Secretary can take to ensure that pregnant and postpartum individuals eligible for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1936 et seq.) have access to free and accessible drop-in child care services during prenatal and postpartum appointments, including identification of the funding necessary to carry out such actions.

(6) DROP-IN CHILD CARE SERVICES DEFINED.—In this subsection, the term ''drop-in child care services'' means child care (including early childhood education) services that are—

(A) delivered at a facility that meets the requirements of all applicable laws and regulations of the State or local government in which

it is located, including the requirements for licensing of the facility as a child care facility; and

(B) provided in single encounters without requiring full-time enrollment of a person in a child care program.

(7) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $5,000,000 for the period of fiscal years 2023 through 2025.

(g) GRANTS TO LOCAL ENTITIES ADDRESSING SOCIAL DETERMINANTS OF MATERNAL HEALTH.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall award grants to eligible entities to—

(A) address social determinants of maternal health for pregnant and postpartum individuals; and

(B) eliminate racial and ethnic inequities in maternal health outcomes.

(2) APPLICATION.—To be eligible to receive a grant under this subsection an eligible entity shall submit to the Secretary an application at such time,

in such manner, and containing such information as the Secretary may provide.

(3) PRIORITIZATION.—In awarding grants under paragraph (1), the Secretary shall give priority to an eligible entity that—

(A) is a community-based organization, or will partner with a community-based organization to carry out the activities under paragraph (4);

(B) is operating in an area with high rates of adverse maternal health outcomes or significant racial or ethnic inequities in maternal health outcomes; and

(C) is operating in an area with a high poverty rate.

(4) ACTIVITIES.—An eligible entity that receives a grant under this subsection may use funds received through the grant to—

(A) hire and retain staff;

(B) develop and distribute a list of available resources with respect to social service programs in a community;

(C) establish a resource center that provides multiple social service programs in a single location;

(D) offer programs and resources in the communities in which the respective eligible entities are located to address social determinants of health for pregnant and postpartum individuals; and

(E) consult with such pregnant and postpartum individuals to conduct an assessment of the activities under this paragraph.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide to grant recipients under this subsection technical assistance to plan for sustaining programs to address social determinants of maternal health among pregnant and postpartum individuals after the period of the grant.

(6) REPORTING.—

(A) GRANTEES.—Not later than 1 year after the date on which an eligible entity first receives a grant under this subsection, and annually thereafter, an eligible entity shall submit to the Secretary, and make publicly available, a report on the status of activities conducted using the grant. Each such report shall include data on the effects of such activities, disaggregated by race, ethnicity, gender, and other relevant factors.

(B) SECRETARY.—Not later than the end of fiscal year 2026, the Secretary shall submit to Congress a report that includes—

(i) a summary of the reports received under subparagraph (A); and

(ii) recommendations for—

(I) improving maternal health outcomes; and

(II) reducing or eliminating racial and ethnic inequities in maternal health outcomes.

(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $15,000,000 for each of fiscal years 2023 through 2027.

(h) DEFINITIONS.—In this section:

(1) CULTURALLY CONGRUENT.—The term ''culturally congruent'', with respect to care or maternity care provided to a health care consumer, means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other relevant stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

(B) has a focus on maternal or perinatal health.

(3) MATERNAL MORTALITY.—The term ''maternal mortality'' means a death occurring during or within a one-year period after pregnancy, caused by pregnancy-related or childbirth complications, including a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications.

(4) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or

dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(6) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(7) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(8) SOCIAL DETERMINANTS OF MATERNAL HEALTH DEFINED.—The term ''social determinants of maternal health'' means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include poverty, employment, food security, support for

and access to lactation and other infant feeding options, housing stability, and related factors;

(B) neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

(D) household factors, which may include ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors;

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) health care access factors, including health insurance coverage, access to culturally congruent health care services, providers, and

non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

SEC. 5208. DATA TO SAVE MOMS.

(a) SHORT TITLE.—This section may be cited as the ''Data to Save Moms Act''.

(b) FUNDING FOR MATERNAL MORTALITY REVIEW COMMITTEES TO PROMOTE REPRESENTATIVE COMMUNITY ENGAGEMENT.—

(1) IN GENERAL.—Section 317K(d) of the Public Health Service Act (42 U.S.C. 247b–12(d)) is amended by adding at the end the following:

''(9) GRANTS TO PROMOTE REPRESENTATIVE COMMUNITY ENGAGEMENT IN MATERNAL MORTALITY REVIEW COMMITTEES.—

''(A) IN GENERAL.—The Secretary may, using funds made available pursuant to subparagraph (C), provide assistance to an applicable maternal mortality review committee of a State, Indian tribe, tribal organization, or Urban Indian organization (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603))—

"(i) to select for inclusion in the membership of such a committee community members from the State, Indian tribe, tribal organization, or Urban Indian organization by—

"(I) prioritizing community members who can increase the diversity of the committee's membership with respect to race and ethnicity, location, and professional background, including members with non-clinical experiences; and

"(II) to the extent applicable, using funds reserved under subsection (f), to address barriers to maternal mortality review committee participation for community members, including through providing required training, reducing transportation barriers, providing compensation, and providing other supports as may be necessary;

"(ii) to establish initiatives to conduct outreach and community engagement efforts within communities throughout the State or Indian tribe to seek input from

community members on the work of such maternal mortality review committee, with a particular focus on outreach to people who are members of minority groups; and

"(iii) to release public reports assessing—

"(I) the pregnancy-related death and pregnancy-associated death review processes of the maternal mortality review committee, with a particular focus on the maternal mortality review committee's sensitivity to the unique circumstances of pregnant and postpartum individuals from racial and ethnic minority groups (as such term is defined in section 1707(g)(1)) who have suffered pregnancy-related deaths; and

"(II) the impact of the use of funds made available pursuant to paragraph (C) on increasing the diversity of the maternal mortality review committee membership and promoting community engagement efforts throughout the State or Indian tribe.

"(B) TECHNICAL ASSISTANCE.—The Secretary shall provide (either directly through the Department of Health and Human Services or by contract) technical assistance to any maternal mortality review committee receiving a grant under this paragraph on best practices for increasing the diversity of the maternal mortality review committee's membership and for conducting effective community engagement throughout the State or Indian tribe.

"(C) AUTHORIZATION OF APPROPRIATIONS.—In addition to any funds made available under subsection (f), there are authorized to be appropriated to carry out this paragraph $10,000,000 for each of fiscal years 2023 through 2027.".

(2) RESERVATION OF FUNDS.—Section 317K(f) of the Public Health Service Act (42 U.S.C. 247b–12(f)) is amended by adding at the end the following: "Of the amount made available under the preceding sentence for a fiscal year, not less than $1,500,000 shall be reserved for grants awarded under subsection (d)(9) to Indian tribes, tribal organizations, or Urban Indian organizations (as those

terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).''.

(c) DATA COLLECTION AND REVIEW.—Section 317K(d)(3)(A)(i) of the Public Health Service Act (42 U.S.C. 247b–12(d)(3)(A)(i)) is amended—

(1) by redesignating subclauses (II) and (III) as subclauses (V) and (VI), respectively; and

(2) by inserting after subclause (I) the following:

''(II) to the extent practicable, reviewing cases of severe maternal morbidity, according to the most up-to-date indicators;

''(III) to the extent practicable, reviewing deaths during pregnancy or up to 1 year after the end of a pregnancy from suicide, overdose, or other death from a mental health condition or substance use disorder attributed to, or aggravated by, pregnancy or childbirth complications;

''(IV) to the extent practicable, consulting with local community-based organizations representing pregnant and postpartum individuals from de-

mographic groups disproportionately impacted by poor maternal health outcomes to ensure that, in addition to clinical factors, non-clinical factors that might have contributed to a pregnancy-related death are appropriately considered;''.

(d) REVIEW OF MATERNAL HEALTH DATA COLLECTION PROCESSES AND QUALITY MEASURES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator for the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall consult with relevant stakeholders—

(A) to review existing maternal health data collection processes and quality measures; and

(B) to make recommendations to improve such processes and measures, including topics described under paragraph (3).

(2) COLLABORATION.—In carrying out this subsection, the Secretary shall consult with a diverse group of maternal health stakeholders, which may include—

(A) pregnant and postpartum individuals and their family members, and nonprofit organizations representing such individuals, with a particular focus on patients from racial and ethnic minority groups;

(B) community-based organizations that provide support for pregnant and postpartum individuals, with a particular focus on patients from racial and ethnic minority groups;

(C) membership organizations for maternity care providers;

(D) organizations representing perinatal health workers;

(E) organizations that focus on maternal mental or behavioral health;

(F) organizations that focus on intimate partner violence;

(G) institutions of higher education, with a particular focus on minority-serving institutions;

(H) licensed and accredited hospitals, birth centers, midwifery practices, or other medical practices that provide maternal health care services to pregnant and postpartum patients;

(I) relevant State and local public agencies, including State maternal mortality review committees; and

(J) the National Quality Forum, or such other standard-setting organizations specified by the Secretary.

(3) TOPICS.—The review of maternal health data collection processes and recommendations to improve such processes and measures required under paragraph (1) shall assess all available relevant information, including information from State-level sources, and shall consider at least the following:

(A) Current State and Tribal practices for maternal health, maternal mortality, and severe maternal morbidity data collection and dissemination, including consideration of—

(i) the timeliness of processes for amending a death certificate when new information pertaining to the death becomes available to reflect whether the death was a pregnancy-related death;

(ii) relevant data collected with electronic health records, including data on race, ethnicity, socioeconomic status, insur-

ance type, and other relevant demographic information;

(iii) maternal health data collected and publicly reported by hospitals, health systems, midwifery practices, and birth centers;

(iv) the barriers preventing States from correlating maternal outcome data with race and ethnicity data;

(v) processes for determining the cause of a pregnancy-associated death in States that do not have a maternal mortality review committee;

(vi) whether maternal mortality review committees include multidisciplinary and diverse membership (as described in section 317K(d)(1)(A) of the Public Health Service Act (42 U.S.C. 247b–12(d)(1)(A)));

(vii) whether members of maternal mortality review committees participate in trainings on bias, racism, or discrimination, and the quality of such trainings;

(viii) the extent to which States have implemented systematic processes of listen-

ing to the stories of pregnant and postpartum individuals and their family members, with a particular focus on pregnant and postpartum individuals from racial and ethnic minority groups and their family members, to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective States;

(ix) the extent to which maternal mortality review committees are considering social determinants of maternal health when examining the causes of pregnancy-associated and pregnancy-related deaths;

(x) the extent to which maternal mortality review committees are making actionable recommendations based on their reviews of adverse maternal health outcomes and the extent to which such recommendations are being implemented by appropriate stakeholders;

(xi) the legal and administrative barriers preventing the collection, collation,

and dissemination of State maternity care data;

(xii) the effectiveness of data collection and reporting processes in separating pregnancy-associated deaths from pregnancy-related deaths; and

(xiii) the current Federal, State, local, and Tribal funding support for the activities referred to in clauses (i) through (xii).

(B) Whether the funding support referred to in subparagraph (A)(xiii) is adequate for States to carry out optimal data collection and dissemination processes with respect to maternal health, maternal mortality, and severe maternal morbidity.

(C) Current quality measures for maternity care, including prenatal measures, labor and delivery measures, and postpartum measures, including topics such as—

(i) effective quality measures for maternity care used by hospitals, health systems, midwifery practices, birth centers, health plans, and other relevant entities;

(ii) the sufficiency of current outcome measures used to evaluate maternity care

for driving improved care, experiences, and outcomes in maternity care payment and delivery system models;

(iii) maternal health quality measures that other countries effectively use;

(iv) validated measures that have been used for research purposes that could be tested, refined, and submitted for national endorsement;

(v) barriers preventing maternity care providers and insurers from implementing quality measures that are aligned with best practices;

(vi) the frequency with which maternity care quality measures are reviewed and revised;

(vii) the strengths and weaknesses of the Prenatal and Postpartum Care measures of the Health Plan Employer Data and Information Set measures established by the National Committee for Quality Assurance;

(viii) the strengths and weaknesses of maternity care quality measures under the Medicaid program under title XIX of the

Social Security Act (42 U.S.C. 1396 et seq.) and the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.), including the extent to which States voluntarily report relevant measures;

(ix) the extent to which maternity care quality measures are informed by patient experiences that include measures of patient-reported experience of care;

(x) the current processes for collecting stratified data on the race and ethnicity of pregnant and postpartum individuals in hospitals, health systems, midwifery practices, and birth centers, and for incorporating such racially and ethnically stratified data in maternity care quality measures;

(xi) the extent to which maternity care quality measures account for the unique experiences of pregnant and postpartum individuals from racial and ethnic minority groups; and

(xii) the extent to which hospitals, health systems, midwifery practices, and

birth centers are implementing existing maternity care quality measures.

(D) Recommendations on authorizing additional funds and providing additional technical assistance to improve maternal mortality review committees and State and Tribal maternal health data collection and reporting processes.

(E) Recommendations for new authorities that may be granted to maternal mortality review committees to be able to—

(i) access records from other Federal and State agencies and departments that may be necessary to identify causes of pregnancy-associated and pregnancy-related deaths that are unique to pregnant and postpartum individuals from specific populations, such as veterans and individuals who are incarcerated; and

(ii) work with relevant experts who are not members of the maternal mortality review committee to assist in the review of pregnancy-associated deaths of pregnant and postpartum individuals from specific populations, such as veterans and individuals who are incarcerated.

(F) Recommendations to improve and standardize current quality measures for maternity care, with a particular focus on racial and ethnic inequities in maternal health outcomes.

(G) Recommendations to improve the coordination by the Department of Health and Human Services of the efforts undertaken by the agencies and organizations within the Department related to maternal health data and quality measures.

(4) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to the Congress, and make publicly available, a report on the results of the review of maternal health data collection processes and quality measures and recommendations to improve such processes and measures required under paragraph (1).

(5) DEFINITIONS.—In this subsection:

(A) MATERNAL MORTALITY REVIEW COMMITTEE.—The term ''maternal mortality review committee'' means a maternal mortality review committee duly authorized by a State and receiving funding under section 317K(a)(2)(D) of

the Public Health Service Act (42 U.S.C. 247b–12(a)(2)(D)).

(B) PREGNANCY-ASSOCIATED DEATH.—The term ''pregnancy-associated'', with respect to a death, means a death of a pregnant or postpartum individual, by any cause, that occurs during, or within 1 year following, the individual's pregnancy, regardless of the outcome, duration, or site of the pregnancy.

(C) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related'', with respect to a death, means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection for each of fiscal years 2023 through 2027.

(e) INDIAN HEALTH SERVICE STUDY ON MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY.—

(1) IN GENERAL.—The Director of the Indian Health Service (referred to in this subsection as the ''Director'') shall, in coordination with entities described in paragraph (2)—

(A) not later than 90 days after the date of enactment of this Act, enter into a contract with an independent research organization or Tribal Epidemiology Center to conduct a comprehensive study on maternal mortality and severe maternal morbidity in the populations of American Indian and Alaska Native individuals; and

(B) not later than 3 years after the date of the enactment of this Act, submit to Congress a report on such study that contains recommendations for policies and practices that can be adopted to improve maternal health outcomes for pregnant and postpartum American Indian and Alaska Native individuals.

(2) PARTICIPATING ENTITIES.—The entities described in this paragraph shall consist of 12 members, selected by the Director from among individuals nominated by Indian Tribes and Tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assist-

ance Act (25 U.S.C. 5304)), and Urban Indian organizations (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)). In selecting such members, the Director shall ensure that each of the 12 service areas of the Indian Health Service is represented.

(3) CONTENTS OF STUDY.—The study conducted pursuant to paragraph (1) shall—

(A) examine the causes of maternal mortality and severe maternal morbidity that are unique to American Indian and Alaska Native individuals;

(B) include a systematic process of listening to the stories of American Indian and Alaska Native pregnant and postpartum individuals to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective communities;

(C) distinguish between the causes of, landscape of maternity care at, and recommendations to improve maternal health outcomes within, the different settings in which American Indian and Alaska Native pregnant

and postpartum individuals receive maternity care, such as—

(i) facilities operated by the Indian Health Service;

(ii) an Indian health program operated by an Indian Tribe or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act; and

(iii) an Urban Indian health program operated by an Urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act;

(D) review processes for coordinating programs of the Indian Health Service with social services provided through other programs administered by the Secretary of Health and Human Services (other than the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.), and the Children's Health Insur-

ance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.));

(E) review current data collection and quality measurement processes and practices;

(F) assess causes and frequency of maternal mental health conditions and substance use disorders;

(G) consider social determinants of health, including poverty, lack of health insurance, unemployment, sexual violence, and environmental conditions in Tribal areas;

(H) consider the role that historical mistreatment of American Indian and Alaska Native people has played in causing currently high rates of maternal mortality and severe maternal morbidity;

(I) consider how current funding of the Indian Health Service affects the ability of the Service to deliver quality maternity care;

(J) consider the extent to which the delivery of maternity care services is culturally appropriate for American Indian and Alaska Native pregnant and postpartum individuals;

(K) make recommendations to reduce misclassification of American Indian and Alaska

Native pregnant and postpartum individuals, including consideration of best practices in training for maternal mortality review committee members to be able to correctly classify American Indian and Alaska Native individuals; and

(L) make recommendations informed by the stories shared by American Indian and Alaska Native pregnant and postpartum individuals pursuant to subparagraph (B) to improve maternal health outcomes for such individuals.

(4) REPORT.—The agreement entered into under paragraph (1) with an independent research organization or Tribal Epidemiology Center shall require that the organization or center transmit to Congress a report on the results of the study conducted pursuant to that agreement not later than 36 months after the date of the enactment of this Act.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $2,000,000 for each of fiscal years 2023 through 2025.

(f) GRANTS TO MINORITY-SERVING INSTITUTIONS TO STUDY MATERNAL MORTALITY, SEVERE MATERNAL

MORBIDITY, AND OTHER ADVERSE MATERNAL HEALTH OUTCOMES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a program under which the Secretary shall award grants to research centers, health professions schools and programs, and other entities at minority-serving institutions to study specific aspects of the maternal health crisis among pregnant and postpartum individuals from racial and ethnic minority groups. Such research may—

(A) include the development and implementation of systematic processes of listening to the stories of pregnant and postpartum individuals from racial and ethnic minority groups, and perinatal health workers supporting such individuals, to fully understand the causes of, and inform potential solutions to, the maternal mortality and severe maternal morbidity crisis within their respective communities;

(B) assess the potential causes of relatively low rates of maternal mortality among Hispanic individuals, including potential racial misclassification and other data collection and reporting issues that might be misrepresenting

maternal mortality rates among Hispanic individuals in the United States; and

(C) assess differences in rates of adverse maternal health outcomes among subgroups identifying as Hispanic.

(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) TECHNICAL ASSISTANCE.—The Secretary may use not more than 10 percent of the funds made available under paragraph (7)—

(A) to conduct outreach to minority-serving institutions to raise awareness of the availability of grants under paragraph (1);

(B) to provide technical assistance in the application process for such a grant; and

(C) to promote capacity building, as needed to enable entities described in such paragraph to submit such an application.

(4) REPORTING REQUIREMENT.—Each entity awarded a grant under this subsection shall periodi-

cally submit to the Secretary a report on the status of activities conducted using the grant.

(5) EVALUATION.—Beginning one year after the date on which the first grant is awarded under this subsection, the Secretary shall submit to Congress an annual report summarizing the findings of research conducted using funds made available under this subsection.

(6) MINORITY-SERVING INSTITUTIONS DEFINED.—In this subsection, the term ''minority-serving institution'' means an eligible institution described in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection $10,000,000 for each of fiscal years 2023 through 2027.

(g) DEFINITIONS.—In this section:

(1) CULTURALLY CONGRUENT.—The term ''culturally congruent'', with respect to care or maternity care, means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

(B) has a focus on maternal or perinatal health.

(3) MATERNAL MORTALITY.—The term ''maternal mortality'' means a death occurring during or within a one-year period after pregnancy, caused by pregnancy-related or childbirth complications, including a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications.

(4) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or

dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(6) PREGNANCY-ASSOCIATED DEATH.—The term ''pregnancy-associated death'' means a death of a pregnant or postpartum individual, by any cause, that occurs during, or within 1 year following, the individual's pregnancy, regardless of the outcome, duration, or site of the pregnancy.

(7) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related death'' means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(8) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(9) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(10) SOCIAL DETERMINANTS OF MATERNAL HEALTH DEFINED.—The term ''social determinants of maternal health'' means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include poverty, employment, food security, support for and access to lactation and other infant feeding options, housing stability, and related factors;

(B) neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimi-

nation or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

(D) household factors, which may include ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors;

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) health care access factors, including health insurance coverage, access to culturally congruent health care services, providers, and non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

SEC. 5209. KIRA JOHNSON ACT.

(a) INVESTMENTS IN COMMUNITY-BASED ORGANIZATIONS TO IMPROVE BLACK MATERNAL HEALTH OUTCOMES.—

(1) AWARDS.—Following the 1-year period described in paragraph (3), the Secretary of Health and Human Services (in this subsection referred to

as the ''Secretary'') shall award grants to eligible entities to establish or expand programs to prevent maternal mortality and severe maternal morbidity among Black pregnant and postpartum individuals.

(2) ELIGIBILITY.—To be eligible to seek a grant under this subsection, an entity shall be a community-based organization offering programs and resources aligned with evidence-based practices for improving maternal health outcomes for Black pregnant and postpartum individuals.

(3) OUTREACH AND TECHNICAL ASSISTANCE PERIOD.—During the 1-year period beginning on the date of enactment of this Act, the Secretary shall—

(A) conduct outreach to encourage eligible entities to apply for grants under this subsection; and

(B) provide technical assistance to eligible entities on best practices for applying for grants under this subsection.

(4) SPECIAL CONSIDERATION.—

(A) OUTREACH.—In conducting outreach under paragraph (3), the Secretary shall give special consideration to eligible entities that—

(i) are based in, and provide support for, communities with high rates of adverse

maternal health outcomes or significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available;

(ii) are led by Black people; and

(iii) offer programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for Black pregnant and postpartum individuals.

(B) AWARDS.—In awarding grants under this subsection, the Secretary shall give special consideration to eligible entities that—

(i) are described in clauses (i), (ii), and (iii) of subparagraph (A);

(ii) offer programs and resources designed in consultation with and intended for Black pregnant and postpartum individuals; and

(iii) offer programs and resources in the communities in which the respective eligible entities are located that—

(I) promote maternal mental health and maternal substance use disorder treatments and supports that

are aligned with evidence-based practices for improving maternal mental and behavioral health outcomes for Black pregnant and postpartum individuals;

(II) address social determinants of maternal health for pregnant and postpartum individuals;

(III) promote evidence-based health literacy and pregnancy, childbirth, and parenting education for pregnant and postpartum individuals;

(IV) provide support from perinatal health workers to pregnant and postpartum individuals;

(V) provide culturally congruent training to perinatal health workers;

(VI) conduct or support research on maternal health issues disproportionately impacting Black pregnant and postpartum individuals;

(VII) provide support to family members of individuals who suffered a pregnancy-associated death or pregnancy-related death;

(VIII) operate midwifery practices that provide culturally congruent maternal health care and support, including for the purposes of—

(aa) supporting additional education, training, and certification programs, including support for distance learning;

(bb) providing financial support to current and future midwives to address education costs, debts, and other needs;

(cc) clinical site investments;

(dd) supporting preceptor development trainings;

(ee) expanding the midwifery practice; or

(ff) related needs identified by the midwifery practice and described in the practice's application; or

(IX) have developed other programs and resources that address community-specific needs for pregnant and postpartum individuals and are

aligned with evidence-based practices for improving maternal health outcomes for Black pregnant and postpartum individuals.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide to grant recipients under this subsection technical assistance on—

(A) capacity building to establish or expand programs to prevent adverse maternal health outcomes among Black pregnant and postpartum individuals;

(B) best practices in data collection, measurement, evaluation, and reporting; and

(C) planning for sustaining programs to prevent maternal mortality and severe maternal morbidity among Black pregnant and postpartum individuals after the period of the grant.

(6) EVALUATION.—Not later than the end of fiscal year 2026, the Secretary shall submit to the Congress an evaluation of the grant program under this subsection that—

(A) assesses the effectiveness of outreach efforts during the application process in diversifying the pool of grant recipients;

(B) makes recommendations for future outreach efforts to diversify the pool of grant recipients for Department of Health and Human Services grant programs and funding opportunities related to maternal health;

(C) assesses the effectiveness of programs funded by grants under this subsection in improving maternal health outcomes for Black pregnant and postpartum individuals, to the extent practicable; and

(D) makes recommendations for future Department of Health and Human Services grant programs and funding opportunities that deliver funding to community-based organizations that provide programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for Black pregnant and postpartum individuals.

(7) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.

(b) INVESTMENTS IN COMMUNITY-BASED ORGANIZATIONS TO IMPROVE MATERNAL HEALTH OUTCOMES IN UNDERSERVED COMMUNITIES.—

(1) AWARDS.—Following the 1-year period described in paragraph (3), the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall award grants to eligible entities to establish or expand programs to prevent maternal mortality and severe maternal morbidity among underserved groups.

(2) ELIGIBILITY.—To be eligible to seek a grant under this subsection, an entity shall be a community-based organization offering programs and resources aligned with evidence-based practices for improving maternal health outcomes for pregnant and postpartum individuals.

(3) OUTREACH AND TECHNICAL ASSISTANCE PERIOD.—During the 1-year period beginning on the date of enactment of this Act, the Secretary shall—

(A) conduct outreach to encourage eligible entities to apply for grants under this subsection; and

(B) provide technical assistance to eligible entities on best practices for applying for grants under this subsection.

(4) SPECIAL CONSIDERATION.—

(A) OUTREACH.—In conducting outreach under paragraph (3), the Secretary shall give special consideration to eligible entities that—

(i) are based in, and provide support for, communities with high rates of adverse maternal health outcomes or significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available;

(ii) are led by individuals from racially, ethnically, and geographically diverse backgrounds; and

(iii) offer programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for pregnant and postpartum individuals.

(B) AWARDS.—In awarding grants under this subsection, the Secretary shall give special consideration to eligible entities that—

(i) are described in clauses (i), (ii), and (iii) of subparagraph (A);

(ii) offer programs and resources designed in consultation with and intended for pregnant and postpartum individuals from underserved groups; and

(iii) offer programs and resources in the communities in which the respective eligible entities are located that—

(I) promote maternal mental health and maternal substance use disorder treatments and support that are aligned with evidence-based practices for improving maternal mental and behavioral health outcomes for pregnant and postpartum individuals;

(II) address social determinants of maternal health for pregnant and postpartum individuals;

(III) promote evidence-based health literacy and pregnancy, childbirth, and parenting education for pregnant and postpartum individuals;

(IV) provide support from perinatal health workers to pregnant and postpartum individuals;

(V) provide culturally congruent training to perinatal health workers;

(VI) conduct or support research on maternal health outcomes and inequities;

(VII) provide support to family members of individuals who suffered a pregnancy-associated death or pregnancy-related death;

(VIII) operate midwifery practices that provide culturally congruent maternal health care and support, including for the purposes of—

(aa) supporting additional education, training, and certification programs, including support for distance learning;

(bb) providing financial support to current and future midwives to address education costs, debts, and other needs;

(cc) clinical site investments;

(dd) supporting preceptor development trainings;

(ee) expanding the midwifery practice; or

(ff) related needs identified by the midwifery practice and described in the practice's application; or

(iv) have developed other programs and resources that address community-specific needs for pregnant and postpartum individuals and are aligned with evidence-based practices for improving maternal health outcomes for pregnant and postpartum individuals.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide to grant recipients under this subsection technical assistance on—

(A) capacity building to establish or expand programs to prevent adverse maternal health outcomes among pregnant and postpartum individuals from underserved groups;

(B) best practices in data collection, measurement, evaluation, and reporting; and

(C) planning for sustaining programs to prevent maternal mortality and severe maternal morbidity among pregnant and postpartum individuals from underserved groups after the period of the grant.

(6) EVALUATION.—Not later than the end of fiscal year 2026, the Secretary shall submit to the

Congress an evaluation of the grant program under this subsection that—

(A) assesses the effectiveness of outreach efforts during the application process in diversifying the pool of grant recipients;

(B) makes recommendations for future outreach efforts to diversify the pool of grant recipients for Department of Health and Human Services grant programs and funding opportunities related to maternal health;

(C) assesses the effectiveness of programs funded by grants under this subsection in improving maternal health outcomes for pregnant and postpartum individuals from underserved groups, to the extent practicable; and

(D) makes recommendations for future Department of Health and Human Services grant programs and funding opportunities that deliver funding to community-based organizations that provide programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for pregnant and postpartum individuals.

(7) DEFINITION.—In this subsection, the term ''underserved groups'' refers to pregnant and postpartum individuals—

(A) from racial and ethnic minority groups;

(B) whose household income is equal to or less than 150 percent of the Federal poverty line;

(C) who live in health professional shortage areas (as such term is defined in section 332 of the Public Health Service Act (42 U.S.C. 254e));

(D) who live in counties with no hospital offering obstetric care, no birth center, and no obstetric provider; or

(E) who live in counties with a level of vulnerability of moderate-to-high or higher, according to the Social Vulnerability Index of the Centers for Disease Control and Prevention.

(8) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.

(c) RESPECTFUL MATERNITY CARE TRAINING FOR ALL EMPLOYEES IN MATERNITY CARE SETTINGS.—Part

B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.), as amended by section 3002, is further amended by adding at the end the following new section:

"SEC. 743. RESPECTFUL MATERNITY CARE TRAINING FOR ALL EMPLOYEES IN MATERNITY CARE SETTINGS.

''(a) GRANTS.—The Secretary shall award grants for programs to reduce and prevent bias, racism, and discrimination in maternity care settings and to advance respectful, culturally congruent, trauma-informed care.

''(b) SPECIAL CONSIDERATION.—In awarding grants under subsection (a), the Secretary shall give special consideration to applications for programs that would—

''(1) apply to all maternity care providers and any employees who interact with pregnant and postpartum individuals in the provider setting, including front desk employees, sonographers, schedulers, health care professionals, hospital or health system administrators, security staff, and other employees;

''(2) emphasize periodic, as opposed to one-time, trainings for all birthing professionals and employees described in paragraph (1);

''(3) address implicit bias, racism, and cultural humility;

''(4) be delivered in ongoing education settings for providers maintaining their licenses, with a preference for trainings that provide continuing education units;

''(5) include trauma-informed care best practices and an emphasis on shared decision making between providers and patients;

''(6) include antiracism training and programs;

''(7) be delivered in undergraduate programs that funnel into health professions schools;

''(8) be delivered in settings that apply to providers of the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966;

''(9) integrate bias training in obstetric emergency simulation trainings or related trainings;

''(10) include training for emergency department employees and emergency medical technicians on recognizing warning signs for severe pregnancy-related complications;

''(11) offer training to all maternity care providers on the value of racially, ethnically, and professionally diverse maternity care teams to provide culturally congruent care; or

''(12) be based on one or more programs designed by a historically Black college or university or other minority-serving institution.

''(c) APPLICATION.—To seek a grant under subsection (a), an entity shall submit an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) REPORTING TO SECRETARY.—Each recipient of a grant under this section shall annually submit to the Secretary a report on the status of activities conducted using the grant, including, as applicable, a description of the impact of training provided through the grant on patient outcomes and patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families.

''(e) DISSEMINATION OF FINDINGS.—Based on the annual reports submitted pursuant to subsection (d), the Secretary—

''(1) shall produce an annual report on the findings resulting from programs funded through this section;

''(2) shall disseminate such report to all recipients of grants under this section and to the public; and

''(3) may include in such report findings on best practices for improving patient outcomes and patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families in maternity care settings.

''(f) DEFINITIONS.—In this section:

''(1) The term 'postpartum' means the one-year period beginning on the last day of an individual's pregnancy.

''(2) The term 'culturally congruent' means in agreement with the preferred cultural values, beliefs, world view, language, and practices of the health care consumer and other stakeholders.

''(3) The term 'maternity care provider' means a health care provider who—

''(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

''(B) has a focus on maternal or perinatal health.

''(4) The term 'racial and ethnic minority group' has the meaning given such term in section 1707(g)(1).

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2023 through 2027.''.

(d) STUDY ON REDUCING AND PREVENTING BIAS, RACISM, AND DISCRIMINATION IN MATERNITY CARE SETTINGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an agreement, not later than 90 days after the date of enactment of this Act, with the National Academies of Sciences, Engineering, and Medicine (referred to in this subsection as the ''National Academies'') under which the National Academies agree to—

(A) conduct a study on the design and implementation of programs to reduce and prevent bias, racism, and discrimination in maternity care settings and to advance respectful, culturally congruent, trauma-informed care; and

(B) not later than 24 months after the date of the enactment of this Act—

(i) complete the study; and

(ii) transmit a report on the results of the study to the Congress.

(2) POSSIBLE TOPICS.—The agreement entered into pursuant to paragraph (1) may provide for the study of any of the following:

(A) The development of a scorecard or other evaluation standards for programs designed to reduce and prevent bias, racism, and discrimination in maternity care settings to assess the effectiveness of such programs in improving patient outcomes and patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families.

(B) Determination of the types and frequency of training to reduce and prevent bias, racism, and discrimination in maternity care settings that are demonstrated to improve patient outcomes or patient experience for pregnant and postpartum individuals from racial and ethnic minority groups and their families.

(e) RESPECTFUL MATERNITY CARE COMPLIANCE PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as

the ''Secretary'') shall award grants to accredited hospitals, health systems, and other maternity care settings to establish as an integral part of quality implementation initiatives within one or more hospitals or other birth settings a respectful maternity care compliance program.

(2) PROGRAM REQUIREMENTS.—A respectful maternity care compliance program funded through a grant under this subsection shall—

(A) institutionalize mechanisms to allow patients receiving maternity care services, the families of such patients, or perinatal health workers supporting such patients to report instances of racism or evidence of bias on the basis of race, ethnicity, or another protected class;

(B) institutionalize response mechanisms through which representatives of the program can directly follow up with the patient, if possible, and the patient's family in a timely manner;

(C) prepare, and make publicly available, a hospital- or health system-wide strategy to reduce bias on the basis of race, ethnicity, or an-

other protected class in the delivery of maternity care that includes—

(i) information on the training programs to reduce and prevent bias, racism, and discrimination on the basis of race, ethnicity, or another protected class for all employees in maternity care settings;

(ii) information on the number of cases reported to the compliance program; and

(iii) the development of methods to routinely assess the extent to which bias, racism, or discrimination on the basis of race, ethnicity, or another protected class are present in the delivery of maternity care to patients from racial and ethnic minority groups;

(D) develop mechanisms to routinely collect and publicly report hospital-level data related to patient-reported experience of care; and

(E) provide annual reports to the Secretary with information about each case reported to the compliance program over the course of the year containing such information as the Secretary may require, such as—

(i) de-identified demographic information on the patient in the case, such as race, ethnicity, gender identity, and primary language;

(ii) the content of the report from the patient or the family of the patient to the compliance program;

(iii) the response from the compliance program; and

(iv) to the extent applicable, institutional changes made as a result of the case.

(3) SECRETARY REQUIREMENTS.—

(A) PROCESSES.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall establish processes for—

(i) disseminating best practices for establishing and implementing a respectful maternity care compliance program within a hospital or other birth setting;

(ii) promoting coordination and collaboration between hospitals, health systems, and other maternity care delivery 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

respectful maternity care compliance programs pursuant to paragraph (2)(E).

(II) Based on such assessment, recommendations for potential accountability mechanisms related to cases of racism or bias on the basis of race, ethnicity, or another protected class in the delivery of maternity care services at hospitals and other birth settings. Such recommendations shall take into consideration medical and non-medical factors that contribute to adverse patient experiences and maternal health outcomes.

(iii) REPORT.—The Secretary shall submit to the Congress, and make publicly available, a report on the results of the study under this subparagraph.

(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2028.

(f) GAO REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act and annually thereafter, the Comptroller General of the United States shall submit to the Congress, and make publicly available, a report on the establishment of respectful maternity care compliance programs within hospitals, health systems, and other maternity care settings.

(2) MATTERS INCLUDED.—The report under paragraph (1) shall include the following:

(A) Information regarding the extent to which hospitals, health systems, and other maternity care settings have elected to establish respectful maternity care compliance programs, including—

(i) which hospitals and other birth settings elect to establish compliance programs and when such programs are established;

(ii) to the extent practicable, impacts of the establishment of such programs on maternal health outcomes and patient and family experiences in the hospitals and other birth settings that have established such programs, especially for patients from

racial and ethnic minority groups and their families;

(iii) information on geographic areas, and types of hospitals or other birth settings, where respectful maternity care compliance programs are not being established and information on factors contributing to decisions to not establish such programs; and

(iv) recommendations for establishing respectful maternity care compliance programs in geographic areas, and types of hospitals or other birth settings, where such programs are not being established.

(B) Whether the funding made available to carry out this subsection has been sufficient and, if applicable, recommendations for additional appropriations to carry out this subsection.

(C) Such other information as the Comptroller General determines appropriate.

(g) DEFINITIONS.—In this section:

(1) CULTURALLY CONGRUENT.—The term ''culturally congruent'', with respect to care or maternity care, means care that is in agreement with the pre-

ferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

(B) has a focus on maternal or perinatal health.

(3) MATERNAL MORTALITY.—The term ''maternal mortality'' means a death occurring during or within a one-year period after pregnancy, caused by pregnancy-related or childbirth complications, including a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications.

(4) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a doula, commu-

nity health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(6) PREGNANCY-ASSOCIATED DEATH.—The term ''pregnancy-associated death'' means a death of a pregnant or postpartum individual, by any cause, that occurs during, or within 1 year following, the individual's pregnancy, regardless of the outcome, duration, or site of the pregnancy.

(7) PREGNANCY-RELATED DEATH.—The term ''pregnancy-related death'' means a death of a pregnant or postpartum individual that occurs during, or within 1 year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(8) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g)(1) of

the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(9) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(10) SOCIAL DETERMINANTS OF MATERNAL HEALTH DEFINED.—The term ''social determinants of maternal health'' means non-clinical factors that impact maternal health outcomes, including—

(A) economic factors, which may include poverty, employment, food security, support for and access to lactation and other infant feeding options, housing stability, and related factors;

(B) neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

(D) household factors, which may include ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors;

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) health care access factors, including health insurance coverage, access to culturally congruent health care services, providers, and non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

SEC. 5210. MOMS MATTER.

(a) MATERNAL MENTAL HEALTH EQUITY GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Sec-

retary for Mental Health and Substance Use, shall establish a program to award grants to eligible entities to address maternal mental health conditions and substance use disorders with respect to pregnant and postpartum individuals, with a focus on racial and ethnic minority groups.

(2) APPLICATION.—To be eligible to receive a grant under this subsection, an eligible entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may provide, including how such entity will use funds for activities described in paragraph (4) that are culturally congruent.

(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to an eligible entity that—

(A) is, or will partner with, a community-based organization to address maternal mental health conditions and substance use disorders described in paragraph (1);

(B) is operating in an area with high rates of—

(i) adverse maternal health outcomes; or

(ii) significant racial or ethnic inequities in maternal health outcomes; and

(C) is operating in a health professional shortage area designated under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(4) USE OF FUNDS.—An eligible entity that receives a grant under this subsection shall use funds for the following:

(A) Establishing or expanding maternity care programs to improve the integration of maternal health and behavioral health care services into primary care settings where pregnant individuals regularly receive health care services.

(B) Establishing or expanding group prenatal care programs or postpartum care programs.

(C) Expanding existing programs that improve maternal mental and behavioral health during the prenatal and postpartum periods, with a focus on individuals from racial and ethnic minority groups.

(D) Providing services and support for pregnant and postpartum individuals with ma-

ternal mental health conditions and substance use disorders, including referrals to addiction treatment centers that offer evidence-based treatment options.

(E) Addressing stigma associated with maternal mental health conditions and substance use disorders, with a focus on racial and ethnic minority groups.

(F) Raising awareness of warning signs of maternal mental health conditions and substance use disorders, with a focus on pregnant and postpartum individuals from racial and ethnic minority groups.

(G) Establishing or expanding programs to prevent suicide or self-harm among pregnant and postpartum individuals.

(H) Offering evidence-aligned programs at freestanding birth centers that provide maternal mental and behavioral health care education, treatments, and services, and other services for individuals throughout the prenatal and postpartum period.

(I) Establishing or expanding programs to provide education and training to maternity care providers with respect to—

(i) identifying potential warning signs for maternal mental health conditions or substance use disorders in pregnant and postpartum individuals, with a focus on individuals from racial and ethnic minority groups; and

(ii) in the case where such providers identify such warning signs, offering referrals to mental and behavioral health care professionals.

(J) Developing a website, or other source, that includes information on health care providers who treat maternal mental health conditions and substance use disorders.

(K) Establishing or expanding programs in communities to improve coordination between maternity care providers and mental and behavioral health care providers who treat maternal mental health conditions and substance use disorders, including through the use of toll-free hotlines.

(L) Carrying out other programs aligned with evidence-based practices for addressing maternal mental health conditions and substance use disorders for pregnant and

postpartum individuals from racial and ethnic minority groups.

(5) REPORTING.—

(A) ELIGIBLE ENTITIES.—An eligible entity that receives a grant under paragraph (1) shall submit annually to the Secretary, and make publicly available, a report on the activities conducted using funds received through a grant under this subsection. Such reports shall include quantitative and qualitative evaluations of such activities, including the experience of individuals who received health care through such grant.

(B) SECRETARY.—Not later than the end of fiscal year 2024, the Secretary shall submit to Congress a report that includes—

(i) a summary of the reports received under subparagraph (A);

(ii) an evaluation of the effectiveness of grants awarded under this subsection;

(iii) recommendations with respect to expanding coverage of evidence-based screenings and treatments for maternal mental health conditions and substance use disorders; and

(iv) recommendations with respect to ensuring activities described under paragraph (4) continue after the end of a grant period.

(6) DEFINITIONS.—In this subsection:

(A) CULTURALLY CONGRUENT.—The term ''culturally congruent'', with respect to care or maternity care, means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(B) ELIGIBLE ENTITY.—The term ''eligible entity'' means—

(i) a community-based organization serving pregnant and postpartum individuals, including such organizations serving individuals from racial and ethnic minority groups and other underserved populations;

(ii) a nonprofit or patient advocacy organization with expertise in maternal mental and behavioral health;

(iii) a maternity care provider;

(iv) a mental or behavioral health care provider who treats maternal mental health conditions or substance use disorders;

(v) a State or local governmental entity, including a State or local public health department;

(vi) an Indian Tribe or Tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)); and

(vii) an Urban Indian organization (as such term is defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

(C) FREESTANDING BIRTH CENTER.—The term ''freestanding birth center'' has the meaning given that term under section 1905(l) of the Social Security Act (42 U.S.C. 1396d(1)).

(D) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(i) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confed-

eration of Midwives, nurse practitioner, or clinical nurse specialist; and

(ii) has a focus on maternal or perinatal health.

(E) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $25,000,000 for each of fiscal years 2023 through 2026.

(b) GRANTS TO GROW AND DIVERSIFY THE MATERNAL MENTAL AND BEHAVIORAL HEALTH CARE WORKFORCE.—Title VII of the Public Health Service Act is amended by inserting after section 757 of such Act (42 U.S.C. 294f) the following new section:

''SEC. 758. MATERNAL MENTAL AND BEHAVIORAL HEALTH CARE WORKFORCE GRANTS.

''(a) IN GENERAL.—The Secretary may award grants to entities to establish or expand programs described in subsection (b) to grow and diversify the maternal mental and behavioral health care workforce.

''(b) USE OF FUNDS.—Recipients of grants under this section shall use the grants to grow and diversify the

maternal mental and behavioral health care workforce by—

''(1) establishing schools or programs that provide education and training to individuals seeking appropriate licensing or certification as mental or behavioral health care providers who will specialize in maternal mental health conditions or substance use disorders; or

''(2) expanding the capacity of existing schools or programs described in paragraph (1), for the purposes of increasing the number of students enrolled in such schools or programs, including by awarding scholarships for students.

''(c) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to any entity that—

''(1) has demonstrated a commitment to recruiting and retaining students and faculty from racial and ethnic minority groups;

''(2) has developed a strategy to recruit and retain a diverse pool of students into the maternal mental or behavioral health care workforce program or school supported by funds received through the grant, particularly from racial and ethnic minority groups and other underserved populations;

''(3) has developed a strategy to recruit and retain students who plan to practice in a health professional shortage area designated under section 332;

''(4) has developed a strategy to recruit and retain students who plan to practice in an area with significant racial and ethnic inequities in maternal health outcomes, to the extent practicable; and

''(5) includes in the standard curriculum for all students within the maternal mental or behavioral health care workforce program or school a bias, racism, or discrimination training program that includes training on implicit bias and racism.

''(d) REPORTING.—As a condition on receipt of a grant under this section for a maternal mental or behavioral health care workforce program or school, an entity shall agree to submit to the Secretary an annual report on the activities conducted through the grant, including—

''(1) the number and demographics of students participating in the program or school;

''(2) the extent to which students in the program or school are entering careers in—

''(A) health professional shortage areas designated under section 332; and

"(B) areas with significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available; and

"(3) whether the program or school has included in the standard curriculum for all students a bias, racism, or discrimination training program that includes training on implicit bias and racism, and if so the effectiveness of such training program.

"(e) PERIOD OF GRANTS.—The period of a grant under this section shall be up to 5 years.

"(f) APPLICATION.—To seek a grant under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including any information necessary for prioritization under subsection (c).

"(g) TECHNICAL ASSISTANCE.—The Secretary shall provide, directly or by contract, technical assistance to entities seeking or receiving a grant under this section on the development, use, evaluation, and post-grant period sustainability of the maternal mental or behavioral health care workforce programs or schools proposed to be, or being, established or expanded through the grant.

"(h) REPORT BY THE SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall prepare and submit to the Congress, and

post on the internet website of the Department of Health and Human Services, a report on the effectiveness of the grant program under this section at—

''(1) recruiting students from racial and ethnic minority groups and other underserved populations;

''(2) increasing the number of mental or behavioral health care providers specializing in maternal mental health conditions or substance use disorders from racial and ethnic minority groups and other underserved populations;

''(3) increasing the number of mental or behavioral health care providers specializing in maternal mental health conditions or substance use disorders working in health professional shortage areas designated under section 332; and

''(4) increasing the number of mental or behavioral health care providers specializing in maternal mental health conditions or substance use disorders working in areas with significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available.

''(i) DEFINITIONS.—In this section:

''(1) RACIAL AND ETHNIC MINORITY GROUP.—The term 'racial and ethnic minority group' has the meaning given such term in section 1707(g)(1).

''(2) MENTAL OR BEHAVIORAL HEALTH CARE PROVIDER.—The term 'mental or behavioral health care provider' refers to a health care provider in the field of mental and behavioral health, including substance use disorders, acting in accordance with State law.

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2023 through 2027.''.

SEC. 5211. TASKFORCE RECOMMENDING IMPROVEMENTS FOR UNADDRESSED MENTAL PERINATAL & POSTPARTUM HEALTH (TRIUMPH) FOR NEW MOMS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317L–1 (42 U.S.C. 247b–13a) the following:

''SEC. 317L–2. TASK FORCE ON MATERNAL MENTAL HEALTH.

''(a) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this section, the Secretary shall establish a task force, to be known as the Task Force on Maternal Mental Health (in this section referred to as the 'Task Force') to identify, evaluate, and make rec-

ommendations to coordinate and improve, Federal responses to maternal mental health conditions.

"(b) MEMBERSHIP.—

"(1) COMPOSITION.—The Task Force shall be composed of—

"(A) the Assistant Secretary for Health of the Department of Health and Human Services (or the Assistant Secretary's designee) who shall serve as the Chair of the Task Force;

"(B) the Federal members under paragraph (2); and

"(C) the non-Federal members under paragraph (3).

"(2) FEDERAL MEMBERS.—In addition to the Assistant Secretary for Health, the Federal members of the Task Force shall consist of the heads of the following Federal departments and agencies (or their designees):

"(A) The Administration for Children and Families.

"(B) The Agency for Healthcare Research and Quality.

"(C) The Centers for Disease Control and Prevention.

"(D) The Centers for Medicare & Medicaid Services.

"(E) The Health Resources and Services Administration.

"(F) The Food and Drug Administration.

"(G) The Indian Health Service.

"(H) The Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

"(I) The Office of Minority Health of the Department of Health and Human Services.

"(J) The Office of the Surgeon General of the Department of Health and Human Services.

"(K) The Office on Women's Health of the Department of Health and Human Services.

"(L) The National Institutes of Health.

"(M) The Substance Abuse and Mental Health Services Administration.

"(N) Such other Federal departments and agencies as the Secretary determines that serve individuals with maternal mental health conditions, such as the Department of Veterans Affairs, the Department of Justice, the Department of Labor, the Department of Housing and

Urban Development, and the Department of Defense.

''(3) NON-FEDERAL MEMBERS.—The non-Federal members of the Task Force shall—

''(A) compose not more than one-half, and not less than one-third, of the total membership of the Task Force;

''(B) be appointed by the Secretary; and

''(C) include—

''(i) representatives of medical societies with expertise in maternal or mental health;

''(ii) representatives of nonprofit organizations with expertise in maternal or mental health;

''(iii) relevant industry representatives; and

''(iv) other representatives, as appropriate.

''(4) DEADLINE FOR DESIGNATING DESIGNEES.—If the Assistant Secretary for Health, or the head of a Federal department or agency serving as a member of the Task Force under paragraph (2), chooses to be represented on the Task Force by a designee, the Assistant Secretary or head shall

designate such designee not later than 90 days after the date of the enactment of this section.

''(c) DUTIES.—The Task Force shall—

''(1) create and regularly update a report that identifies, analyzes, and evaluates the state of national maternal mental health policy and programs at the Federal, State, and local levels, and identifies best practices including—

''(A) a set of evidence-based, evidence-informed, and promising practices with respect to—

''(i) prevention strategies for individuals at risk of experiencing a maternal mental health condition, including strategies and recommendations to address social determinants of health;

''(ii) the identification, screening, diagnosis, intervention, and treatment of individuals and families affected by a maternal mental health condition;

''(iii) the expeditious referral to, and implementation of, practices and supports that prevent and mitigate the effects of a maternal mental health condition, including strategies and recommendations to

eliminate the racial and ethnic inequities that exist in maternal mental health; and

"(iv) community-based or multigenerational practices that support individuals and families affected by a maternal mental health condition; and

"(B) Federal and State programs and activities to prevent, screen, diagnose, intervene, and treat maternal mental health conditions;

"(2) develop and regularly update a national strategy for maternal mental health, taking into consideration the findings of the reports under paragraph (1), on how the Task Force and Federal departments and agencies represented on the Task Force will prioritize options for, and implement a coordinated approach to, addressing maternal mental health conditions, including by—

"(A) increasing prevention, screening, diagnosis, intervention, treatment, and access to care, including clinical and nonclinical care such as peer-support and community health workers, through the public and private sectors;

"(B) providing support for pregnant or postpartum individuals who are at risk for or

experiencing a maternal mental health condition, and their families as appropriate;

"(C) reducing racial, ethnic, geographic, and other health inequities for prevention, diagnosis, intervention, treatment, and access to care;

"(D) identifying opportunities for local- and State-level partnerships;

"(E) identifying options for modifying, strengthening, and coordinating Federal programs and activities, including existing infant and maternity programs, such as the Medicaid program under title XIX of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act, in order to increase research, prevention, identification, intervention, and treatment with respect to maternal mental health;

"(F) providing recommendations to ensure research, services, supports, and prevention activities are not unnecessarily duplicative; and

"(G) planning, data sharing, and communication within and across Federal departments, agencies, offices, and programs;

''(3) solicit public comments from stakeholders for the report under paragraph (1) and the national strategy under paragraph (2), including comments from frontline service providers, mental health professionals, researchers, experts in maternal mental health, institutions of higher education, public health agencies (including maternal and child health programs), and industry representatives, in order to inform the activities and reports of the Task Force; and

''(4) disaggregate any data collected under this section by race, ethnicity, geographical location, age, marital status, socioeconomic level, and other factors as determined appropriate by the Secretary.

''(d) MEETINGS.—The Task Force shall—

''(1) meet not less than two times each year; and

''(2) convene public meetings, as appropriate, to fulfill its duties under this section.

''(e) REPORTS TO PUBLIC AND FEDERAL LEADERS.—The Task Force shall make publicly available and submit to the heads of relevant Federal departments and agencies, the Committee on Energy and Commerce of the House of Representatives, the Committee on Health, Edu-

cation, Labor, and Pensions of the Senate, and other relevant congressional committees, the following:

"(1) Not later than 1 year after the first meeting of the Task Force, an initial report under subsection (c)(1).

"(2) Not later than 2 years after the first meeting of the Task Force, an initial national strategy under subsection (c)(2).

"(3) Each year thereafter—

"(A) an updated report under subsection (c)(1);

"(B) an updated national strategy under subsection (c)(2); or

"(C) if no such update is made, a report summarizing the activities of the Task Force.

"(f) REPORTS TO GOVERNORS.—Upon finalizing the initial national strategy under subsection (c)(2), and upon making relevant updates to such strategy, the Task Force shall submit a report to the Governors of all States describing opportunities for local- and State-level partnerships identified under subsection (c)(2)(D).

"(g) SUNSET.—The Task Force shall terminate on the date that is 6 years after the date on which the Task Force is established under subsection (a).".

SEC. 5212. PROTECT MOMS FROM DOMESTIC VIOLENCE.

(a) STUDY BY DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

(1) STUDY.—The Secretary, in collaboration with the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families, and in consultation with the Attorney General of the United States, the Director of the Indian Health Service, and stakeholders (including community-based organizations, culturally specific organizations, and Tribal public health authorities), shall conduct a study on the extent to which individuals are more at risk of maternal mortality or severe maternal morbidity as a result of being a victim of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage.

(2) REPORTS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall complete the study under paragraph (1) and submit a report to the Congress on the results of such study. Such report shall include—

(A) an analysis of the extent to which domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking,

child sexual abuse, and forced marriage contribute to, or result in, maternal mortality;

(B) an analysis of the impact of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, and forced marriage on access to health care (including mental health care) and substance use disorder treatment and recovery support;

(C) a breakdown (including by race and ethnicity) of categories of individuals who are disproportionately victims of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage that contributes to, or results in, pregnancy-related death;

(D) an analysis of the impact on health, mental health, and substance use resulting from domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, and forced marriage among Alaskan Natives, Native Hawaiians, and American Indians during the prenatal and postpartum period;

(E) an assessment of the factors that increase or decrease risks for maternal mortality or severe maternal morbidity among victims of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage;

(F) an assessment of increased risk of maternal mortality or severe maternal morbidity stemming from suicide, substance use disorders, or drug overdose due to domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage;

(G) recommendations for legislative or policy changes—

(i) to reduce maternal mortality rates; and

(ii) to address health inequities that contribute to inequities in such rates and deaths;

(H) best practices to reduce maternal mortality and severe maternal morbidity among victims of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex

trafficking, child sexual abuse, and forced marriage, including—

(i) reducing reproductive coercion, mental health conditions, and substance use coercion; and

(ii) routinely assessing pregnant people for domestic violence and other forms of reproductive violence; and

(I) any other information on maternal mortality or severe maternal morbidity the Secretary determines appropriate to include in the report.

(b) STUDY BY NATIONAL ACADEMY OF MEDICINE.—

(1) IN GENERAL.—The Secretary shall seek to enter into an arrangement with the National Academy of Medicine (or, if the Academy declines to enter into such arrangement, another appropriate entity) to study—

(A) the impact of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, and forced marriage on an individual's health; relative to

(B) maternal mortality and severe maternal morbidity.

(2) TOPICS.—The study under paragraph (1) shall—

(A) examine—

(i) whether domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage, or generational intimate partner violence, trauma, and psychiatric disorders, increase the risk of suicide, substance use, and drug overdose among pregnant and postpartum persons; and

(ii) the intersection of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, and forced marriage as a social determinant of health; and

(B) give particular focus to impacts among African American, American Indian, Native Hawaiian, Alaskan Native, and LGBTQ birthing persons.

(c) GRANTS FOR INNOVATIVE APPROACHES.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, and in collaboration

with the Administration for Children and Families, the Indian Health Service, and the Substance Abuse and Mental Health Services Administration, shall award grants to eligible entities for developing and implementing innovative approaches to improve maternal and child health outcomes of victims of domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage.

(2) ELIGIBLE ENTITY.—To seek a grant under this subsection, an entity shall be—

(A) a State, local, or federally recognized Tribal government;

(B) a nonprofit organization or community-based organization that provides prevention or intervention services related to domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage;

(C) a tribal organization or Urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603));

(D) an entity, the principal purpose of which is to provide health care, such as a hos-

pital, clinic, health department, freestanding birthing center, perinatal health worker, or maternity care provider;

(E) an institution of higher education; or

(F) a comprehensive substance use disorder parenting program.

(3) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to applicants proposing to address—

(A) mental health and substance use disorders among pregnant persons; or

(B) pregnant and postpartum persons experiencing intimate partner violence.

(4) FREESTANDING BIRTH CENTER DEFINED.—In this subsection, the term ''freestanding birth center'' has the meaning given that term in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(1)).

(5) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $25,000,000 for the period of fiscal years 2023 through 2025.

(d) GUIDANCE.—Not later than 2 years after the date of enactment of this Act, the Secretary shall issue

and disseminate guidance to States, Tribes, territories, maternity care providers, and managed care entities on—

(1) providing universal education on healthy relationships and intimate partner violence;

(2) developing protocols on—

(A) routine assessment of intimate partner violence; and

(B) health promotion and strategies for trauma-informed care plans; and

(3) creating sustainable partnerships with community-based organizations that address domestic violence, dating violence, sexual assault, stalking, human trafficking, sex trafficking, child sexual abuse, or forced marriage.

(e) DEFINITIONS.—In this section:

(1) The term ''maternal mortality''—

(A) means death that—

(i) occurs during, or within the 1-year period after, pregnancy; and

(ii) is attributed to or aggravated by pregnancy-related or childbirth complications; and

(B) includes a suicide, drug overdose death, homicide (including a domestic violence-related homicide), or other death resulting from

a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications.

(2) The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, nurse, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

(B) has a focus on maternal or perinatal health.

(3) The term ''perinatal health worker'' means a worker who—

(A) is a doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator; and

(B) provides assistance with perinatal health.

(4) The term ''postpartum'' refers to the 12-month period following childbirth.

(5) The term ''Secretary'' means the Secretary of Health and Human Services.

(6) The term ''severe maternal morbidity'' means a health condition, including a mental health condition or substance use disorder, that—

(A) is attributed to or aggravated by pregnancy or childbirth; and

(B) results in significant short-term or long-term consequences to the health of the individual who was pregnant.

SEC. 5213. PERINATAL WORKFORCE.

(a) HHS AGENCY DIRECTIVES.—

(1) GUIDANCE TO STATES.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall issue and disseminate guidance to States to educate providers, managed care entities, and other insurers about the value and process of delivering respectful maternal health care through diverse and multidisciplinary care provider models.

(B) CONTENTS.—The guidance required by subparagraph (A) shall address how States can encourage and incentivize hospitals, health

systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers—

(i) to recruit and retain maternity care providers, mental and behavioral health care providers acting in accordance with State law, registered dietitians or nutrition professionals (as such term is defined in section 1861(vv)(2) of the Social Security Act (42 U.S.C. 1395x(vv)(2))), and lactation consultants certified by the International Board of Lactation Consultants Examiners—

(I) from racially, ethnically, and linguistically diverse backgrounds;

(II) with experience practicing in racially and ethnically diverse communities; and

(III) who have undergone training on implicit bias and racism;

(ii) to incorporate into maternity care teams—

(I) midwives who meet, at a minimum, the international definition of the midwife and global standards for

midwifery education, as established by the International Confederation of Midwives; and

(II) perinatal health workers;

(iii) to provide collaborative, culturally congruent care; and

(iv) to provide opportunities for individuals enrolled in accredited midwifery education programs to participate in job shadowing with maternity care teams in hospitals, health systems, midwifery practices, and freestanding birth centers.

(2) STUDY ON RESPECTFUL AND CULTURALLY CONGRUENT MATERNITY CARE.—

(A) STUDY.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health (in this paragraph referred to as the ''Secretary''), shall conduct a study on best practices in respectful and culturally congruent maternity care.

(B) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall—

(i) complete the study required by subparagraph (A);

(ii) submit to the Congress, and make publicly available, a report on the results of such study; and

(iii) include in such report—

(I) a compendium of examples of hospitals, health systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers that are delivering respectful and culturally congruent maternal health care;

(II) a compendium of examples of hospitals, health systems, midwifery practices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers that have made progress in reducing inequities in maternal health outcomes and improving birthing experiences for pregnant and postpartum individuals from racial and ethnic minority groups; and

(III) recommendations to hospitals, health systems, midwifery prac-

tices, freestanding birth centers, other maternity care provider groups, managed care entities, and other insurers, for best practices in respectful and 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:

"SEC. 758A. PERINATAL WORKFORCE GRANTS.

''(a) IN GENERAL.—The Secretary shall award grants to entities to establish or expand programs described in subsection (b) to grow and diversify the perinatal workforce.

''(b) USE OF FUNDS.—Recipients of grants under this section shall use the grants to grow and diversify the perinatal workforce by—

''(1) establishing schools or programs that provide education and training to individuals seeking appropriate licensing or certification as—

''(A) physician assistants who will complete clinical training in the field of maternal and perinatal health; or

''(B) perinatal health workers; and

''(2) expanding the capacity of existing schools or programs described in paragraph (1), for the purposes of increasing the number of students enrolled in such schools or programs, including by awarding scholarships for students.

''(c) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to any entity that—

''(1) has demonstrated a commitment to recruiting and retaining students and faculty from racial and ethnic minority groups;

''(2) has developed a strategy to recruit and retain a diverse pool of students into the perinatal workforce program or school supported by funds received through the grant, particularly from racial and ethnic minority groups and other underserved populations;

''(3) has developed a strategy to recruit and retain students who plan to practice in a health professional shortage area designated under section 332;

''(4) has developed a strategy to recruit and retain students who plan to practice in an area with significant racial and ethnic inequities in maternal health outcomes, to the extent practicable; and

''(5) includes in the standard curriculum for all students within the perinatal workforce program or school a bias, racism, or discrimination training program that includes training on implicit bias and racism.

''(d) REPORTING.—As a condition on receipt of a grant under this section for a perinatal workforce program or school, an entity shall agree to submit to the Secretary an annual report on the activities conducted through the grant, including—

''(1) the number and demographics of students participating in the program or school;

''(2) the extent to which students in the program or school are entering careers in—

''(A) health professional shortage areas designated under section 332; and

''(B) areas with significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available; and

''(3) whether the program or school has included in the standard curriculum for all students a bias, racism, or discrimination training program that includes explicit and implicit bias, and if so the effectiveness of such training program.

''(e) PERIOD OF GRANTS.—The period of a grant under this section shall not exceed 5 years.

''(f) APPLICATION.—To seek a grant under this section, an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including any information necessary for prioritization under subsection (c).

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide, directly or by contract, technical assistance to entities seeking or receiving a grant under this section on the development, use, evaluation, and post-grant period sustainability of the perinatal workforce programs or schools proposed to be, or being, established or expanded through the grant.

''(h) REPORT BY THE SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall prepare and submit to the Congress, and post on the internet website of the Department of Health and Human Services, a report on the effectiveness of the grant program under this section at—

''(1) recruiting students from racial and ethnic minority groups;

''(2) increasing the number of physician assistants who will complete clinical training in the field of maternal and perinatal health, and perinatal

health workers, from racial and ethnic minority groups and other underserved populations;

''(3) increasing the number of physician assistants who will complete clinical training in the field of maternal and perinatal health, and perinatal health workers, working in health professional shortage areas designated under section 332; and

''(4) increasing the number of physician assistants who will complete clinical training in the field of maternal and perinatal health, and perinatal health workers, working in areas with significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available.

''(i) DEFINITION.—In this section, the term 'racial and ethnic minority group' has the meaning given such term in section 1707(g).

''(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2023 through 2027.''.

(c) GRANTS TO GROW AND DIVERSIFY THE NURSING WORKFORCE IN MATERNAL AND PERINATAL HEALTH.—Title VIII of the Public Health Service Act is amended by inserting after section 811 of that Act (42 U.S.C. 296j) the following:

"SEC. 812. PERINATAL NURSING WORKFORCE GRANTS.

''(a) IN GENERAL.—The Secretary shall award grants to schools of nursing to grow and diversify the perinatal nursing workforce.

''(b) USE OF FUNDS.—Recipients of grants under this section shall use the grants to grow and diversify the perinatal nursing workforce by providing scholarships to students seeking to become—

''(1) nurse practitioners whose education includes a focus on maternal and perinatal health; or

''(2) clinical nurse specialists whose education includes a focus on maternal and perinatal health.

''(c) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to any school of nursing that—

''(1) has developed a strategy to recruit and retain a diverse pool of students seeking to enter careers focused on maternal and perinatal health, particularly students from racial and ethnic minority groups and other underserved populations;

''(2) has developed a partnership with a practice setting in a health professional shortage area designated under section 332 for the clinical placements of the school's students;

''(3) has developed a strategy to recruit and retain students who plan to practice in an area with

significant racial and ethnic inequities in maternal health outcomes, to the extent practicable; and

''(4) includes in the standard curriculum for all students seeking to enter careers focused on maternal and perinatal health a bias, racism, or discrimination training program that includes education on implicit bias and racism.

''(d) REPORTING.—As a condition on receipt of a grant under this section, a school of nursing shall agree to submit to the Secretary an annual report on the activities conducted through the grant, including, to the extent practicable—

''(1) the number and demographics of students in the school of nursing seeking to enter careers focused on maternal and perinatal health;

''(2) the extent to which such students are preparing to enter careers in—

''(A) health professional shortage areas designated under section 332; and

''(B) areas with significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available; and

''(3) whether the standard curriculum for all students seeking to enter careers focused on maternal and perinatal health includes a bias, racism, or

discrimination training program that includes education on implicit bias and racism.

''(e) PERIOD OF GRANTS.—The period of a grant under this section shall be up to 5 years.

''(f) APPLICATION.—To seek a grant under this section, an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including any information necessary for prioritization under subsection (c).

''(g) TECHNICAL ASSISTANCE.—The Secretary shall provide, directly or by contract, technical assistance to schools of nursing seeking or receiving a grant under this section on the processes of awarding and evaluating scholarships through the grant.

''(h) REPORT BY THE SECRETARY.—Not later than 4 years after the date of enactment of this section, the Secretary shall prepare and submit to the Congress, and post on the internet website of the Department of Health and Human Services, a report on the effectiveness of the grant program under this section at—

''(1) recruiting students from racial and ethnic minority groups and other underserved populations;

''(2) increasing the number of nurse practitioners and clinical nurse specialists entering careers

focused on maternal and perinatal health from racial and ethnic minority groups and other underserved populations;

''(3) increasing the number of nurse practitioners and clinical nurse specialists entering careers focused on maternal and perinatal health working in health professional shortage areas designated under section 332; and

''(4) increasing the number of nurse practitioners and clinical nurse specialists entering careers focused on maternal and perinatal health working in areas with significant racial and ethnic inequities in maternal health outcomes, to the extent such data are available.

''(i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of fiscal years 2023 through 2027.''.

(d) GAO REPORT.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, and every 5 years thereafter, the Comptroller General of the United States shall submit to Congress a report on barriers to maternal health education and access to care in the United States. Such report shall include the in-

formation and recommendations described in paragraph (2).

(2) CONTENT OF REPORT.—The report under paragraph (1) shall include—

(A) an assessment of current barriers to entering accredited midwifery education programs, and recommendations for addressing such barriers, particularly for low-income people and people from racial and ethnic minority groups;

(B) an assessment of current barriers to entering and successfully completing accredited education programs for other health professional careers related to maternity care, including maternity care providers, mental and behavioral health care providers acting in accordance with State law, registered dietitians or nutrition professionals (as such term is defined in section 1861(vv)(2) of the Social Security Act (42 U.S.C. 1395x(vv)(2)), and lactation consultants certified by the International Board of Lactation Consultants Examiners, particularly for low-income people and people from racial and ethnic minority groups;

(C) an assessment of current barriers that prevent midwives from meeting the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, and recommendations for addressing such barriers, particularly for low-income people and people from racial and ethnic minority groups;

(D) an assessment of inequities in access to maternity care providers, mental or behavioral health care providers acting in accordance with State law, registered dietitians or nutrition professionals (as such term is defined in section 1861(vv)(2) of the Social Security Act (42 U.S.C. 1395x(vv)(2))), lactation consultants certified by the International Board of Lactation Consultants Examiners, and perinatal health workers, stratified by race, ethnicity, gender identity, geographic location, and insurance type and recommendations to promote greater access equity; and

(E) recommendations to promote greater equity in compensation for perinatal health workers under public and private insurers, par-

ticularly for such individuals from racially and ethnically diverse backgrounds.

(e) DEFINITIONS.—In this section:

(1) CULTURALLY CONGRUENT.—The term ''culturally congruent'', with respect to care or maternity care, means care that is in agreement with the preferred cultural values, beliefs, worldview, language, and practices of the health care consumer and other stakeholders.

(2) MATERNITY CARE PROVIDER.—The term ''maternity care provider'' means a health care provider who—

(A) is a physician, physician assistant, midwife who meets at a minimum the international definition of the midwife and global standards for midwifery education as established by the International Confederation of Midwives, nurse practitioner, or clinical nurse specialist; and

(B) has a focus on maternal or perinatal health.

(3) PERINATAL HEALTH WORKER.—The term ''perinatal health worker'' means a doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or

dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(4) POSTPARTUM AND POSTPARTUM PERIOD.—The terms ''postpartum'' and ''postpartum period'' refer to the 1-year period beginning on the last day of the pregnancy of an individual.

(5) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given such term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

SEC. 5214. MIDWIVES SCHOOLS AND PROGRAMS EXPANSION.

(a) MIDWIFERY SCHOOLS AND PROGRAMS.—

(1) IN GENERAL.—Title VII of the Public Health Service Act is amended by inserting after section 760 of such Act (42 U.S.C. 294k) the following:

''SEC. 760A. MIDWIFERY SCHOOLS AND PROGRAMS.

''(a) IN GENERAL.—The Secretary may award grants to institutions of higher education (as defined in subsections (a) and (b) of section 101 of the Higher Education Act of 1965) for the following:

''(1) Direct support of students in an accredited midwifery school or program.

''(2) Establishment or expansion of an accredited midwifery school or program.

''(3) Securing, preparing, or providing support for increasing the number of, qualified preceptors for training the students of an accredited midwifery school or program.

''(b) SPECIAL CONSIDERATIONS.—In awarding grants under subsection (a), the Secretary shall give special consideration to any institution of higher education that—

''(1) agrees to prioritize students who plan to practice in a health professional shortage area designated under section 332; and

''(2) demonstrates a focus on increasing racial and ethnic minority representation in midwifery education.

''(c) RESTRICTION.—The Secretary shall not provide any assistance under this section to be used with respect to a midwifery school or program within a school of nursing (as defined in section 801).

''(d) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $15,000,000 for the period of fiscal years 2023 through 2027.

''(2) ALLOCATION.—Of the amounts made available to carry out this section for any fiscal year, the Secretary shall use—

''(A) 50 percent to award grants for purposes specified in subsection (a)(1);

''(B) 25 percent to award grants for purposes specified in subsection (a)(2); and

''(C) 25 percent to award grants for purposes specified in subsection (a)(3).''.

(2) DEFINITIONS.—

(A) MIDWIFERY SCHOOL OR PROGRAM.—Section 799B(1)(A) of the Public Health Service Act (42 U.S.C. 295p(1)(A)) is amended—

(i) by inserting '' 'midwifery school or program','' before ''and 'school of chiropractic' '';

(ii) by inserting ''a degree or certificate in midwifery or an equivalent degree or certificate,'' before ''and a degree of doctor of chiropractic or an equivalent degree''; and

(iii) by striking ''any such school'' and inserting ''any such school or program''.

(B) ACCREDITED.—Section 799B(1)(E) of the Public Health Service Act (42 U.S.C.

295p(1)(E)) is amended by inserting '' a midwifery school or program,'' before ''or a graduate program in health administration''.

(b) NURSE-MIDWIVES.—Title VIII of the Public Health Service Act, as amended by section 5213, is further amended by inserting after section 812 of that Act, as added by section 5213, the following:

''SEC. 812A. MIDWIFERY EXPANSION PROGRAM.

''(a) IN GENERAL.—The Secretary may award grants to schools of nursing for the following:

''(1) Direct support of students in an accredited nurse-midwifery school or program.

''(2) Establishment or expansion of an accredited nurse-midwifery school or program.

''(3) Securing, preparing, or providing support for increasing the numbers of, preceptors at clinical training sites to precept students training to become certified nurse-midwives.

''(b) SPECIAL CONSIDERATIONS.—In awarding grants under subsection (a), the Secretary shall give special consideration to any school of nursing that—

''(1) agrees to prioritize students who choose to pursue an advanced education degree in nurse-midwifery to practice in a health professional shortage area designated under section 332; and

''(2) demonstrates a focus on increasing racial and ethnic minority representation in nurse-midwifery education.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $20,000,000 for the period of fiscal years 2023 through 2027.

''(2) ALLOCATION.—Of the amounts made available to carry out this section for any fiscal year, the Secretary shall use—

''(A) 50 percent to award grants for purposes specified in subsection (a)(1);

''(B) 25 to award grants for purposes specified in subsection (a)(2); and

''(C) 25 percent to award grants for purposes specified in subsection (a)(3).''.

SEC. 5215. GESTATIONAL DIABETES.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding after section 317H the following:

''SEC. 317H–1. GESTATIONAL DIABETES.

''(a) UNDERSTANDING AND MONITORING GESTATIONAL DIABETES.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease

Control and Prevention, in consultation with the Diabetes Mellitus Interagency Coordinating Committee established under section 429 and representatives of appropriate national health organizations, shall develop a multisite gestational diabetes research project within the diabetes program of the Centers for Disease Control and Prevention to expand and enhance surveillance data and public health research on gestational diabetes.

''(2) AREAS TO BE ADDRESSED.—The research project developed under paragraph (1) shall address—

''(A) procedures to establish accurate and efficient systems for the collection of gestational diabetes data within each State and commonwealth, territory, or possession of the United States;

''(B) the progress of collaborative activities with the National Vital Statistics System, the National Center for Health Statistics, and State health departments with respect to the standard birth certificate, in order to improve surveillance of gestational diabetes;

''(C) postpartum methods of tracking individuals with gestational diabetes after delivery

as well as targeted interventions proven to lower the incidence of type 2 diabetes in that population;

"(D) variations in the distribution of diagnosed and undiagnosed gestational diabetes, and of impaired fasting glucose tolerance and impaired fasting glucose, within and among groups of pregnant individuals; and

"(E) factors and culturally sensitive interventions that influence risks and reduce the incidence of gestational diabetes and related complications during childbirth, including cultural, behavioral, racial, ethnic, geographic, demographic, socioeconomic, and genetic factors.

"(3) REPORT.—Not later than 2 years after the date of the enactment of this section, and annually thereafter, the Secretary shall generate a report on the findings and recommendations of the research project including prevalence of gestational diabetes in the multisite area and disseminate the report to the appropriate Federal and non-Federal agencies.

"(b) EXPANSION OF GESTATIONAL DIABETES RESEARCH.—

"(1) IN GENERAL.—The Secretary shall expand and intensify public health research regarding gestational diabetes. Such research may include—

"(A) developing and testing novel approaches for improving postpartum diabetes testing or screening and for preventing type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes; and

"(B) conducting public health research to further understanding of the epidemiologic, socioenvironmental, behavioral, translation, and biomedical factors and health systems that influence the risk of gestational diabetes and the development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2023 through 2027.

"(c) DEMONSTRATION GRANTS TO LOWER THE RATE OF GESTATIONAL DIABETES.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants, on a

competitive basis, to eligible entities for demonstration projects that implement evidence-based interventions to reduce the incidence of gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and the development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes.

''(2) PRIORITY.—In making grants under this subsection, the Secretary shall give priority to projects focusing on—

''(A) helping individuals who can become pregnant who have 1 or more risk factors for developing gestational diabetes;

''(B) working with individuals who can become pregnant with a history of gestational diabetes during a previous pregnancy;

''(C) providing postpartum care for individuals who can become pregnant with gestational diabetes;

''(D) tracking cases where individuals who can become pregnant with a history of gestational diabetes developed type 2 diabetes;

''(E) educating mothers with a history of gestational diabetes about the increased risk of their child developing diabetes;

"(F) working to prevent gestational diabetes and prevent or delay the development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes; and

"(G) achieving outcomes designed to assess the efficacy and cost-effectiveness of interventions that can inform decisions on long-term sustainability, including third-party reimbursement.

"(3) APPLICATION.—An eligible entity desiring to receive a grant under this subsection shall submit to the Secretary—

"(A) an application at such time, in such manner, and containing such information as the Secretary may require; and

"(B) a plan to—

"(i) lower the rate of gestational diabetes during pregnancy; or

"(ii) develop methods of tracking individuals who can become pregnant with a history of gestational diabetes and develop effective interventions to lower the incidence of the recurrence of gestational dia-

betes in subsequent pregnancies and the development of type 2 diabetes.

"(4) USES OF FUNDS.—An eligible entity receiving a grant under this subsection shall use the grant funds to carry out demonstration projects described in paragraph (1), including—

"(A) expanding community-based health promotion education, activities, and incentives focused on the prevention of gestational diabetes and development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes;

"(B) aiding State- and Tribal-based diabetes prevention and control programs to collect, analyze, disseminate, and report surveillance data on individuals who can become pregnant with, and at risk for, gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, and, for individuals who can become pregnant with a history of gestational diabetes, the development of type 2 diabetes; and

"(C) training and encouraging health care providers—

"(i) to promote risk assessment, high-quality care, and self-management for ges-

tational diabetes and the recurrence of gestational diabetes in subsequent pregnancies; and

''(ii) to prevent the development of type 2 diabetes in individuals who can become pregnant with a history of gestational diabetes, and its complications in the practice settings of the health care providers.

''(5) REPORT.—Not later than 4 years after the date of the enactment of this section, the Secretary shall prepare and submit to the Congress a report concerning the results of the demonstration projects conducted through the grants awarded under this subsection.

''(6) DEFINITION OF ELIGIBLE ENTITY.—In this subsection, the term 'eligible entity' means a nonprofit organization (such as a nonprofit academic center or community health center) or a State, Tribal, or local health agency.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2023 through 2027.

''(d) POSTPARTUM FOLLOWUP REGARDING GESTATIONAL DIABETES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall work with the State- and Tribal-based diabetes prevention and control programs assisted by the Centers to encourage postpartum followup after gestational diabetes, as medically appropriate, for the purpose of reducing the incidence of gestational diabetes, the recurrence of gestational diabetes in subsequent pregnancies, the development of type 2 diabetes in individuals with a history of gestational diabetes, and related complications.''.

SEC. 5216. CONSUMER EDUCATION CAMPAIGN.

Section 229(b) of the Public Health Service Act (42 U.S.C. 237a(b)), as amended—

(1) in paragraph (6), at the end, by striking ''and'';

(2) in paragraph (7), at the end, by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(8) not later than one year after the date of the enactment of this paragraph, develop and implement a 4-year culturally and linguistically appropriate multimedia consumer education campaign that is designed to promote understanding and acceptance of evidence-based maternity practices and

models of care for optimal maternity outcomes among individuals of childbearing ages and families of such individuals and that—

"(A) highlights the importance of protecting, promoting, and supporting the innate capacities of childbearing individuals and their newborns for childbirth, breastfeeding, and attachment;

"(B) promotes understanding of the importance of using obstetric interventions when medically necessary and when supported by strong, high-quality evidence;

"(C) highlights the widespread overuse of maternity practices that have been shown to have benefit when used appropriately in situations of medical necessity, but which can expose pregnant individuals, infants, or both to risk of harm if used routinely and indiscriminately;

"(D) emphasizes the noninvasive maternity practices that have proven correlation or may be associated with improvement in outcomes with no detrimental side effects, and are significantly underused in the United States, including smoking cessation programs in pregnancy, group model prenatal care, continuous labor

support, nonsupine positions for birth, and external version to turn breech babies at term;

''(E) educates consumers about—

''(i) the qualifications of licensed providers of maternity care, including obstetrician-gynecologists, family physicians, certified nurse-midwives, certified midwives, and certified professional midwives; and

''(ii) the best evidence about the safety, satisfaction, outcomes, and costs of such providers;

''(F) informs consumers about the best available research comparing birth center births, planned home births, and hospital births, including information about each setting's safety, satisfaction, outcomes, and costs;

''(G) fosters participation in high-quality, evidence-based childbirth education that promotes a healthy and safe approach to pregnancy, childbirth, and early parenting; is taught by certified educators, peer counselors, and health professionals; and promotes informed decision making by childbearing individuals;

''(H) informs consumers about—

''(i) the effects of systemic, institutional, and interpersonal racism on the health, well-being, and outcomes of birthing people;

''(ii) the importance of respectful, culturally and linguistically appropriate, and culturally congruent care; and

''(iii) the value of community-based and community-led maternal care and support; and

''(I) is pilot tested for consumer comprehension, cultural sensitivity, and acceptance of the messages across geographically, racially, ethnically, and linguistically diverse populations;''.

SEC. 5217. BIBLIOGRAPHIC DATABASE OF SYSTEMATIC REVIEWS FOR CARE OF CHILDBEARING INDIVIDUALS AND NEWBORNS.

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, shall—

(1) make publicly available an online bibliographic database identifying systematic reviews, including an explanation of the level and quality of

evidence, for care of childbearing individuals and newborns; and

(2) initiate regular updates that incorporate newly issued and updated systematic reviews.

(b) SOURCES.—To aim for a comprehensive inventory of systematic reviews relevant to maternal and newborn care, the database shall identify reviews from diverse sources, including—

(1) scientific peer-reviewed journals;

(2) databases, including the Cochrane Database of Systematic Reviews; and

(3) internet websites of agencies and organizations throughout the world that produce such systematic reviews.

(c) FEATURES.—The database shall—

(1) provide bibliographic citations for each record within the database, and for each such citation include an explanation of the level and quality of evidence;

(2) include abstracts, as available;

(3) provide reference to companion documents as may exist for each review, such as evidence tables and guidelines or consumer educational materials developed from the review;

(4) provide links to the source of the full review and to any companion documents;

(5) provide links to the source of a previous version or update of the review;

(6) be searchable by intervention or other topic of the review, reported outcomes, author, title, and source; and

(7) offer to users periodic electronic notification of database updates relating to users' topics of interest.

(d) OUTREACH.—Not later than the first date the database is made publicly available and periodically thereafter, the Secretary of Health and Human Services shall publicize the availability, features, and uses of the database under this section to the stakeholders described in subsection (e).

(e) CONSULTATION.—For purposes of developing the database under this section and maintaining and updating such database, the Secretary of Health and Human Services shall convene and consult with an advisory committee composed of relevant stakeholders, including—

(1) Federal Medicaid administrators and State agencies administrating State plans under title XIX of the Social Security Act pursuant to section 1902(a)(5) of such Act (42 U.S.C. 1396a(a)(5));

(2) providers of maternity and newborn care from both academic and community-based settings, including obstetrician-gynecologists, family physicians, certified nurse midwives, certified midwives, certified professional midwives, physician assistants, perinatal nurses, pediatricians, and nurse practitioners;

(3) maternal-fetal medicine specialists;

(4) neonatologists;

(5) childbearing individuals and advocates for such individuals, including childbirth educators certified by a nationally accredited program, representing communities that are diverse in terms of race, ethnicity, indigenous status, and geographic area;

(6) employers and purchasers;

(7) health facility and system leaders, including both hospital and birth center facilities;

(8) journalists; and

(9) bibliographic informatics specialists.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $2,500,000 for each of the fiscal years 2023 through 2025 for the purpose of developing the database and such sums as may be necessary for each subsequent fiscal year for updating the database

and providing outreach and notification to users, as described in this section.

SEC. 5218. DEVELOPMENT OF INTERPROFESSIONAL MATERNITY CARE EDUCATIONAL MODELS AND TOOLS.

(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, acting in conjunction with the Administrator of Health Resources and Services Administration, shall convene, for a 1-year period, an Interprofessional Maternity Provider Education Commission (referred to in this section as the ''Commission'') to discuss and make recommendations for—

(1) a consensus standard physiologic maternity care curriculum that takes into account the core competencies for basic midwifery practice such as those developed by the American College of Nurse-Midwives and the North American Registry of Midwives, and the educational objectives for physicians practicing in obstetrics and gynecology as determined by the Council on Resident Education in Obstetrics and Gynecology;

(2) suggestions for multidisciplinary use of the consensus physiologic curriculum;

(3) strategies to integrate and coordinate education across maternity care disciplines, including recommendations to increase medical and midwifery student exposure to out-of-hospital birth;

(4) curriculum and strategies for continuing education of practicing perinatal professionals who have completed their undergraduate and graduate education; and

(5) pilot demonstrations of interprofessional educational models.

(b) PARTICIPANTS.—

(1) PROFESSIONS.—The Commission shall include maternity care educators, curriculum developers, service leaders, certification leaders, and accreditation leaders from the various professions that provide or support maternity care in the United States. Such professions shall include obstetrician gynecologists, certified nurse midwives or certified midwives, family practice physicians, nurse practitioners, physician assistants, certified professional midwives, perinatal nurses, doulas, lactation personnel, and community health workers.

(2) CONSUMER ADVOCATES.—The Commission shall also include representation from maternity care consumer advocates.

(c) CURRICULUM.—The consensus standard physiologic maternity care curriculum described in subsection (a)(1) shall—

(1) have a public health focus with a foundation in health promotion and disease prevention;

(2) foster physiologic childbearing and person and family centered care;

(3) reflect the extensive, growing research evidence about—

(A) the innate abilities and processes of the birthing person and the fetus or newborn for labor, birth, postpartum transition, breastfeeding, and attachment, when promoted, supported, and protected; and

(B) the effects of factors that disturb and disrupt these processes;

(4) integrate strategies to reduce maternal and infant morbidity and mortality;

(5) incorporate recommendations to ensure respectful, safe, and seamless consultation, referral, transport, and transfer of care when necessary;

(6) include cultural sensitivity and strategies to decrease inequities in maternity outcomes; and

(7) include implicit bias training.

(d) REPORT.—Not later than 6 months after the final meeting of the Commission, the Secretary of Health and Human Services shall—

(1) submit to Congress a report containing the recommendations made by the Commission under this section; and

(2) make such report publicly available.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of the fiscal years 2023 and 2024, and such sums as are necessary for each of the fiscal years 2025 through 2027.

SEC. 5219. DISSEMINATION OF THE QUALITY FAMILY PLANNING GUIDELINES.

(a) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention shall—

(1) develop a plan for outreach to publicly funded health care providers, including federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4))) and branches of the Indian Health Service, about the quality family planning guidelines referred to in section 5304; and

(2) award grants to eligible entities to implement such guidelines for all patients seeking family planning services.

(b) DEFINITION.—In this section, the term ''eligible entity'' means a publicly funded health care provider that serves persons of reproductive age.

Subtitle D—Federal Agency Coordination on Maternal Health

SEC. 5301. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.

(a) IN GENERAL.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''SEC. 229A. INTERAGENCY COORDINATING COMMITTEE ON THE PROMOTION OF OPTIMAL MATERNITY OUTCOMES.

''(a) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Women's Health under section 229 and in collaboration with the Federal officials specified in subsection (b), shall establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes (referred to in this section as the 'ICCPOM').

''(b) OTHER AGENCIES.—The officials specified in this subsection are the Secretary of Labor, the Secretary of Defense, the Secretary of Veterans Affairs, the Surgeon General, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Indian Health Service, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute of Child Health and Human Development, the Director of the Agency for Healthcare Research and Quality, the Assistant Secretary for Children and Families, the Deputy Assistant Secretary for Minority Health, the Director of the Office of Personnel Management, and such other Federal officials as the Secretary of Health and Human Services determines to be appropriate.

''(c) CHAIR.—The Deputy Assistant Secretary for Women's Health shall serve as the chair of the ICCPOM.

''(d) DUTIES.—The ICCPOM shall guide policy and program development across the Federal Government with respect to promotion of optimal maternity care, provided, however, that nothing in this section shall be construed as transferring regulatory or program authority from an agency to the ICCPOM.

''(e) CONSULTATIONS.—The ICCPOM shall actively seek the input of, and shall consult with, all appropriate and interested stakeholders, including State health departments, public health research and interest groups, foundations, childbearing individuals and their advocates, and maternity care professional associations and organizations, reflecting racially, ethnically, demographically, and geographically diverse communities.

''(f) ANNUAL REPORT.—

''(1) IN GENERAL.—The Secretary, on behalf of the ICCPOM, shall annually submit to Congress a report that summarizes—

''(A) all programs and policies of Federal agencies (including the Medicare Program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act) designed to promote optimal maternity care, focusing particularly on programs and policies that support the adoption of evidence based maternity care, as defined by timely, scientifically sound systematic reviews;

''(B) all programs and policies of Federal agencies (including the Medicare Program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such

Act) designed to address the problems of maternal mortality and morbidity, infant mortality, prematurity, and low birth weight, including such programs and policies designed to address racial and ethnic inequities with respect to each of such problems;

''(C) the extent of progress in reducing maternal mortality and infant mortality, low birth weight, and prematurity at State and national levels; and

''(D) such other information regarding optimal maternity care (such as quality and performance measures) as the Secretary determines to be appropriate.

''(2) REDUCING INEQUITIES WITH RESPECT TO INDIGENOUS STATUS.—The information specified in paragraph (1)(C) shall be included in each such report in a manner that disaggregates such information by race, ethnicity, and indigenous status in order to determine the extent of progress in reducing racial and ethnic inequities and inequities related to indigenous status.

''(3) CERTAIN INFORMATION.—Each report under paragraph (1) shall include information (disaggregated by race, ethnicity, and indigenous

status, as applicable) on the following rates, trends, and costs by State:

"(A) The rate and trend of primary cesarean deliveries and repeat cesarean deliveries.

"(B) The rate and trend of vaginal births after cesarean.

"(C) The rate and trend of vaginal breech births.

"(D) The rate and trend of induction of labor.

"(E) The rate and trend of freestanding birth center births.

"(F) The rate and trend of planned and unplanned home birth.

"(G) The rate and trends of attended births by different types of maternity care providers, including by an obstetrician-gynecologist, family practice physician, obstetrician-gynecologist physician assistant, certified nurse-midwife, certified midwife, and certified professional midwife.

"(H) The rate and trend of severe maternal morbidity.

"(I) The rates and trends of prenatal and postpartum anxiety and depression.

''(J) The rate and trend of pre-term birth.

''(K) The rate and trend of low birth weight.

''(L) The cost of maternity care disaggregated by place of birth and provider of care, including—

''(i) uncomplicated vaginal birth;

''(ii) complicated vaginal birth;

''(iii) uncomplicated cesarean birth; and

''(iv) complicated cesarean birth.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, in addition to amounts authorized to be appropriated under section 229(e), to carry out this section $1,000,000 for each of the fiscal years 2023 through 2027.''.

(b) CONFORMING AMENDMENTS.—

(1) INCLUSION AS DUTY OF HHS OFFICE ON WOMEN'S HEALTH.—Section 229(b) of such Act (42 U.S.C. 237a(b)), as amended by section 5216, is further amended by adding at the end the following new paragraph:

''(9) establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes in accordance with section 229A; and''.

(2) TREATMENT OF BIENNIAL REPORTS.—Section 229(d) of such Act (42 U.S.C. 237a(d)) is amended by inserting ''(other than under subsection (b)(9))'' after ''under this section''.

SEC. 5302. EXPANSION OF CDC PREVENTION RESEARCH CENTERS PROGRAM TO INCLUDE CENTERS ON OPTIMAL MATERNITY OUTCOMES.

(a) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall support the establishment of additional Prevention Research Centers under the Prevention Research Center Program administered by the Centers for Disease Control and Prevention. Such additional centers shall each be known as a Center for Excellence on Optimal Maternity Outcomes.

(b) RESEARCH.—Each Center for Excellence on Optimal Maternity Outcomes shall—

(1) conduct at least one focused program of research to improve maternity outcomes, including the reduction of cesarean birth rates, early elective inductions, prematurity rates, and low birth weight rates within an underserved population that has a disproportionately large burden of suboptimal maternity outcomes, including maternal mortality and morbidity, infant mortality, prematurity, or low

birth weight, which such program shall include developing performance and quality measures for accountability;

(2) work with partners on special interest projects, as specified by the Centers for Disease Control and Prevention and other relevant agencies within the Department of Health and Human Services, and on projects funded by other sources; and

(3) involve a minimum of two distinct birth setting models, such as—

(A) a hospital labor and delivery model and freestanding birth center model; or

(B) a hospital labor and delivery model and planned home birth model.

(c) INTERDISCIPLINARY PROVIDERS.—Each Center for Excellence on Optimal Maternity Outcomes shall include the following interdisciplinary providers of maternity care:

(1) Obstetrician-gynecologists.

(2) At least two of the following providers:

(A) Family practice physicians.

(B) Nurse practitioners.

(C) Physician assistants.

(D) Certified professional midwives, certified nurse-midwives, or certified midwives.

(d) SERVICES.—Research conducted by each Center for Excellence on Optimal Maternity Outcomes shall include at least 2 (and preferably more) of the following supportive provider services:

(1) Mental health.

(2) Doula labor support.

(3) Nutrition education.

(4) Childbirth education.

(5) Social work.

(6) Physical therapy or occupation therapy.

(7) Substance use disorder services.

(8) Home visiting.

(e) COORDINATION.—The programs of research at each of the Centers of Excellence on Optimal Maternity Outcomes shall complement and not replicate the work of the other.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of the fiscal years 2023 through 2027.

SEC. 5303. EXPANDING MODELS TO BE TESTED BY CENTER FOR MEDICARE AND MEDICAID INNOVATION TO EXPLICITLY INCLUDE MATERNITY CARE 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

their impact on quality, equity, and developmental outcomes, notwithstanding any other provision of this section.'';

(2) in subparagraph (C), by adding at the end the following:

''(ix) Whether the model includes a regular process for ensuring the provision of culturally and linguistically appropriate services.

''(x) Whether health care services and supportive services included in the model are tailored to community health and health-related social needs and provided by community-based and community-led providers.

''(xi) Whether the model is designed to mitigate harmful effects of discrimination on the basis of race, sex, disability, ethnicity, language, and age.''; and

(3) by adding at the end the following:

''(D) MANDATORY HEALTH EQUITY MODELS TO BE TESTED.—The Secretary shall select—

''(i) Medicaid global and episode-based payment models for culturally and linguis-

tically appropriate antepartum, labor and delivery, and postpartum doula services, including community-based doula services, that are—

''(I) structured to provide payment to doulas as individuals, health care entity staff, or members of a doula group or collective, or through a third-party administrator;

''(II) designed to reduce racial and intersecting health inequities;

''(III) designed to provide doulas providing support with an equitable and sustainable reimbursement rate;

''(IV) designed to reduce barriers to workforce entry for culturally and linguistically competent and racially congruent doulas to provide services to Medicaid enrollees ; and

''(V) designed with input from community-based doulas, maternal health advocates, reproductive justice advocates, and Medicaid beneficiaries;

''(ii) a Medicaid episode-based payment model for pregnancy-related services,

including health care services and supportive services to address health-related socials needs, during the prenatal, intrapartum, and postpartum periods, to improve health outcomes and reduce racial health inequities, and to be designed with input from maternity care providers, maternal health advocates, reproductive justice advocates, and Medicaid beneficiaries;

''(iii) a Medicaid alternative payment model for a pregnancy-related health home to improve health outcomes during and for one year after pregnancy and during the newborn period, and to reduce racial health inequities, designed with input from maternity care providers, maternal health advocates, reproductive justice advocates, and Medicaid beneficiaries;

''(iv) a Medicaid perinatal health worker service delivery model for culturally and linguistically appropriate and respectful health care and supportive services that are tailored to community health and health-related social needs, designed to improve health outcomes and mitigate harm-

ful effects of racism and other forms of discrimination, and provided by community-based and community-led providers; and

''(v) one or more models exclusively focused on early intervention and prevention for children enrolled in a State plan (or waiver of such plan) under title XIX or a State child health plan under title XXI using evidence-based interventions including parenting support programs, home-visiting services, and dyadic therapy treatment for children and adolescents at-risk.

Such models shall be selected and evaluated based on their impact on quality, equity, and developmental outcomes, notwithstanding any other provision of this section.''.

SEC. 5304. INTERAGENCY UPDATE TO THE QUALITY FAMILY PLANNING GUIDELINES.

(a) IN GENERAL.—Not later than six months after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention and the Office of Population Affairs shall review and expand the 2014 Quality Family Planning Guidelines to address—

(1) health inequities; and

(2) the importance of patient-directed contraceptive decision making.

(b) CONSULTATION.—In carrying out subsection (a), the Director of the Centers for Disease Control and Prevention and the Office of Population Affairs shall convene a meeting, and solicit the views of, stakeholders including experts on health inequities, experts on reproductive coercion, representatives of provider organizations, patient advocates, reproductive justice organizations, organizations that represent racial and ethnic minority communities, organizations that represent people with disabilities, organizations that represent LGBTQ persons, and organizations that represent people with limited English proficiency.

Subtitle E—Reproductive and Sexual Health

SEC. 5401. FINDINGS; SENSE OF CONGRESS ON URGENT BARRIERS TO ABORTION ACCESS AND VITAL SOLUTIONS.

(a) FINDINGS.—Congress finds the following:

(1) Affordable, comprehensive health insurance that includes coverage for a full range of pregnancy-related care, including abortion, is critical to the health of every person regardless of actual or perceived race, color, national origin, immigration status, sex (including sexual orientation, gender iden-

tity, pregnancy, childbirth, a medical condition relating to pregnancy or childbirth, or sex stereotyping), age, or disability status.

(2) Abortion services are essential to health care and access to those services is central to people's ability to participate equally in the economic and social life of the United States. Abortion access allows people who are pregnant to make their own decisions about their pregnancies, their families, and their lives.

(3) Reproductive justice seeks to address restrictions on reproductive health, including abortion, that perpetuate systems of oppression, lack of bodily autonomy, White supremacy, and anti-Black racism. The violent legacy of these systems of oppression has manifested in policies including enslavement, rape, and experimentation on Black people, forced sterilizations, medical experimentation on low-income people's reproductive systems, and the forcible removal of Indigenous children. Access to equitable reproductive health care, including abortion services, has always been deficient in the United States for Black, Indigenous, and other People of Color (BIPOC) and their families. Transgender, nonbinary, and gender expansive individuals, and spe-

cifically those who are Black, disabled, and at the intersections of multiple forms of oppression, also experience inequitable access to abortion services due to systemic violence. Centering abortion rights and access as a ''women's health'' issue restricts access to those with reproductive needs who do not identify as cisgender women. In order to work towards reproductive justice for all communities, transgender, nonbinary, and gender expansive individuals must be centered in conversations of abortion access. Improving abortion access for this community requires a gender-neutral approach to abortion care, rights, and justice policy.

(4) The legacy of restrictions on reproductive health, rights, and justice is not a dated vestige of a dark history. Access to abortion services is obstructed across the United States in various ways, including blockades of health care facilities and associated violence, prohibitions of, and restrictions on, insurance coverage, parental involvement laws (notification and consent), restrictions that shame and stigmatize people seeking abortion services, and medically unnecessary regulations that neither confer any health benefit nor further the safety of abortion services, but which harm people by delaying,

complicating access to, and reducing the availability of, abortion services. As of December 2, 2021, 19 States have enacted 106 restrictions, including 12 new abortion bans, making 2021 the year with the highest number of restrictions passed since *Roe* v. *Wade* was decided in 1973. Additionally, 21 States are poised to immediately ban or significantly restrict access to abortion services if the Supreme Court chooses to overturn or weaken *Roe* v. *Wade*. These unprecedented attacks on abortion rights and access fall especially heavily on people with low incomes, BIPOC, immigrants, young people, people with disabilities, those living in rural and other medically underserved areas, and transgender, nonbinary, and gender expansive individuals.

(5) Since 1976, the Federal Government has withheld funds for abortion coverage in most circumstances through the Hyde amendment and similar coverage restrictions, affecting individuals of reproductive age in the United States who are insured through the Medicaid program, as well as individuals who receive insurance or care through other Federal health plans and programs. Of women aged 15 to 44 enrolled in Medicaid in 2017, 55 percent lived in the 35 States and the District of Columbia that do not

cover abortion, except in limited circumstances. This amounts to roughly 7,300,000 women of reproductive age, including 3,100,000 women living below the Federal poverty level. Women of color are disproportionately likely to be insured by the Medicaid program, and nationwide, 32 percent of Black women and 27 percent of Hispanic women aged 15 to 44 were enrolled in Medicaid in 2017, compared with 16 percent of White women.

(6) Abortion-specific restrictions are even more compounded by the ongoing criminalization of people who are pregnant, including those who are incarcerated, living with HIV, or with substance use disorders. These communities already experience health inequities due to social, political, and environmental inequities, and restrictions on abortion services exacerbate these harms. Removing medically unjustified restrictions on abortion services would constitute one important step on the path toward realizing reproductive justice by ensuring that the full range of reproductive health care is accessible to all who need it.

(7) Abortion-specific restrictions are a tool of gender oppression, as they target health care services that are used primarily by individuals with re-

productive needs. These paternalistic restrictions rely on and reinforce harmful stereotypes about gender roles, people's decision making, and people's need for protection instead of support, undermining their ability to control their own lives and wellbeing. These restrictions harm the basic autonomy, dignity, and equality of individuals with reproductive health needs, and their ability to participate in the social and economic life of the Nation.

(8) Many abortion-specific restrictions do not confer any health or safety benefits on the patient. Instead, these restrictions have the purpose and effect of unduly burdening people's personal and private medical decisions to end their pregnancies by making access to abortion services more difficult, invasive, and costly, often forcing people to travel significant distances and make multiple unnecessary visits to the provider, and in some cases, foreclosing the option altogether.

(9) Congress has used its authority in the past to protect access to abortion services and health care providers' ability to provide abortion services. In the early 1990s, protests and blockades at health care facilities where abortion services were provided, and associated violence, increased dramatically and

reached crisis level, requiring congressional action. Congress passed the Freedom of Access to Clinic Entrances Act (Public Law 103–259; 108 Stat. 694) to address that situation and protect physical access to abortion services.

(10) Congressional action is necessary to put an end to harmful restrictions, to federally protect access to abortion services for everyone regardless of where they live, and to protect the ability of health care providers to provide these services in a safe and accessible manner.

(11) The Equal Access to Abortion Coverage in Health Insurance Act of 2021 or the EACH Act of 2021 (H.R. 2234, S. 1021) introduced in the 117th Congress, would reverse the Hyde amendment and related abortion coverage restrictions. It would create an enforceable statutory right for people who receive health coverage or care through enumerated Federal programs (including Medicaid, the Children's Health Insurance Program, Medicare, and the Indian Health Service, among others) and plans (including government-sponsored health insurance due to a current or former employment relationship) to receive abortion coverage. It would require the Federal Government to facilitate abortion access for in-

dividuals eligible to receive health care in Federal facilities or in facilitates with which it contracts to provide health care, such as immigration detention centers. It also prohibits the Federal Government from prohibiting, restricting, or otherwise inhibiting State or local governments or private health insurance issuers from providing abortion coverage.

(12) The Women's Health Protection Act of 2021 (H.R. 3755, S. 1975) introduced in the 117th Congress, would establish an enforceable statutory right for health care providers to provide, and abortion patients to receive, abortions free from medically unnecessary restrictions, limitations, and bans that delay, and at times, completely obstruct, access to abortion.

(b) SENSE OF CONGRESS.—It is the sense of Congress that eliminating the Hyde amendment, enacting the Equal Access to Abortion Coverage in Health Insurance Act of 2021, and enacting the Women's Health Protection Act of 2021, are critical to—

(1) promoting equitable abortion access, including coverage, for all who seek care;

(2) creating enforceable rights to receive, and receive coverage for, such care;

(3) advancing equitable access to comprehensive health coverage, which cannot be achieved without abortion coverage; and

(4) alleviating urgent racial, gender, and other inequities in health and health care and corresponding reproductive injustices.

SEC. 5402. EMERGENCY CONTRACEPTION EDUCATION AND INFORMATION PROGRAMS.

(a) EMERGENCY CONTRACEPTION PUBLIC EDUCATION PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop and disseminate to the public medically accurate and complete information on emergency contraceptives.

(2) DISSEMINATION.—The Secretary may disseminate medically accurate and complete information under paragraph (1) directly or through arrangements with nonprofit organizations, community health workers, including promotores, consumer groups, institutions of higher education, clinics, the media, and Federal, State, and local agencies.

(3) INFORMATION.—The information disseminated under paragraph (1) shall—

(A) include, at a minimum, a description of emergency contraceptives and an explanation of the use, safety, efficacy, affordability, and availability, including over-the-counter access, of such contraceptives and options for access to such contraceptives without cost-sharing through insurance and other programs; and

(B) be pilot tested for consumer comprehension, cultural and linguistic appropriateness, and acceptance of the messages across geographically, racially, ethnically, and linguistically diverse populations.

(b) EMERGENCY CONTRACEPTION INFORMATION PROGRAM FOR HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with major medical and public health organizations, shall develop and disseminate to health care providers, including pharmacists, information on emergency contraceptives.

(2) INFORMATION.—The information disseminated under paragraph (1) shall include, at a minimum—

(A) information describing the use, safety, efficacy, and availability of emergency contraceptives, and options for access without cost-sharing through insurance and other programs;

(B) a recommendation regarding the use of such contraceptives; and

(C) information explaining how to obtain copies of the information developed under subsection (a) for distribution to the patients of the providers.

(c) DEFINITIONS.—In this section:

(1) HEALTH CARE PROVIDER.—The term ''health care provider'' means an individual who is licensed or certified under State law to provide health care services and who is operating within the scope of such license. Such term shall include a pharmacist.

(2) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the same meaning given such term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section

such sums as may be necessary for each of the fiscal years 2023 through 2027.

SEC. 5403. ACCESS TO BIRTH CONTROL DUTIES OF PHARMACIES TO ENSURE PROVISION OF FDA-APPROVED CONTRACEPTION.

Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following:

"SEC. 249. DUTIES OF PHARMACIES TO ENSURE PROVISION OF FDA-APPROVED CONTRACEPTION.

''(a) IN GENERAL.—Subject to subsection (c), a pharmacy that receives Food and Drug Administration-approved drugs or devices in interstate commerce shall maintain compliance with the following:

''(1) If a customer requests a contraceptive or a medication related to a contraceptive, including emergency contraception, that is in stock, the pharmacy shall ensure that the contraceptive is provided to the customer without delay.

''(2) If a customer requests a contraceptive or a medication related to a contraceptive that is not in stock and the pharmacy in the normal course of business stocks contraception, the pharmacy shall immediately inform the customer that the contracep-

tive is not in stock and without delay offer the customer the following options:

"(A) If the customer prefers to obtain the contraceptive or a medication related to a contraceptive through a referral or transfer, the pharmacy shall—

"(i) locate a pharmacy of the customer's choice or the closest pharmacy confirmed to have the contraceptive or a medication related to a contraceptive in stock; and

"(ii) refer the customer or transfer the prescription to that pharmacy.

"(B) If the customer prefers for the pharmacy to order the contraceptive or a medication related to a contraceptive, the pharmacy shall obtain the contraceptive or medication under the pharmacy's standard procedure for expedited ordering of medication and notify the customer when the contraceptive or medication arrives.

"(3) The pharmacy shall ensure that—

"(A) the pharmacy does not operate an environment in which customers are intimidated, threatened, or harassed in the delivery of serv-

ices relating to a request for contraception or a medication related to a contraceptive;

"(B) the pharmacy's employees do not interfere with or obstruct the delivery of services relating to a request for contraception or a medication related to a contraceptive;

"(C) the pharmacy's employees do not intentionally misrepresent or deceive customers about the availability of a contraceptive or a medication related to a contraceptive, or the mechanism of action of such contraceptive or medication;

"(D) the pharmacy's employees do not breach medical confidentiality with respect to a request for a contraceptive or a medication related to a contraceptive or threaten to breach such confidentiality; or

"(E) the pharmacy's employees do not refuse to return a valid, lawful prescription for a contraceptive or a medication related to a contraceptive upon customer request.

"(b) CONTRACEPTIVES NOT ORDINARILY STOCKED.—Nothing in subsection (a)(2) shall be construed to require any pharmacy to comply with such subsection if the pharmacy does not ordinarily stock contra-

ceptives or a medication related to a contraceptive in the normal course of business.

''(c) REFUSALS PURSUANT TO STANDARD PHARMACY PRACTICE.—This section does not prohibit a pharmacy from refusing to provide a contraceptive or a medication related to a contraceptive to a customer in accordance with any of the following:

''(1) If it is unlawful to dispense the contraceptive or a medication related to a contraceptive to the customer without a valid, lawful prescription and no such prescription is presented.

''(2) If the customer is unable to pay for the contraceptive or the medication related to a contraceptive.

''(3) If the employee of the pharmacy refuses to provide the contraceptive or a medication related to a contraceptive on the basis of a professional clinical judgment.

''(d) RELATION TO OTHER LAW.—

''(1) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to invalidate or limit rights, remedies, procedures, or legal standards under title VII of the Civil Rights Act of 1964.

''(2) CERTAIN CLAIMS.—The Religious Freedom Restoration Act of 1993 shall not provide a

basis for a claim concerning, or a defense to a claim under, this section, or provide a basis for challenging the application or enforcement of this section.

''(e) PREEMPTION.—This section does not preempt any provision of State law or any professional obligation made applicable by a State board or other entity responsible for licensing or discipline of pharmacies or pharmacists, to the extent that such State law or professional obligation provides protections for customers that are greater than the protections provided by this section.

''(f) ENFORCEMENT.—

''(1) CIVIL PENALTY.—A pharmacy that violates a requirement of subsection (a) is liable to the United States for a civil penalty in an amount not exceeding $1,000 per day of violation, not to exceed $100,000 for all violations adjudicated in a single proceeding.

''(2) PRIVATE CAUSE OF ACTION.—Any person aggrieved as a result of a violation of a requirement of subsection (a) may, in any court of competent jurisdiction, commence a civil action against the pharmacy involved to obtain appropriate relief, including actual and punitive damages, injunctive relief, and a reasonable attorney's fee and cost.

''(3) LIMITATIONS.—A civil action under paragraph (1) or (2) may not be commenced against a pharmacy after the expiration of the 5-year period beginning on the date on which the pharmacy allegedly engaged in the violation involved.

''(g) DEFINITIONS.—In this section:

''(1) CONTRACEPTION.—The term 'contraception' or 'contraceptive' means any drug or device approved by the Food and Drug Administration to prevent pregnancy.

''(2) EMPLOYEE.—The term 'employee' means a person hired, by contract or any other form of an agreement, by a pharmacy.

''(3) MEDICATION RELATED TO A CONTRACEPTIVE.—The term 'medication related to a contraceptive' means any drug or device approved by the Food and Drug Administration that a medical professional determines necessary to use before or in conjunction with a contraceptive.

''(4) PHARMACY.—The term 'pharmacy' means an entity that—

''(A) is authorized by a State to engage in the business of selling prescription drugs at retail; and

''(B) employs one or more employees.

''(5) PRODUCT.—The term 'product' means a Food and Drug Administration-approved drug or device.

''(6) PROFESSIONAL CLINICAL JUDGMENT.—The term 'professional clinical judgment' means the use of professional knowledge and skills to form a clinical judgment, in accordance with prevailing medical standards.

''(7) WITHOUT DELAY.—The term 'without delay', with respect to a pharmacy providing, providing a referral for, or ordering contraception, or transferring the prescription for contraception, means within the usual and customary timeframe at the pharmacy for providing, providing a referral for, or ordering other products, or transferring the prescription for other products, respectively.

''(h) EFFECTIVE DATE.—This section shall take effect on the 31st day after the date of the enactment of this section, without regard to whether the Secretary has issued any guidance or final rule regarding this section.''.

SEC. 5404. REAL EDUCATION AND ACCESS FOR HEALTHY YOUTH.

(a) PURPOSE.—The purpose of this section is to provide young people with sex education and sexual health services that—

(1) promote and uphold the rights of young people to information and services that empower them to make decisions about their bodies, health, sexuality, families, and communities in all areas of life;

(2) are evidence-informed, comprehensive in scope, confidential, equitable, accessible, medically accurate and complete, age and developmentally appropriate, culturally responsive, and trauma-informed and resilience-oriented;

(3) provide information about the prevention, treatment, and care of pregnancy, sexually transmitted infections, and interpersonal violence;

(4) provide information about the importance of consent as a basis for healthy relationships and for autonomy in health care;

(5) provide information on gender roles and gender discrimination;

(6) provide information on the historical and current condition in which education and health systems, policies, programs, services, and practices have uniquely and adversely impacted Black, Indigenous, Latinx, Asian, Asian American and Pacific Islander, and other People of Color; and

(7) redress inequities in the delivery of sex education and sexual health services to marginalized young people.

(b) DEFINITIONS.—In this section:

(1) AGE AND DEVELOPMENTALLY APPROPRIATE.—The term ''age and developmentally appropriate'' means topics, messages, and teaching methods suitable to particular ages, age groups, or developmental levels, based on cognitive, emotional, social, and behavioral capacity of most young people at that age level.

(2) CHARACTERISTICS OF EFFECTIVE PROGRAMS.—The term ''characteristics of effective programs'' means the aspects of evidence-informed programs, including development, content, and implementation of such programs, that—

(A) have been shown to be effective in terms of increasing knowledge, clarifying values and attitudes, increasing skills, and impacting behavior; and

(B) are widely recognized by leading medical and public health agencies to be effective in changing sexual behaviors that lead to sexually transmitted infections, unintended pregnancy, and interpersonal violence among young people.

(3) CONSENT.—The term ''consent'' means affirmative, conscious, and voluntary agreement to engage in interpersonal, physical, or sexual activity.

(4) CULTURALLY RESPONSIVE.—The term ''culturally responsive'' means education and services that—

(A) embrace and actively engage and adjust to young people and their various cultural identities;

(B) recognize the ways in which many marginalized young people face unique barriers in our society that result in increased adverse health outcomes and associated stereotypes; and

(C) may address the ways in which racism has shaped national health care policy, the lasting historical trauma associated with reproductive health experiments and forced sterilizations of Black, Latinx, and Indigenous communities, or sexual stereotypes assigned to young People of Color or LGBTQ+ people.

(5) EVIDENCE-INFORMED.—The term ''evidence-informed'' means incorporates characteristics, content, or skills that have been proven to be effective through evaluation in changing sexual behavior.

(6) GENDER EXPRESSION.—The term ''gender expression'' means the expression of one's gender, such as through behavior, clothing, haircut, or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

(7) GENDER IDENTITY.—The term ''gender identity'' means the gender-related identity, appearance, mannerisms, or other gender-related characteristics of an individual, regardless of the individual's designated sex at birth.

(8) INCLUSIVE.—The term ''inclusive'' means content and skills that ensure marginalized young people are valued, respected, centered, and supported in sex education instruction and materials.

(9) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(10) INTERPERSONAL VIOLENCE.—The term ''interpersonal violence'' means abuse, assault, bullying, dating violence, domestic violence, harassment, intimate partner violence, or stalking.

(11) MARGINALIZED YOUNG PEOPLE.—The term ''marginalized young people'' means young peo-

ple who are disadvantaged by underlying structural barriers and social inequities, including young people who are—

(A) Black, Indigenous, and other People of Color;

(B) immigrants;

(C) in contact with the foster care system;

(D) in contact with the juvenile justice system;

(E) experiencing homelessness;

(F) pregnant or parenting;

(G) lesbian, gay, bisexual, transgender, or queer;

(H) living with HIV;

(I) living with disabilities;

(J) from families with low incomes; or

(K) living in rural areas.

(12) MEDICALLY ACCURATE AND COMPLETE.—The term ''medically accurate and complete'' means that—

(A) the information provided through the education is verified or supported by the weight of research conducted in compliance with accepted scientific methods and is published in peer-reviewed journals, where applicable; or

(B) the education contains information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

(13) RESILIENCE.—The term ''resilience'' means the ability to adapt to trauma and tragedy.

(14) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(15) SEX EDUCATION.—The term ''sex education'' means high quality teaching and learning that—

(A) is delivered, to the maximum extent practicable, following the National Sexuality Education Standards of the Future of Sex Education Initiative;

(B) is about a broad variety of topics related to sex and sexuality, including—

(i) puberty and adolescent development;

(ii) sexual and reproductive anatomy and physiology;

(iii) sexual orientation, gender identity, and gender expression;

(iv) contraception, pregnancy, and reproduction;

(v) HIV and other STIs;

(vi) consent and healthy relationships; and

(vii) interpersonal violence;

(C) explores values and beliefs about such topics; and

(D) helps young people in gaining the skills that are needed to navigate relationships and manage one's own sexual health.

(16) SEXUAL DEVELOPMENT.—The term ''sexual development'' means the lifelong process of physical, behavioral, cognitive, and emotional growth and change as it relates to an individual's sexuality and sexual maturation, including puberty, identity development, socio-cultural influences, and sexual behaviors.

(17) SEXUAL HEALTH SERVICES.—The term ''sexual health services'' includes—

(A) sexual health information, education, and counseling;

(B) all methods of contraception approved by the Food and Drug Administration;

(C) routine gynecological care, including human papillomavirus (HPV) vaccines and cancer screenings;

(D) pre-exposure prophylaxis or post-exposure prophylaxis;

(E) substance use and mental health services;

(F) interpersonal violence survivor services; and

(G) other prevention, care, or treatment services.

(18) SEXUAL ORIENTATION.—The term ''sexual orientation'' means an individual's romantic, emotional, or sexual attraction to other people.

(19) TRAUMA.—The term ''trauma'' means a response to an event, series of events, or set of circumstances that is experienced or witnessed by an individual or group of people as physically or emotionally harmful or life-threatening with lasting adverse effects on their functioning and mental, physical, social, emotional, or spiritual well-being.

(20) TRAUMA-INFORMED AND RESILIENCE-ORIENTED.—The term ''trauma-informed and resilience-oriented'' means an approach that realizes the prevalence of trauma, recognizes the various ways individuals, organizations, and communities may respond to trauma differently, recognizes that resil-

ience can be built, and responds by putting this knowledge into practice.

(21) YOUNG PEOPLE.—The term ''young people'' means individuals who are ages 10 through 29 at the time of commencement of participation in a project supported under this section.

(22) YOUTH-FRIENDLY SEXUAL HEALTH SERVICES.—The term ''youth-friendly sexual health servvices'' means sexual health services that are provided in a confidential, equitable, and accessible manner that makes it easy and comfortable for young people to seek out and receive services.

(c) GRANTS FOR SEX EDUCATION AT ELEMENTARY AND SECONDARY SCHOOLS AND YOUTH-SERVING ORGANIZATIONS.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out projects that provide young people with sex education.

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means a public or private entity that delivers health education to young people.

(4) APPLICATIONS.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to eligible entities that are—

(A) State educational agencies or local educational agencies; or

(B) Indian Tribes or Tribal organizations, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(6) USE OF FUNDS.—Each eligible entity that receives a grant under this subsection shall use the grant funds to carry out a project that provides young people with sex education.

(d) GRANTS FOR SEX EDUCATION AT INSTITUTIONS OF HIGHER EDUCATION.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Secretary of Education, shall

award grants, on a competitive basis, to institutions of higher education or consortia of such institutions to enable such institutions to provide students with age and developmentally appropriate sex education.

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) APPLICATIONS.—An institution of higher education or consortium of such institutions desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to an institution of higher education that—

(A) has an enrollment of needy students, as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

(B) is a Hispanic-serving institution, as defined in section 502(a) of such Act (20 U.S.C. 1101a(a));

(C) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(D) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(E) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(F) is a Predominantly Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(G) is a Native American-serving, nontribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(H) is an Asian American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(I) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(5) USES OF FUNDS.—An institution of higher education or consortium of such institutions receiving a grant under this subsection shall use grant funds to develop and implement a project to inte-

grate sex education into the institution of higher education in order to reach a large number of students, by carrying out 1 or more of the following activities:

(A) Adopting and incorporating age and developmentally appropriate sex education into student orientation, general education, or courses.

(B) Developing or adopting and implementing educational programming outside of class that delivers age and developmentally appropriate sex education to students.

(C) Developing or adopting and implementing innovative technology-based approaches to deliver age and developmentally appropriate sex education to students.

(D) Developing or adopting and implementing peer-led activities to generate discussion, educate, and raise awareness among students about age and developmentally appropriate sex education.

(E) Developing or adopting and implementing policies and practices to link students to sexual health services.

(e) GRANTS FOR EDUCATOR TRAINING.—

(1) PROGRAM AUTHORIZED.—The Secretary, in coordination with the Secretary of Education, shall award grants, on a competitive basis, to eligible entities to enable such eligible entities to carry out the activities described in paragraph (5).

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means—

(A) a State educational agency or local educational agency;

(B) an Indian Tribe or Tribal organization, as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304);

(C) a State or local department of health;

(D) an educational service agency;

(E) a nonprofit institution of higher education or a consortium of such institutions; or

(F) a national or statewide nonprofit organization or consortium of nonprofit organizations that has as its primary purpose the improvement of provision of sex education through training and effective teaching of sex education.

(4) APPLICATION.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) AUTHORIZED ACTIVITIES.—

(A) REQUIRED ACTIVITY.—Each eligible entity receiving a grant under this subsection shall use grant funds for professional development and training of relevant teachers, health educators, faculty, administrators, and staff, in order to increase effective teaching of sex education to young people.

(B) PERMISSIBLE ACTIVITIES.—Each eligible entity receiving a grant under this subsection may use grant funds to—

(i) provide training and support for educators about the content, skills, and professional disposition needed to implement sex education effectively;

(ii) develop and provide training and support to educators on incorporating anti-racist and gender inclusive policies and practices in sex education;

(iii) support the dissemination of information on effective practices and research findings concerning the teaching of sex education;

(iv) support research on—

(I) effective sex education teaching practices; and

(II) the development of assessment instruments and strategies to document—

(aa) young people's understanding of sex education; and

(bb) the effects of sex education;

(v) convene conferences on sex education, in order to effectively train educators in the provision of sex education; and

(vi) develop and disseminate appropriate research-based materials to foster sex education.

(C) SUBGRANTS.—Each eligible entity receiving a grant under this subsection may award subgrants to nonprofit organizations that possess a demonstrated record of providing

training to teachers, health educators, faculty, administrators, and staff on sex education to—

(i) train educators in sex education;

(ii) support internet or distance learning related to sex education;

(iii) promote rigorous academic standards and assessment techniques to guide and measure student performance in sex education;

(iv) encourage replication of best practices and model programs to promote sex education;

(v) develop and disseminate effective, research-based sex education learning materials; or

(vi) develop academic courses on the pedagogy of sex education at institutions of higher education.

(f) AUTHORIZATION OF GRANTS TO SUPPORT THE DELIVERY OF SEXUAL HEALTH SERVICES TO MARGINALIZED YOUNG PEOPLE.—

(1) PROGRAM AUTHORIZED.—The Secretary shall award grants, on a competitive basis, to eligible entities to enable such entities to provide youth-

friendly sexual health services to marginalized young people.

(2) DURATION.—Grants awarded under this subsection shall be for a period of 5 years.

(3) ELIGIBLE ENTITY.—In this subsection, the term ''eligible entity'' means—

(A) a public or private youth-serving organization; or

(B) a covered entity, as defined in section 340B of the Public Health Service Act (42 U.S.C. 256b).

(4) APPLICATIONS.—An eligible entity desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(5) USES OF FUNDS.—Each eligible entity that receives a grant under this subsection may use the grant funds to—

(A) develop and implement an evidence-informed project to deliver sexual health services to marginalized young people;

(B) establish, alter, or modify staff positions, service delivery policies and practices, service delivery locations, service delivery envi-

ronments, service delivery schedules, or other services components in order to increase youth-friendly sexual health services to marginalized young people;

(C) conduct outreach to marginalized young people to invite them to participate in the eligible entity's sexual health services and to provide feedback to inform improvements in the delivery of such services;

(D) establish and refine systems of referral to connect marginalized young people to other sexual health services and supportive services;

(E) establish partnerships and collaborations with entities providing services to marginalized young people to link such young people to sexual health services, such as by delivering health services at locations where they congregate, providing transportation to locations where sexual health services are provided, or other linkages to services approaches;

(F) provide evidence-informed, comprehensive in scope, confidential, equitable, accessible, medically accurate and complete, age and developmentally appropriate, culturally responsive, and trauma-informed and resilience-oriented

sexual health information to marginalized young people in the languages and cultural contexts that are most appropriate for the marginalized young people to be served by the eligible entity;

(G) promote effective communication regarding sexual health among marginalized young people; and

(H) provide training and support for eligible entity personnel and community members who work with marginalized young people about the content, skills, and professional disposition needed to provide youth-friendly sex education and youth-friendly sexual health services.

(g) REPORTING AND IMPACT EVALUATION.—

(1) GRANTEE REPORT TO SECRETARY.—For each year an eligible entity receives grant funds under subsection (c), (d), (e), or (f), the eligible entity shall submit to the Secretary a report that includes—

(A) the use of grant funds by the eligible entity;

(B) how the use of grant funds has increased the access of young people to sex education or sexual health services; and

(C) such other information as the Secretary may require.

(2) SECRETARY'S REPORT TO CONGRESS.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to Congress a report on the activities funded under this section. The Secretary's report to Congress shall include—

(A) a statement of how grants awarded by the Secretary meet the purposes described in subsection (a); and

(B) information about—

(i) the number of eligible entities that are receiving grant funds under subsections (c), (d), (e), and (f);

(ii) the specific activities supported by grant funds awarded under subsections (c), (d), (e), and (f);

(iii) the number of young people served by projects funded under subsections (c), (d), (e), and (f), in the aggregate and disaggregated and cross-tabulated by grant program, race and ethnicity, sex, sexual orientation, gender identity, and

other characteristics determined by the Secretary (except that such disaggregation or cross-tabulation shall not be required in a case in which the results would reveal personally identifiable information about an individual young person);

(iv) the number of teachers, health educators, faculty, school administrators, and staff trained under subsection (e); and

(v) the status of the evaluation required under paragraph (3).

(3) MULTI-YEAR EVALUATION.—

(A) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall enter into a contract with a nonprofit organization with experience in conducting impact evaluations to conduct a multi-year evaluation on the impact of the projects funded under subsections (c), (d), (e), and (f) and to report to Congress and the Secretary on the findings of such evaluation.

(B) EVALUATION.—The evaluation conducted under this paragraph shall—

(i) be conducted in a manner consistent with relevant, nationally recognized

professional and technical evaluation standards;

(ii) use sound statistical methods and techniques relating to the behavioral sciences, including quasi-experimental designs, inferential statistics, and other methodologies and techniques that allow for conclusions to be reached;

(iii) be carried out by an independent organization that has not received a grant under subsection (c), (d), (e), or (f); and

(iv) be designed to provide information on output measures and outcome measures to be determined by the Secretary.

(C) REPORT.—Not later than 6 years after the date of enactment of this Act, the organization conducting the evaluation under this paragraph shall prepare and submit to the appropriate committees of Congress and the Secretary a report on such evaluation. Such report shall be made publicly available, including on the website of the Department of Health and Human Services.

(h) NONDISCRIMINATION.—Activities funded under this section shall not discriminate on the basis of actual or perceived sex (including sexual orientation and gender identity), age, parental status, race, color, ethnicity, national origin, disability, or religion. Nothing in this section shall be construed to invalidate or limit rights, remedies, procedures, or legal standards available under any other Federal law or any law of a State or a political subdivision of a State, including the Civil Rights Act of 1964 (42 U.S.C. 2000a et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), and section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116).

(i) LIMITATION.—No Federal funds provided under this section may be used for sex education or sexual health services that—

(1) withhold health-promoting or life-saving information about sexuality-related topics, including HIV;

(2) are medically inaccurate or incomplete;

(3) promote gender or racial stereotypes or are unresponsive to gender or racial inequities;

(4) fail to address the needs of sexually active young people;

(5) fail to address the needs of pregnant or parenting young people;

(6) fail to address the needs of survivors of interpersonal violence;

(7) fail to address the needs of young people of all physical, developmental, or mental abilities;

(8) fail to be inclusive of individuals with varying gender identities, gender expressions, and sexual orientations; or

(9) are inconsistent with the ethical imperatives of medicine and public health.

(j) AMENDMENTS TO OTHER LAWS.—

(1) AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.—Section 2500 of the Public Health Service Act (42 U.S.C. 300ee) is amended by striking subsections (b) through (d) and inserting the following:

''(b) CONTENTS OF PROGRAMS.—All programs of education and information receiving funds under this title shall include information about the potential effects of intravenous substance use.''.

(2) AMENDMENTS TO THE ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965.—Section 8526

of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7906) is amended—

(A) by striking paragraphs (3), (5), and (6);

(B) in paragraph (2), by inserting ''or'' after the semicolon;

(C) by redesignating paragraph (4) as paragraph (3); and

(D) in paragraph (3), as redesignated by subparagraph (C), by striking the semicolon and inserting a period.

(k) FUNDING.—

(1) AUTHORIZATION.—For the purpose of carrying out this section, there is authorized to be appropriated $100,000,000 for each of fiscal years 2022 through 2027. Amounts appropriated under this paragraph shall remain available until expended.

(2) RESERVATIONS OF FUNDS.—

(A) IN GENERAL.—Of the amount authorized under paragraph (1), the Secretary shall reserve—

(i) not more than 30 percent for the purposes of awarding grants for sex education at elementary and secondary schools

and youth-serving organizations under subsection (c);

(ii) not more than 10 percent for the purpose of awarding grants for sex education at institutions of higher education under subsection (d);

(iii) not more than 15 percent for the purpose of awarding grants for educator training under subsection (e);

(iv) not more than 30 percent for the purpose of awarding grants for sexual health services for marginalized youth under subsection (f); and

(v) not less than 5 percent for the purpose of carrying out the reporting and impact evaluation required under subsection (g).

(B) RESEARCH, TRAINING AND TECHNICAL ASSISTANCE.—The Secretary shall reserve not less than 10 percent of the amount authorized under paragraph (1) for expenditures by the Secretary to provide, directly or through a competitive grant process, research, training, and technical assistance, including dissemination of research and information regarding effective

and promising practices, providing consultation and resources, and developing resources and materials to support the activities of recipients of grants. In carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in sex education and sexual health services standards setting, design, development, delivery, research, monitoring, and evaluation.

(3) REPROGRAMMING OF ABSTINENCE ONLY UNTIL MARRIAGE PROGRAM FUNDING.—The unobligated balance of funds made available to carry out section 510 of the Social Security Act (42 U.S.C. 710) (as in effect on the day before the date of enactment of this Act) are hereby transferred and shall be used by the Secretary to carry out this section. The amounts transferred and made available to carry out this section shall remain available until expended.

(4) REPEAL OF ABSTINENCE ONLY UNTIL MARRIAGE PROGRAM.—Section 510 of the Social Security Act (42 U.S.C. 710 et seq.) is repealed.

SEC. 5405. COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES.

(a) MEDICARE.—

(1) LIMITATION ON PAYMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by moving the indentation of subparagraph (W) 2 ems to the left;

(B) in subparagraph (X)—

(i) by moving the indentation 2 ems to the left; and

(ii) by striking ''and'' at the end;

(C) in subparagraph (Y), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (Y) the following new subparagraph:

''(Z) in the case of a hospital or critical access hospital, to adopt and enforce a policy to ensure compliance with the requirements of subsection (l) and to meet the requirements of such subsection.''.

(2) ASSISTANCE TO VICTIMS.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(l) COMPASSIONATE ASSISTANCE FOR RAPE EMERGENCIES.—

''(1) IN GENERAL.—For purposes of subsection (a)(1)(Z), a hospital meets the requirements of this

subsection if the hospital provides each of the services described in paragraph (2) to each individual, whether or not eligible for benefits under this title or under any other form of health insurance, who comes to the hospital on or after January 1, 2022, and—

''(A) who states to hospital personnel that they are victims of sexual assault;

''(B) who is accompanied by an individual who states to hospital personnel that the individual is a victim of sexual assault; or

''(C) whom hospital personnel, during the course of treatment and care for the individual, have reason to believe is a victim of sexual assault.

''(2) REQUIRED SERVICES DESCRIBED.—For purposes of paragraph (1), the services described in this subparagraph are the following:

''(A) Provision of medically and factually accurate and unbiased written and oral information about emergency contraception that—

''(i) is written in clear and concise language;

''(ii) is readily comprehensible;

''(iii) includes an explanation that emergency contraceptives—

''(I) have been approved by the Food and Drug Administration for individuals and are a safe and effective way to prevent pregnancy after unprotected intercourse or contraceptive failure if taken in a timely manner;

''(II) are more effective the sooner it is taken; and

''(III) do not cause an abortion and cannot interrupt an established pregnancy;

''(iv) meet such conditions regarding the provision of such information in languages other than English as the Secretary may establish; and

''(v) are provided without regard to the ability of the individual or their family to pay costs associated with the provision of such information to the individual.

''(B) Immediate offer to provide emergency contraception to the individual at the hospital and, in the case that such individual accepts such offer, immediate provision to such indi-

vidual of such contraception on the same day it is requested without regard to the inability of the individual or their family to pay costs associated with the offer and provision of such contraception.

''(C) Development and implementation of a written policy to ensure that an individual is present at the hospital, or on-call, who—

''(i) has authority to dispense or prescribe emergency contraception, independently, or under a protocol prepared by a physician for the administration of emergency contraception at the hospital to a victim of sexual assault; and

''(ii) is trained to comply with the requirements of this section.

''(D) Provision of medically and factually accurate and unbiased written and oral information and counseling about post-exposure prophylaxis (PEP) protocol for the prevention of HIV.

''(E) Immediate offer to begin PEP to the individual at the hospital except in cases where the medical professional's best judgement is that further evaluation is required or that such

a regimen will be substantially detrimental to the health of such individual. Such provision shall be offered regardless of the individual's ability to pay. Hospitals shall be responsible for ensuring adequate supply of PEP medications to provide to patients.

''(3) HOSPITAL DEFINED.—For purposes of this paragraph, the term 'hospital' includes a critical access hospital, as defined in section 1861(mm)(1).''.

(b) LIMITATION ON PAYMENT UNDER MEDICAID.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 4106(b)(2), is further amended—

(1) in paragraph (27), by striking ''or'' after the semicolon;

(2) in paragraph (28), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (28) the following new paragraph:

''(29) with respect to any amount expended for care or services furnished under the plan by a hospital on or after January 1, 2023, unless such hospital meets the requirements specified in section 1866(l) for purposes of title XVIII.''.

SEC. 5406. MENSTRUAL EQUITY FOR ALL ACT OF 2022.

(a) SHORT TITLE.—This section may be cited as the ''Menstrual Equity for All Act of 2022''.

(b) MENSTRUAL PRODUCTS FOR STUDENTS AT ELEMENTARY AND SECONDARY SCHOOLS.—

(1) IN GENERAL.—Section 4108(5)(C) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7118(5)(C)) is amended—

(A) in clause (vi), by striking ''or'' after the semicolon;

(B) in clause (vii), by inserting ''or'' after the semicolon; and

(C) by adding at the end the following:

''(viii) provide free menstrual products to students who use menstrual products;''.

(2) DEFINITIONS.—Section 4102 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7112) is amended—

(A) by redesignating paragraphs (6) through (8) as paragraphs (7) through (9), respectively; and

(B) by inserting after paragraph (5) the following:

''(6) MENSTRUAL PRODUCTS.—The term 'menstrual products' means sanitary napkins and tam-

pons that conform to applicable industry standards.''.

(3) RULEMAKING.—Not later than 1 year after the date of enactment of this section, the Secretary of Education, in consultation with the Secretary of Health and Human Services, shall promulgate rules with respect to the definition of ''menstrual products'' in paragraph (6) of section 4102 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7112), as amended by paragraph (2).

(c) MENSTRUAL PRODUCTS FOR STUDENTS AT INSTITUTIONS OF HIGHER EDUCATION.—

(1) PURPOSE.—The purpose of this section is to alleviate—

(A) the barriers to academic success faced by many college and graduate students due to the inability of such students to afford to purchase menstrual products; and

(B) the unique set of burdens that college and graduate students experiencing period poverty face that can be compounded by lack of access to basic needs such as housing, food, transportation, and access to physical and mental 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—

(A) support programs that provide free menstrual products to students; and

(B) report on best practices of such programs.

(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 percent of the grants awarded under this subsection shall be awarded to community colleges.

(5) GRANT USES.—A grant awarded under this 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—

(i) campus restroom facilities;

(ii) wellness centers; and

(iii) on-campus residential buildings;

(B) report on best practices of such programs;

(C) conduct outreach to students to encourage participation in menstrual equity programs and services;

(D) help eligible students apply for and enroll in local, State, and Federal public assistance programs; and

(E) coordinate and collaborate with government or community-based organizations to carry out the activities described in subparagraphs (A) through (D).

(6) PRIORITY.—In awarding grants under this subsection, the Secretary shall prioritize—

(A) institutions with Federal Pell Grant enrollment that is at least 25 percent of the total enrollment of such institution; and

(B) historically Black colleges and universities, Hispanic-serving institutions, Asian American and Native American Pacific Islander-serving institutions, and other minority serving institutions.

(7) MENSTRUAL PRODUCT DEFINED.—In this subsection, the term ''menstrual product'' means a sanitary napkin or tampon that conforms to industry standards.

(8) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of funds appropriated for a fiscal year to the Fund for the Improvement of Postsecondary Education under section 741 of the Higher Education Act of 1965 (20 U.S.C. 1138), $5,000,000 to carry out the grant program under this subsection.

(d) MENSTRUAL PRODUCTS FOR INCARCERATED INDIVIDUALS AND DETAINEES.—

(1) REQUIREMENT FOR STATES.—Not later than 180 days after the date of enactment of this section, and annually thereafter, the chief executive officer of each State that receives a grant under subpart 1 of part E of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10151 et seq.) (commonly referred to as the ''Edward Byrne Memorial Justice Assistance Grant Program'') shall submit to the Attorney General a certification, in such form and containing such information as the Attorney General may require, that—

(A) all incarcerated individuals and detainees in the custody of that State, a political subdivision thereof, or an agent of that State or a political subdivision thereof have access to menstrual products—

(i) on demand; and

(ii) at no cost to such individuals and detainees; and

(B) no visitor is prohibited from visiting an incarcerated individual due to the visitor's use of menstrual products.

(2) REDUCTION IN GRANT FUNDING.—If the chief executive officer of a State fails to submit a certification required under paragraph (1) during a fiscal year, the Attorney General shall reduce the amount that the State would have otherwise received under section 505 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10156) by 20 percent for the following fiscal year.

(3) REALLOCATION.—Amounts not allocated to a State under section 505 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (34 U.S.C. 10156) for a fiscal year pursuant to paragraph (2) shall be reallocated under such section to States that submit such certifications.

(4) MENSTRUAL PRODUCTS.—For the purposes of paragraph (1), the term ''menstrual products'' means sanitary napkins and tampons that conform to applicable industry standards.

(5) AVAILABILITY FOR FEDERAL PRISONERS.—The Attorney General shall issue rules requiring, and the Director of the Bureau of Prisons shall take such actions as may be necessary to ensure—

(A) the distribution and accessibility (without charge) of menstrual products to prisoners in the custody of the Bureau of Prisons, including any prisoner in a Federal penal or correctional institution, any Federal prisoner in a State penal or correctional institution, and any Federal prisoner in a facility administered by a private detention entity; and

(B) that each prisoner described in subparagraph (A) who requires menstrual products may receive them in sufficient quantity.

(6) AVAILABILITY FOR DETAINEES.—The Secretary of Homeland Security shall take such actions as may be necessary to ensure that menstrual products are distributed and made accessible to each alien detained by the Secretary of Homeland Secu-

rity, including any alien in a facility administered by a private detention entity, at no expense to the alien.

(e) MENSTRUAL PRODUCTS AVAILABILITY FOR HOMELESS INDIVIDUALS UNDER EMERGENCY FOOD AND SHELTER GRANT PROGRAM.—Section 316(a) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11346(a)) is amended—

(1) in paragraph (5), by striking ''and'' at the end;

(2) in paragraph (6), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new paragraph:

''(7) guidelines that ensure that amounts provided under the program to private nonprofit organizations and local governments may be used to provide sanitary napkins and tampons that conform to applicable industry standards.''.

(f) MENSTRUAL PRODUCTS COVERED BY MEDICAID.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2007(d)(3) and 5201(a)(5)(G)(i), is amended—

(A) in subsection (a)—

(i) by redesignating paragraph (32) as paragraph (33);

(ii) in paragraph (31), by striking ''and'' after the semicolon; and

(iii) by inserting after paragraph (31) the following new paragraph:

''(32) menstrual products (as defined in subsection (oo)); and''; and

(B) by adding at the end the following:

''(oo) MENSTRUAL PRODUCTS.—For purposes of subsection (a)(32), the term 'menstrual products' means sanitary napkins, tampons, liners, cups, and similar items used by individuals with respect to menstruation and that conform to industry standards.''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall apply with respect to medical assistance furnished during or after the first calendar quarter beginning on or after the date that is 1 year after the date of the enactment of this section.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396

et seq.) that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this section, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this section. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(g) MENSTRUAL PRODUCTS FOR EMPLOYEES.—Section 6 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655) is amended by adding at the end the following:

''(h) The Secretary shall by rule promulgate a requirement that each employer with not less than 100 employees provide menstrual products free of charge for employees of the employer. For purposes of the preceding

sentence, 'menstrual products' means sanitary napkins and tampons that conform to applicable industry standards.''.

(h) MENSTRUAL PRODUCTS IN FEDERAL BUILDINGS.—

(1) DEFINITIONS.—In this subsection:

(A) APPROPRIATE AUTHORITY.—The term ''appropriate authority'' means the head of a Federal agency, the Architect of the Capitol, or any other official authority responsible for the operation of a covered public building.

(B) COVERED PUBLIC BUILDING.—

(i) IN GENERAL.—The term ''covered public building'' means a public building (as defined in section 3301(a) of title 40, United States Code) that is open to the public and contains a public restroom.

(ii) INCLUSIONS.—The term ''covered public building'' includes specified buildings and grounds (as defined in section 6301 of title 40, United States Code) and the Capitol Buildings (as defined in section 5101 of that title).

(C) COVERED RESTROOM.—The term ''covered restroom'' means a public restroom in a covered public building.

(D) MENSTRUAL PRODUCTS.—The term ''menstrual products'' means sanitary napkins and tampons that conform to applicable industry standards.

(2) REQUIREMENT.—Each appropriate authority shall ensure that menstrual products are stocked in, and available free of charge in, each covered restroom in each covered public building under the jurisdiction of that authority.

SEC. 5407. ADDITIONAL FOCUS AREA FOR THE OFFICE ON WOMEN'S HEALTH.

Section 229(b) of the Public Health Service Act (42 U.S.C. 237a(b)), as amended by sections 5216 and 5301, is further amended by adding at the end the following:

''(10) facilitate policymakers, health system leaders and providers, consumers, and other stakeholders in understanding optimal maternity care and support for the provision of such care, including the priorities of—

''(A) protecting, promoting, and supporting the innate capacities of childbearing individuals

and their newborns for childbirth, breastfeeding, and attachment;

"(B) using obstetric interventions only when such interventions are supported by strong, high-quality evidence, and minimizing overuse of maternity practices that have been shown to have benefit in limited situations and that can expose people, infants, or both to risk of harm if used routinely and indiscriminately, including continuous electronic fetal monitoring, labor induction, epidural analgesia, primary cesarean section, and routine repeat cesarean birth;

"(C) reliably incorporating noninvasive, evidence-based practices that have a documented correlation with considerable improvement in outcomes with no detrimental side effects, such as smoking cessation programs in pregnancy, maternal immunizations, and proven models (including group prenatal care, midwifery care, and doula support) that integrate health assessment, education, and support into a unified program and supporting evidence-based breastfeeding promotion efforts with re-

spect for a breastfeeding individual's personal decision making;

''(D) a shared understanding of the qualifications of licensed providers of maternity care and the best evidence about the safety, satisfaction, outcomes, and costs of maternity care, and appropriate deployment of such caregivers within the maternity care workforce to address the needs of childbearing individuals and newborns and the growing shortage of maternity caregivers;

''(E) a shared understanding of the results of the best available research comparing hospital, birth center, and planned home births, including information about each setting's safety, satisfaction, outcomes, and costs;

''(F) a shared understanding of the importance for the safety and choices of birthing families of an integrated maternity care system with seamless processes for consultation, shared care, transfer and transport across maternity care settings, and providers when birthing people and their newborns require a higher level of care;

''(G) high-quality, evidence-based childbirth education that—

''(i) promotes a healthy and safe approach to pregnancy, childbirth, and early parenting;

''(ii) is taught by certified educators, peer counselors, and health professionals; and

''(iii) promotes informed decision making by childbearing individuals; and

''(H) developing measures that enable a more robust, balanced set of standardized maternity care measures, including performance and quality measures.''.

SEC. 5408. INCLUDING SERVICES FURNISHED BY CERTAIN STUDENTS, INTERNS, AND RESIDENTS SUPERVISED BY CERTIFIED NURSE MIDWIVES OR CERTIFIED MIDWIVES WITHIN INPATIENT HOSPITAL SERVICES UNDER MEDICARE.

(a) IN GENERAL.—Section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b)) is amended—

(1) in paragraph (6), by striking ''; or'' at the end and inserting '', or in the case of services in a hospital or osteopathic hospital by a student midwife or an intern or resident-in-training under a teaching

program previously described in this paragraph who is in the field of obstetrics and gynecology, if such student midwife, intern, or resident-in-training is supervised by a certified nurse-midwife or certified midwife to the extent permitted under applicable State law and as may be authorized by the hospital;'';

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new paragraph:

''(8) a certified nurse-midwife or certified midwife where the hospital has a teaching program approved as specified in paragraph (6), if—

''(A) the hospital elects to receive any payment due under this title for reasonable costs of such services; and

''(B) all certified nurse-midwives or certified midwives in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 5409. GRANTS TO PROFESSIONAL ORGANIZATIONS AND MINORITY-SERVING INSTITUTIONS TO INCREASE DIVERSITY IN MATERNAL, REPRODUCTIVE, AND SEXUAL HEALTH PROFESSIONALS.

(a) GRANTS TO HEALTH PROFESSIONAL ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall carry out a grant program under which the Secretary may make to eligible organizations—

(A) for fiscal year 2023, planning grants described in paragraph (2); and

(B) for the subsequent 4-year period, implementation grants described in paragraph (3).

(2) PLANNING GRANTS.—

(A) IN GENERAL.—Planning grants described in this paragraph are grants for the following purposes:

(i) To collect data and identify any workforce inequalities, with respect to a health profession, at each of the following areas along the health professional continuum:

(I) Pipeline availability, with respect to students at the high school and college or university levels considering, and working toward, entrance in the profession, including barriers triggered by criminal records.

(II) Entrance into the training program for the profession.

(III) Graduation from such training program.

(IV) Entrance into practice, including barriers triggered by criminal records.

(V) Retention in practice for more than a 5-year period.

(ii) To develop one or more strategies to address the workforce inequalities within the health profession, as identified under (and in response to the findings pursuant to) clause (i).

(B) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible health professional organization shall submit to the Secretary an application in such form and

manner and containing such information as specified by the Secretary.

(C) AMOUNT.—Each grant awarded under this paragraph shall be for an amount not to exceed $300,000.

(D) REPORT.—Each recipient of a grant under this paragraph shall submit to the Secretary a report containing—

(i) information on the extent and distribution of workforce inequities identified through the grant; and

(ii) reasonable objectives and strategies developed to address such inequalities within a 5-, 10-, and 25-year period.

(3) IMPLEMENTATION GRANTS.—

(A) IN GENERAL.—Implementation grants described in this paragraph are grants to implement one or more of the strategies developed pursuant to a planning grant awarded under paragraph (2).

(B) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible health professional organization shall submit to the Secretary an application in such form and

manner as specified by the Secretary. Each such application shall contain information on—

(i) the capability of the organization to carry out a strategy described in subparagraph (A);

(ii) the involvement of partners or coalitions; and

(iii) the organization's plans for developing sustainability of the efforts after the culmination of the grant cycle, and any other information specified by the Secretary.

(C) AMOUNT; DURATION.—Each grant awarded under this paragraph shall be for an amount not to exceed $500,000 each year of the grant. The term of a grant under this subsection shall not exceed 4 years.

(D) REPORTS.—For each of the first 3 years for which an eligible health professional organization is awarded a grant under this paragraph, the organization shall submit to the Secretary of Health and Human Services a report on the activities carried out by such organization through the grant during such year and objectives for the subsequent year. For the

fourth year for which an eligible health professional organization is awarded a grant under this paragraph, the organization shall submit to the Secretary a report that includes an analysis of all the activities carried out by the organization through the grant and a detailed plan for the continuation of the organization's outreach efforts.

(4) ELIGIBLE HEALTH PROFESSIONAL ORGANIZATION DEFINED.—For purposes of this subsection, the term ''eligible health professional organization'' means a professional organization representing obstetrician-gynecologists, certified nurse midwives, certified midwives, family practice physicians, nurse practitioners whose scope of practice includes maternity or sexual and reproductive health care, physician assistants whose scope of practice includes obstetrical or sexual and reproductive health care, or certified professional midwives, adolescent medicine specialists, and pediatricians who provide sexual and reproductive health care.

(b) GRANTS TO MINORITY-SERVING INSTITUTIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration

(referred to in this section as the ''Secretary''), shall carry out a grant program under which the Secretary may make to eligible minority-serving institutions—

(A) for fiscal years 2023 and 2024, planning grants described in paragraph (2); and

(B) for the subsequent ten-year period, implementation grants described in paragraph (3).

(2) PLANNING GRANTS.—

(A) IN GENERAL.—Planning grants described in this paragraph are grants for plans relating to the following purposes:

(i) To develop or expand academic programs to educate maternity care clinicians and maternity care support personnel, including—

(I) nurses with the intention of providing maternity, newborn, or sexual and reproductive health care;

(II) nurse-practitioners whose scope of practice includes maternity, newborn, or sexual and reproductive health care; and

(III) maternity care support personnel, such as doulas and lactation counselors.

(ii) To develop or expand academic programs to educate obstetrician-gynecologists.

(B) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible minority-serving institution shall submit to the Secretary an application in such form and manner and containing such information as specified by the Secretary.

(C) AMOUNT.—Each grant awarded under this paragraph shall be for an amount not to exceed $400,000 for each of two years.

(D) REPORT.—Each recipient of a grant under this paragraph shall submit to the Secretary an annual report describing the planned development or expansion of educational programs, including—

(i) the types of clinical or support personnel and the degrees or certificates to be conferred;

(ii) the associated curricula;

(iii) the faculty and their capabilities and commitments, including any plans for recruitment;

(iv) the anticipated number of students to be enrolled and plans for their recruitment and social, emotional, and financial support; and

(v) the objectives and strategies for addressing inequities and preparing students to provide high-quality culturally congruent care.

(3) IMPLEMENTATION GRANTS.—

(A) IN GENERAL.—Implementation grants described in this paragraph are grants to implement the strategies developed under paragraph (2).

(B) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible minority-serving institution shall submit to the Secretary of Health and Human Services an application in such form and manner as specified by the Secretary. Each such application shall contain information on the capability of the institution to carry out a strategy described in paragraph (2), plans for sustainability of the

program after the culmination of the grant cycle, and any other information specified by the Secretary.

(C) AMOUNT.—Each grant under this paragraph shall be for an amount not to exceed $1,000,000 each year during the 10-year period of the grant.

(D) REPORTS.—

(i) INITIAL PERIOD.—For each of the first 9 years for which an eligible minority-serving institution is awarded a grant under this paragraph, the institution shall submit a report to the Secretary on the activities carried out by such institution through the grant during such year and objectives for the subsequent year.

(ii) FINAL YEAR.—For the tenth year for which an eligible minority-serving institution is awarded a grant under this paragraph, the organization shall submit to the Secretary a report that includes an analysis of all the activities carried out by the institution through the grant and a detailed plan for continuation of the educational program.

(4) ELIGIBLE MINORITY-SERVING INSTITUTIONS DEFINED.—For the purposes of this subsection, the term ''minority-serving institution'' means a historically Black college or university, Tribal college or university, Latino-serving institution, Asian American and Pacific Islander serving institution, or other minority-serving institution of higher education.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out—

(1) subsection (a), $2,000,000 for fiscal year 2023 and $3,000,000 for each of the fiscal years 2024 through 2027; and

(2) subsection (b), $4,000,000 for each of fiscal years 2023 and 2024 and $10,000,000 for each of fiscal years 2025 through 2034.

Subtitle F—Children's Health

SEC. 5501. CARING FOR KIDS ACT.

(a) PERMANENT EXTENSION OF CHILDREN'S HEALTH INSURANCE PROGRAM.—

(1) IN GENERAL.—Section 2104(a)(28) of the Social Security Act (42 U.S.C. 1397dd(a)(28)) is amended to read as follows:

''(28) for fiscal year 2027 and each subsequent year, such sums as are necessary to fund allotments to States under subsections (c) and (m).''.

(2) ALLOTMENTS.—

(A) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—

(i) in paragraph (2)(B)(i), by striking '',, 2023, and 2027'' and inserting ''and 2023'';

(ii) in paragraph (7)—

(I) in subparagraph (A), by striking ''and ending with fiscal year 2027,''; and

(II) in the flush left matter at the end, by striking ''or fiscal year 2026'' and inserting ''fiscal year 2026, or a subsequent even-numbered fiscal year'';

(iii) in paragraph (9)—

(I) by striking ''(10), or (11)'' and inserting ''or (10)''; and

(II) by striking ''2023, or 2027,'' and inserting ''or 2023''; and

(iv) by striking paragraph (11).

(B) CONFORMING AMENDMENT.—Section 50101(b)(2) of the Bipartisan Budget Act of 2018 (Public Law 115–123) is repealed.

(b) PERMANENT EXTENSIONS OF OTHER PROGRAMS AND DEMONSTRATION PROJECTS.—

(1) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1139A(i)(1) of the Social Security Act (42 U.S.C. 1320b–9a(i)(1)) is amended—

(A) in subparagraph (C), by striking at the end ''and'';

(B) in subparagraph (D), by striking the period at the end and insert a semicolon; and

(C) by adding at the end the following new subparagraphs:

''(E) for fiscal year 2028, $15,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)); and

''(F) for a subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over such previous fiscal year, for the purpose of carrying out this section (other than subsections (e), (f), and (g)).''.

(2) EXPRESS LANE ELIGIBILITY OPTION.—Section 1902(e)(13) of the Social Security Act (42 U.S.C. 1396a(e)(13)) is amended by striking subparagraph (I).

(3) ASSURANCE OF AFFORDABILITY STANDARD FOR CHILDREN AND FAMILIES.—

(A) IN GENERAL.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)) is amended—

(i) in the paragraph heading, by striking ''THROUGH SEPTEMBER 30, 2027''; and

(ii) in subparagraph (A), in the matter preceding clause (i)—

(I) by striking ''During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2027'' and inserting ''Beginning on the date of the enactment of the Patient Protection and Affordable Care Act'';

(II) by striking ''During the period that begins on October 1, 2019, and ends on September 30, 2027''

and inserting ''Beginning on October 1, 2019''; and

(III) by striking ''The preceding sentences shall not be construed as preventing a State during any such periods from'' and inserting ''The preceding sentences shall not be construed as preventing a State from''.

(B) CONFORMING AMENDMENTS.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)) is amended—

(i) in the paragraph heading, by striking ''THROUGH SEPTEMBER 30, 2027''; and

(ii) by striking ''through September 30'' and all that follows through ''ends on September 30, 2027'' and inserting ''(but beginning on October 1, 2019,''.

(4) QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)) is amended—

(A) in the paragraph heading, by striking ''FOR FISCAL YEARS 2009 THROUGH 2027'' and inserting ''AFTER FISCAL YEAR 2008''; and

(B) in subparagraph (A), by striking ''for any of fiscal years 2009 through 2027'' and inserting ''for any fiscal year after fiscal year 2008''.

(5) OUTREACH AND ENROLLMENT PROGRAM.—Section 2113 of the Social Security Act (42 U.S.C. 1397mm) is amended—

(A) in subsection (a)—

(i) in paragraph (1), by striking ''during the period of fiscal years 2009 through 2027'' and inserting '', beginning with fiscal year 2009,'';

(ii) in paragraph (2)—

(I) by striking ''10 percent of such amounts'' and inserting ''10 percent of such amounts for the period or the fiscal year for which such amounts are appropriated''; and

(II) by striking ''during such period'' and inserting '', during such period or such fiscal year,''; and

(iii) in paragraph (3), by striking ''For the period of fiscal years 2024 through 2027, an amount equal to 10 percent of such amounts'' and inserting ''Be-

ginning with fiscal year 2024, an amount equal to 10 percent of such amounts for the period or the fiscal year for which such amounts are appropriated''; and

(B) in subsection (g)—

(i) by striking ''2017,,'' and inserting ''2017,'';

(ii) by striking ''and $48,000,000'' and inserting ''$48,000,000''; and

(iii) by inserting after ''through 2027'' the following: '', $12,000,000 for fiscal year 2028, and, for each fiscal year after fiscal year 2028, the amount appropriated under this subsection for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over such previous fiscal year''.

(6) CHILD ENROLLMENT CONTINGENCY FUND.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—

(A) in paragraph (2)—

(i) in subparagraph (A)(ii)—

(I) by striking ''and 2024 through 2026'' and inserting ''beginning with fiscal year 2024''; and

(II) by striking ''2023, and 2027'' and inserting '', and 2023''; and

(ii) in subparagraph (B)—

(I) by striking ''2024 through 2026'' and inserting ''beginning with fiscal year 2024''; and

(II) by striking ''2023, and 2027'' and inserting '', and 2023''; and

(B) in paragraph (3)(A)—

(i) by striking ''fiscal years 2024 through 2026'' and inserting ''beginning with fiscal year 2024''; and

(ii) by striking ''2023, or 2027'' and inserting '', or 2023''.

SEC. 5502. END DIAPER NEED ACT OF 2021.

(a) TARGETED FUNDING FOR DIAPER ASSISTANCE (INCLUDING DIAPERING SUPPLIES AND ADULT INCONTINENCE MATERIALS AND SUPPLIES) THROUGH THE SOCIAL SERVICES BLOCK GRANT PROGRAM.—

(1) INCREASE IN FUNDING FOR SOCIAL SERVICES BLOCK GRANT PROGRAM.—

(A) IN GENERAL.—The amount specified in subsection (c) of section 2003 of the Social Security Act (42 U.S.C. 1397b) for purposes of subsections (a) and (b) of such section is deemed to be $1,900,000,000 for each of fiscal years 2023 through 2026, of which, the amount equal to $200,000,000, reduced by the amounts reserved under subparagraph (B)(ii) for each such fiscal year, shall be obligated by States in accordance with paragraph (2).

(B) APPROPRIATION.—

(i) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated $200,000,000 for each of fiscal years 2023 through 2026, to carry out this subsection.

(ii) RESERVATIONS.—

(I) PURPOSES.—The Secretary shall reserve, from the amount appropriated under clause (i) to carry out this subsection—

(aa) for each of fiscal years 2023 through 2026, not more than 2 percent of the amount appropriated for the fiscal year for purposes of entering into an agreement with a national entity described in clause (iii) to assist in providing technical assistance and training, to support effective policy, practice, research, and cross-system collaboration among grantees and subgrantees, and to assist in the administration of the program described in this subsection; and

(bb) for fiscal year 2023, an amount, not to exceed $2,000,000, for purposes of conducting an evaluation under paragraph (4).

(II) NO STATE ENTITLEMENT TO RESERVED FUNDS.—The State entitlement under section 2002(a) of the Social Security Act (42 U.S.C.

1397a(a)) shall not apply to the amounts reserved under subclause (I).

(iii) NATIONAL ENTITY DESCRIBED.—A national entity described in this clause is a nonprofit organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code, that—

(I) has experience in more than 1 State in the area of—

(aa) community distributions of basic need services, including experience collecting, warehousing, and distributing basic necessities such as diapers, food, or menstrual products;

(bb) child care;

(cc) child development activities in low-income communities; or

(dd) motherhood, fatherhood, or parent education efforts serving low-income parents of young children;

(II) demonstrates competency to implement a project, provide fiscal accountability, collect data, and prepare reports and other necessary documentation; and

(III) demonstrates a willingness to share information with researchers, practitioners, and other interested parties.

(2) RULES GOVERNING USE OF ADDITIONAL FUNDS.—

(A) IN GENERAL.—Funds are used in accordance with this paragraph if—

(i) the State, in consultation with relevant stakeholders, including agencies, professional associations, and nonprofit organizations, distributes the funds to eligible entities to—

(I) decrease the need for diapers and diapering supplies and adult incontinence materials and supplies in low-income families and meet such unmet needs of infants and toddlers, medically complex children, and low-

income adults and adults with disabilities in such families through—

(aa) the distribution of free diapers and diapering supplies, medically necessary diapers, and adult incontinence materials and supplies;

(bb) community outreach to assist in participation in existing diaper distribution programs or programs that distribute medically necessary diapers or adult incontinence materials and supplies; or

(cc) improving access to diapers and diapering supplies, medically necessary diapers, and adult incontinence materials and supplies; and

(II) increase the ability of communities and low-income families in such communities to provide for the need for diapers and diapering supplies, medically necessary diapers, and adult continence materials and sup-

plies, of infants and toddlers, medically complex children, and low-income adults and adults with disabilities;

(ii) the funds are used subject to the limitations in section 2005 of the Social Security Act (42 U.S.C. 1397d);

(iii) the funds are used to supplement, not supplant, State general revenue funds provided for the purposes described in clause (i); and

(iv) the funds are not used for costs that are reimbursable by the Federal Emergency Management Agency, under a contract for insurance, or by self-insurance.

(B) ALLOWABLE USES BY ELIGIBLE ENTITIES.—An eligible entity receiving funds made available under paragraph (1) shall use the funds for any of the following:

(i) To pay for the purchase and distribution of diapers and diapering supplies, medically necessary diapers, and funding diaper (including medically necessary diapers) distribution that serves low-income families with—

(I) 1 or more children 3 years of age or younger; or

(II) 1 or more medically complex children.

(ii) To pay for the purchase and distribution of adult incontinence materials and supplies and funding distribution of such materials and supplies that serves low-income families with 1 or more low-income adults or adults with disabilities who rely on adult incontinence materials and supplies.

(iii) To integrate activities carried out under clause (i) with other basic needs assistance programs serving eligible children and their families, including the following:

(I) Programs funded by the temporary assistance for needy families program under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.), including the State maintenance of effort provisions of such program.

(II) Programs designed to support the health of eligible children,

such as the Children's Health Insurance Program under title XXI of the Social Security Act, the Medicaid program under title XIX of such Act, or State funded health care programs.

(III) Programs funded through the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966.

(IV) Programs that offer early home visiting services, including the maternal, infant, and early childhood home visiting program (including the Tribal home visiting program) under section 511 of the Social Security Act (42 U.S.C. 711).

(V) Programs to provide improved and affordable access to child care, including programs funded through the Child Care and Development Fund, the temporary assistance for needy families program under part A of title IV of the Social Security

Act (42 U.S.C. 601 et seq.), or a State-funded program.

(C) AVAILABILITY OF FUNDS.—

(i) FUNDS DISTRIBUTED TO ELIGIBLE ENTITIES.—Funds made available under paragraph (1) that are distributed to an eligible entity by a State for a fiscal year may be expended by the eligible entity only in such fiscal year or the succeeding fiscal year.

(ii) EVALUATION.—Funds reserved under paragraph (1)(B)(ii)(I)(aa) to carry out the evaluation under paragraph (4) shall be available for expenditure during the 3-year period that begins on the date of enactment of this Act.

(D) NO EFFECT ON OTHER PROGRAMS.—Any assistance or benefits received by a family through funds made available under paragraph (1) shall be disregarded for purposes of determining the family's eligibility for, or amount of, benefits under any other Federal needs-based programs.

(3) ANNUAL REPORTS.—A State shall include in the annual report required under section 2006 of

the Social Security Act (42 U.S.C. 1397e) covering each of fiscal years 2022 through 2025, information detailing how eligible entities, including subgrantees, used funds made available under paragraph (1) to distribute diapers and diapering supplies and adult incontinence materials and supplies to families in need. Each such report shall include the following:

(A) The number and age of infants, toddlers, medically complex children, and low-income adults and adults with disabilities who received assistance or benefits through such funds.

(B) The number of families that have received assistance or benefits through such funds.

(C) The number of diapers, medically necessary diapers, or adult incontinence materials and supplies (such as adult diapers, briefs, protective underwear, pull-ons, pull-ups, liners, shields, guards, pads, undergarments), and the number of each type of diapering or adult incontinence supply, distributed through the use of such funds.

(D) The ZIP Code or ZIP Codes where the eligible entity (or subgrantee) distributed dia-

pers and diapering supplies and adult incontinence materials and supplies.

(E) The method or methods the eligible entity (or subgrantee) uses to distribute diapers and diapering supplies and, adult incontinence materials and supplies.

(F) Such other information as the Secretary may specify.

(4) EVALUATION.—The Secretary, in consultation with States, the national entity described in paragraph (1)(B)(iii), and eligible entities receiving funds made available under this subsection, shall—

(A) not later than 2 years after the date of enactment of this Act—

(i) complete an evaluation of the effectiveness of the assistance program carried out pursuant to this subsection, such as the effect of activities carried out under this section on mitigating the health and developmental risks of unmet diaper need among infants, toddlers, medically complex children, and other family members in low-income families, including the risks of diaper dermatitis, urinary tract infections,

and parental and child depression and anxiety;

(ii) submit to the relevant congressional committees a report on the results of such evaluation; and

(iii) publish the results of the evaluation on the internet website of the Department of Health and Human Services;

(B) not later than 3 years after the date of enactment of this Act, update the evaluation required by subparagraph (A)(i); and

(C) not later than 90 days after completion of the updated evaluation under subparagraph (B)—

(i) submit to the relevant congressional committees a report describing the results of such updated evaluation; and

(ii) publish the results of such evaluation on the internet website of the Department of Health and Human Services.

(5) GUIDANCE.—Not later than 180 days after enactment of this Act, the Secretary shall issue guidance regarding how the provisions of this subsection should be carried out, including information

regarding eligible entities, allowable use of funds, and reporting requirements.

(6) DEFINITIONS.—In this subsection:

(A) ADULT INCONTINENCE MATERIALS AND SUPPLIES.—The term ''adult incontinence materials and supplies'' means those supplies that are used to assist low-income adults or adults with disabilities and includes adult diapers, briefs, protective underwear, pull-ons, pull-ups, liners, shields, guards, pads, undergarments, disposable wipes, over-the-counter adult diaper rash cream products, intermittent catheterization, indwelling catheters, condom catheters, urinary drainage bags, external collection devices, wearable urinals, and penile clamps.

(B) ADULTS WITH DISABILITIES.—The term ''adults with disabilities'' means individuals who—

(i) have attained age 18; and

(ii) have a disability (as such term is defined, with respect to an individual, in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102)).

(C) DIAPER.—The term ''diaper'' means an absorbent garment that—

(i) is washable or disposable that may be worn by an infant or toddler who is not toilet-trained; and

(ii) if disposable—

(I) does not use any latex or common allergens; and

(II) meets or exceeds the quality standards for diapers commercially available through retail sale in the following categories:

(aa) Absorbency (with acceptable rates for first and second wetting).

(bb) Waterproof outer cover.

(cc) Flexible leg openings.

(dd) Refastening closures.

(D) DIAPERING SUPPLIES.—The term ''diapering supplies'' means items, including diaper wipes and diaper cream, necessary to ensure that—

(i) an eligible child using a diaper is properly cleaned and protected from diaper rash; or

(ii) a medically complex child who uses a medically necessary diaper is prop-

erly cleaned and protected from diaper rash.

(E) ELIGIBLE CHILD.—The term ''eligible child'' means a child who—

(i) has not attained 4 years of age; and

(ii) is a member of a low-income family.

(F) ELIGIBLE ENTITIES.—The term ''eligible entity'' means a State or local governmental entity, an Indian tribe or tribal organization (as defined in section 4 of the Indian Self-Determination and Education Assistance Act), or a nonprofit organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code that—

(i) has experience in the area of—

(I) community distributions of basic need services, including experience collecting, warehousing, and distributing basic necessities such as diapers, food, or menstrual products;

(II) child care;

(III) child development activities in low-income communities; or

(IV) motherhood, fatherhood, or parent education efforts serving low-income parents of young children;

(ii) demonstrates competency to implement a project, provide fiscal accountability, collect data, and prepare reports and other necessary documentation; and

(iii) demonstrates a willingness to share information with researchers, practitioners, and other interested parties.

(G) FEDERAL POVERTY LINE.—The term ''Federal poverty line'' means the Federal poverty line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 applicable to a family of the size involved.

(H) LOW-INCOME.—The term ''low-income'', with respect to a family, means a family whose self-certified income is not more than 200 percent of the Federal poverty line.

(I) MEDICALLY COMPLEX CHILD.—The term ''medically complex child'' means an indi-

vidual who has attained age 3 and for whom a licensed health care provider has provided a diagnosis of bowel or bladder incontinence, a bowel or bladder condition that causes excess urine or stool (such as short gut syndrome or diabetes insipidus), or a severe skin condition that causes skin erosions (such as epidermolysis bullosa).

(J) MEDICALLY NECESSARY DIAPER.—The term ''medically necessary diaper'' means an absorbent garment that is—

(i) washable or disposable;

(ii) worn by a medically complex child who has been diagnosed with bowel or bladder incontinence, a bowel or bladder condition that causes excess urine or stool (such as short gut syndrome or diabetes insipidus), or a severe skin condition that causes skin erosions (such as epidermolysis bullosa) and needs such garment to correct or ameliorate such condition; and

(iii) if disposable—

(I) does not use any latex or common allergens; and

(II) meets or exceeds the quality standards for diapers commercially available through retail sale in the following categories:

(aa) Absorbency (with acceptable rates for first and second wetting).

(bb) Waterproof outer cover.

(cc) Flexible leg openings.

(dd) Refastening closures.

(7) EXEMPTION OF PROGRAM FROM SEQUESTRATION.—

(A) IN GENERAL.—Section 255(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 905(h)) is amended by inserting after ''Supplemental Security Income Program (28–0406–0–1–609).'' the following:

''Targeted funding for States for diaper assistance (including diapering supplies and adult incontinence materials and supplies) through the Social Services Block Grant Program.''.

(B) APPLICABILITY.—The amendment made by this paragraph shall apply to any sequestration order issued under the Balanced

Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900 et seq.) on or after the date of enactment of this Act.

(b) IMPROVING ACCESS TO DIAPERS FOR MEDICALLY COMPLEX CHILDREN.—Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended by adding at the end the following new paragraph:

''(11)(A) In the case of any waiver under this subsection that provides medical assistance to a medically complex child who has been diagnosed with bowel or bladder incontinence, a bowel or bladder condition that causes excess urine or stool (such as short gut syndrome or diabetes insipidus), or a severe skin condition that causes skin erosions (such as epidermolysis bullosa), such medical assistance shall include, for the duration of the waiver, the provision of 200 medically necessary diapers per month and diapering supplies. Such medical assistance may include the provision of medically necessary diapers in amounts greater than 200 if a licensed health care provider (such as a physician, nurse practitioner, or physician assistant) specifies that such greater amounts are necessary for such medically complex child.

''(B) For purposes of this paragraph:

''(i) The term 'medically complex child' means an individual who has attained age 3 and for whom

a licensed health care provider has provided a diagnosis of 1 or more significant chronic conditions.

''(ii) The term 'medically necessary diaper' means an absorbent garment that is—

''(I) washable or disposable;

''(II) worn by a medically complex child who has been diagnosed with a condition described in subparagraph (A) and needs such garment to correct or ameliorate such condition; and

''(III) if disposable—

''(aa) does not use any latex or common allergens; and

''(bb) meets or exceeds the quality standards for diapers commercially available through retail sale in the following categories:

''(AA) Absorbency (with acceptable rates for first and second wetting).

''(BB) Waterproof outer cover.

''(CC) Flexible leg openings.

''(DD) Refastening closures.

''(iii) The term 'diapering supplies' means items, including diaper wipes and diaper creams,

necessary to ensure that a medically complex child who has been diagnosed with a condition described in subparagraph (A) and uses a medically necessary diaper is properly cleaned and protected from diaper rash.''.

(c) INCLUSION OF DIAPERS AND DIAPERING SUPPLIES AS QUALIFIED MEDICAL EXPENSES.—

(1) HEALTH SAVINGS ACCOUNTS.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended—

(A) by inserting '', medically necessary diapers, and diapering supplies'' after ''menstrual care products'' in the last sentence of subparagraph (A); and

(B) by adding at the end the following new subparagraph:

''(E) MEDICALLY NECESSARY DIAPERS AND DIAPERING SUPPLIES.—For purposes of this paragraph—

''(i) MEDICALLY NECESSARY DIAPERS.—The term 'medically necessary diaper' means an absorbent garment which is washable or disposable and which is worn by an individual who has attained 3 years of age because of medical necessity, such

as someone who has been diagnosed with bowel or bladder incontinence, a bowel or bladder condition that causes excess urine or stool (such as short gut syndrome or diabetes insipidus), or a severe skin condition that causes skin erosions (such as epidermolysis bullosa) and needs such garment to correct or ameliorate such condition, to serve a preventative medical purpose, or to correct or ameliorate defects or physical or mental illnesses or conditions diagnosed by a licensed health care provider, and, if disposable—

''(I) does not use any latex or common allergens; and

''(II) meets or exceeds the quality standards for diapers commercially available through retail sale in the following categories:

''(aa) Absorbency (with acceptable rates for first and second wetting).

''(bb) Waterproof outer cover.

''(cc) Flexible leg openings.

''(dd) Refastening closures.

''(ii) DIAPERING SUPPLIES.—The term 'diapering supplies' means items, including diaper wipes and diaper creams, necessary to ensure that an individual wearing medically necessary diapers is properly cleaned and protected from diaper rash.''.

(2) ARCHER MSAS.—The last sentence of section 220(d)(2)(A) of such Code is amended by inserting '', medically necessary diapers (as defined in section 223(d)(2)(E)), and diapering supplies (as defined in section 223(d)(2)(E))'' after ''menstrual care products (as defined in section 223(d)(2)(D))''.

(3) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106(f) of such Code is amended—

(A) by inserting '', medically necessary diapers (as defined in section 223(d)(2)(E)), and diapering supplies (as defined in section 223(d)(2)(E))'' after ''menstrual care products (as defined in section 223(d)(2)(D))''; and

(B) in the heading, by inserting '', MEDICALLY NECESSARY DIAPERS, AND DIAPERING

SUPPLIES'' after ''MENSTRUAL CARE PRODUCTS''.

(4) EFFECTIVE DATES.—

(A) DISTRIBUTIONS FROM CERTAIN ACCOUNTS.—The amendments made by paragraphs (1) and (2) shall apply to amounts paid after December 31, 2023.

(B) REIMBURSEMENTS.—The amendment made by paragraph (3) shall apply to expenses incurred after December 31, 2023.

SEC. 5503. DECREASING THE RISK FACTORS FOR SUDDEN UNEXPECTED INFANT DEATH AND SUDDEN UNEXPLAINED DEATH IN CHILDHOOD.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health (in this section referred to as the ''Secretary''), shall establish and implement a culturally and linguistically competent public health awareness and education campaign to provide information that is focused on decreasing the risk factors for sudden unexpected infant death and sudden unexplained death in childhood, including educating individuals about safe sleep environments,

sleep positions, and reducing exposure to smoking during pregnancy and after birth.

(b) TARGETED POPULATIONS.—The campaign under subsection (a) shall be designed to reduce health inequities through the targeting of populations with high rates of sudden unexpected infant death and sudden unexplained death in childhood.

(c) CONSULTATION.—In establishing and implementing the campaign under subsection (a), the Secretary shall consult with national organizations representing health care providers, including nurses and physicians, parents, child care providers, children's advocacy and safety organizations, maternal and child health programs, nutrition professionals focusing on people, infants, and children, and other individuals and groups determined necessary by the Secretary for such establishment and implementation.

(d) GRANTS.—

(1) IN GENERAL.—In carrying out the campaign under subsection (a), the Secretary shall award grants to national organizations, State and local health departments, and community-based organizations for the conduct of education and outreach programs for nurses, parents, child care pro-

viders, public health agencies, and community organizations.

(2) APPLICATION.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

Subtitle G—Nutrition for Women, Children, Families

SEC. 5601. CLOSING THE MEAL GAP.

(a) ELIMINATION OF TIME LIMIT.—

(1) IN GENERAL.—Section 6 of the Food and Nutrition Act of 2008 (7 U.S.C. 2015) is amended—

(A) by striking subsection (o); and

(B) by redesignating subsections (p) through (s) as subsections (o) through (r), respectively.

(2) ADDITIONAL ALLOCATIONS FOR STATES THAT ENSURE AVAILABILITY OF WORK OPPORTUNI-

TIES.—Section 16(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (C)(iv)(I)—

(I) by striking ''(F)(viii)'' each place it appears and inserting ''(E)(viii)'';

(II) by striking ''(F)(vii)(I)'' each place it appears and inserting ''(E)(vii)(I)'';

(III) in item (bb)(BB), by striking ''(F)(vii)(II)'' and inserting ''(E)(vii)(II)''; and

(IV) in item (cc), by striking ''(F)(vii)'' and inserting ''(E)(vii)'';

(ii) by striking subparagraph (E); and

(iii) by redesignating subparagraph (F) as subparagraph (E);

(B) in paragraphs (3) and (4), by striking ''(1)(F)'' each place it appears and inserting ''(1)(E)''; and

(C) in paragraph (5)(C)—

(i) in clause (ii), by adding ''and'' at the end;

(ii) in clause (iii), by striking ''; and'' and inserting a period; and

(iii) by striking clause (iv).

(3) CONFORMING AMENDMENTS.—

(A) Section 5 of the Food and Nutrition Act of 2008 (7 U.S.C. 2014) is amended—

(i) in subsection (a), in the second sentence, by striking ''(r)'' and inserting ''(q)''; and

(ii) in subsection (g)(3), in the first sentence, by striking ''16(h)(1)(F)'' and inserting ''16(h)(1)(E)''.

(B) Section 6(d)(4) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(d)(4)) is amended—

(i) in subparagraph (B)(ii)(I)(bb)(DD), by striking ''or subsection (o)''; and

(ii) in subparagraph (N), by striking ''or subsection (o)'' each place it appears.

(C) Section 7 of the Food and Nutrition Act of 2008 (7 U.S.C. 2016) is amended—

(i) in subsection (a), by striking ''Except as provided in subsection (i), EBT'' and inserting ''EBT'';

(ii) in subsection (f)(3)—

(I) by striking subparagraph (B); and

(II) by redesignating subparagraph (C) as subparagraph (B);

(iii) in subsection (h)—

(I) in paragraph (13)(B), by striking ''subsection (j)(1)(H)'' and inserting ''subsection (i)(1)''; and

(II) in paragraph (14)(B)(ii)(III), by striking ''section 7(f)(2)(B)'' and inserting ''subsection (f)(2)(B)'';

(iv) by striking subsection (i); and

(v) by redesignating subsections (j) and (k) as subsections (i) and (j), respectively.

(D) Section 16(h)(1) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)) is amended—

(i) in subparagraph (B), in the matter preceding clause (i), by striking ''that—'' and all that follows through the period at the end of clause (ii) and inserting ''that

is determined and adjusted by the Secretary.''; and

(ii) in clause (ii)(III)(ee)(AA) of subparagraph (E) (as redesignated by paragraph (2)(A)(iii)), by striking '', individuals subject to the requirements under section 6(o),''.

(E) Section 17(b)(1)(B)(iv) of the Food and Nutrition Act of 2008 (7 U.S.C. 2026(b)(1)(B)(iv)) is amended—

(i) in subclause (V), by adding ''or'' at the end after the semicolon;

(ii) in subclause (VI), by striking ''; or'' and inserting a period; and

(iii) by striking subclause (VII).

(F) Section 51(d)(8)(A)(ii) of the Internal Revenue Code of 1986 is amended—

(i) in subclause (I), by striking '', or'' at the end and inserting a period;

(ii) in the matter preceding subclause (I), by striking ''family—'' and all that follows through ''receiving'' in subclause (I) and inserting ''family receiving''; and

(iii) by striking subclause (II).

(G) Section 103(a)(2) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3113) is amended—

(i) by striking subparagraph (D); and

(ii) by redesignating subparagraphs (E) through (K) as subparagraphs (D) through (J), respectively.

(H) Section 121(b)(2)(B) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3151) is amended—

(i) by striking clause (iv); and

(ii) by redesignating clauses (v) through (vii) as clauses (iv) through (vi), respectively.

(4) Section 703(c)(1) of division N of the Consolidated Appropriations Act, 2021 (7 U.S.C. 2016 note; Public Law 116–260), is amended by striking ''section 7(k)(14) of the Food and Nutrition Act of 2008'' and inserting ''section 7(j)(4) of the Food and Nutrition Act of 2008 (7 U.S.C. 2016(j)(4))''.

(b) PARTICIPATION OF PUERTO RICO, AMERICAN SAMOA, AND THE NORTHERN MARIANA ISLANDS IN SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.—

(1) DEFINITIONS.—

(A) STATE.—Section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(r)) is amended by inserting ''the Commonwealth of Puerto Rico, American Samoa, the Commonwealth of the Northern Mariana Islands,'' after ''Guam,''.

(B) THRIFTY FOOD PLAN.—Section 3(u)(3) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(u)(3)) is amended by inserting ''the Commonwealth of Puerto Rico, American Samoa, the Commonwealth of the Northern Mariana Islands,'' after ''Guam,''.

(2) ELIGIBLE HOUSEHOLDS.—Section 5 of the Food and Nutrition Act of 2008 (7 U.S.C. 2014) (as amended by section 4003(g)(1)(A)(iv)) is amended—

(A) in subsection (c), in the undesignated matter at the end, by striking ''States or Guam'' and inserting ''States, Guam, the Commonwealth of Puerto Rico, American Samoa, or the Commonwealth of the Northern Mariana Islands'';

(B) in subsection (e)(1)(B)—

(i) in the subparagraph heading, by striking ''GUAM'' and inserting ''GUAM, THE COMMONWEALTH OF THE NORTHERN

MARIANA ISLANDS, AND AMERICAN SAMOA'';

(ii) in clause (i), in the matter preceding subclause (I), by inserting '', the Commonwealth of the Northern Mariana Islands, and American Samoa'' after ''Guam''; and

(iii) in clause (ii), in the matter preceding subclause (I), by inserting '', the Commonwealth of the Northern Mariana Islands, and American Samoa'' after ''Guam''; and

(C) by adding at the end the following:

''(n) PUERTO RICO, AMERICAN SAMOA, AND THE NORTHERN MARIANA ISLANDS.—Notwithstanding any other provision of this Act, including the requirements under this section, the Commonwealth of Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands shall each establish their own standards of eligibility for participation by households in the supplemental nutrition assistance program.''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by paragraphs (1) and (2) shall be effective with respect to the Commonwealth of Puerto

Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands, as applicable, on the date described in subparagraph (B) if the Secretary of Agriculture submits to Congress a certification under subsection (f)(2)(B) of section 19 of the Food and Nutrition Act of 2008 (7 U.S.C. 2028).

(B) DATE DESCRIBED.—The date referred to in subparagraph (A) is, with respect to the Commonwealth of Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands, the date established by the Commonwealth of Puerto Rico, American Samoa, or the Commonwealth of the Northern Mariana Islands, respectively, in the applicable plan of operation submitted to the Secretary of Agriculture under subsection (f)(1) of section 19 of the Food and Nutrition Act of 2008 (7 U.S.C. 2028).

(c) TRANSITION OF PUERTO RICO, AMERICAN SAMOA, AND THE NORTHERN MARIANA ISLANDS TO SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.—Section 19 of the Food and Nutrition Act of 2008 (7 U.S.C. 2028) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(C) the Commonwealth of the Northern Mariana Islands.''; and

(2) by adding at the end the following:

''(f) TRANSITION OF PUERTO RICO, AMERICAN SAMOA, AND THE NORTHERN MARIANA ISLANDS TO SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.—

''(1) REQUEST FOR PARTICIPATION.—A governmental entity may submit to the Secretary a request to participate in the supplemental nutrition assistance program, which shall include a plan of operation described in section 11(d), which shall include the date on which the governmental entity intends to begin participation in the program.

''(2) CERTIFICATION BY SECRETARY.—

''(A) IN GENERAL.—The Secretary shall certify a governmental entity that submits a request under paragraph (1) as qualified to participate in the supplemental nutrition assistance program if the Secretary—

"(i) approves the plan of operation submitted with the request, in accordance with this subsection; and

"(ii) approves the applications described in paragraph (4) in accordance with that paragraph.

"(B) SUBMISSION OF CERTIFICATION TO CONGRESS.—The Secretary shall submit each certification under subparagraph (A) to Congress.

"(3) DETERMINATION OF PLAN OF OPERATION.—

"(A) APPROVAL.—The Secretary shall approve a plan of operation submitted with a request under paragraph (1) if the plan satisfies the requirements under this Act for a plan of operation.

"(B) DISAPPROVAL.—If the Secretary does not approve a plan of operation submitted with a request under paragraph (1), the Secretary shall provide to the governmental entity a statement that describes each requirement under this Act that is not satisfied by the plan.

"(4) APPROVAL OF RETAIL FOOD STORES.—

''(A) SOLICITATION OF APPLICATIONS.—If the Secretary approves a plan of operation under paragraph (3)(A) for a governmental entity, the Secretary shall accept applications from retail food stores located in that governmental entity to be authorized under section 9 to participate in the supplemental nutrition assistance program.

''(B) DETERMINATION.—The Secretary shall authorize a retail food store applying to participate in the supplemental nutrition assistance program under subparagraph (A) if the application satisfies the requirements under this Act for authorization of a retail food store.

''(5) PUERTO RICO.—In the case of a request under paragraph (1) by the Commonwealth of Puerto Rico, notwithstanding subsection (g), the Secretary shall allow the Commonwealth of Puerto Rico to continue to carry out under the supplemental nutrition assistance program the Family Market Program established pursuant to this section.

''(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this subsection such sums as are

necessary for fiscal year 2023, to remain available until expended.

''(g) TERMINATION OF EFFECTIVENESS.—

''(1) IN GENERAL.—Subsections (a) through (e) shall cease to be effective with respect to the Commonwealth of Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands, as applicable, on the date described in paragraph (2) if the Secretary submits to Congress a certification under subsection (f)(2)(B) for that governmental entity.

''(2) DATE DESCRIBED.—The date referred to in paragraph (1) is, with respect to the Commonwealth of Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands, the date established by the Commonwealth of Puerto Rico, American Samoa, or the Commonwealth of the Northern Mariana Islands, respectively, in the applicable plan of operation submitted to the Secretary under subsection (f)(1).''.

SEC. 5602. REPEAL OF DENIAL OF SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS.

Section 115 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (21 U.S.C. 862a) is amended—

(1) in subsection (a)—

(A) by striking paragraph (2);

(B) in paragraph (1), by striking ", or" and inserting a period; and

(C) in the matter preceding paragraph (1), by striking "for—" and all that follows through "assistance" in paragraph (1) and inserting "for assistance";

(2) in subsection (b)—

(A) by striking paragraph (2);

(B) in paragraph (1), by striking the paragraph designation and heading and all that follows through "The amount" and inserting "The amount"; and

(3) in subsection (e)—

(A) by striking paragraph (2);

(B) in paragraph (1), by striking ", and" and inserting a period; and

(C) in the matter preceding paragraph (1), by striking "it—" and all that follows through "in section 419(5)" in paragraph (1) and inserting "the term in section 419(5)".

Subtitle H—Universal School Meals Program

SEC. 5701. SHORT TITLE.

This subtitle may be cited as the ''Universal School Meals Program Act of 2022''.

SEC. 5702. EFFECTIVE DATE.

Unless otherwise provided, this subtitle, and the amendments made by this subtitle, shall take effect 1 year after the date of enactment of this Act.

SEC. 5703. FREE SCHOOL BREAKFAST PROGRAM.

(a) IN GENERAL.—Section 4(a) of the Child Nutrition Act of 1966 (42 U.S.C. 1773(a)) is amended, in the first sentence—

(1) by striking ''is hereby'' and inserting ''are''; and

(2) by inserting ''to provide free breakfast to all children enrolled at those schools'' before ''in accordance''.

(b) APPORTIONMENT TO STATES.—Section 4(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1773(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)(i), by striking subclause (II) and inserting the following:

"(II) the national average payment for free breakfasts, as specified in subparagraph (B).";

(B) by striking subparagraph (B) and inserting the following:

"(B) PAYMENT AMOUNTS.—

"(i) IN GENERAL.—The national average payment for each free breakfast shall be $2.72, adjusted annually for inflation in accordance with clause (ii) and rounded in accordance with clause (iii).

"(ii) INFLATION ADJUSTMENT.—

"(I) IN GENERAL.—The annual inflation adjustment under clause (i) shall reflect changes in the cost of operating the free breakfast program under this section, as indicated by the change in the Consumer Price Index for food away from home for all urban consumers.

"(II) BASIS.—Each inflation annual adjustment under clause (i) shall reflect the changes in the Consumer Price Index for food away from home

for the most recent 12-month period for which that data is available.

''(iii) ROUNDING.—On July 1, 2022, and annually thereafter, the national average payment rate for free breakfast shall be—

''(I) adjusted to the nearest lower-cent increment; and

''(II) based on the unrounded amounts for the preceding 12-month period.'';

(C) by striking subparagraphs (C) and (E); and

(D) by redesignating subparagraph (D) as subparagraph (C);

(2) by striking paragraphs (2) and (3);

(3) by redesignating paragraphs (4) and (5) as paragraphs (2) and (3), respectively; and

(4) in paragraph (3) (as so redesignated), by striking ''paragraph (3) or (4)'' and inserting ''paragraph (2)''.

(c) STATE DISBURSEMENT TO SCHOOLS.—Section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773) is amended by striking subsection (c) and inserting the following:

''(c) STATE DISBURSEMENT TO SCHOOLS.—Funds apportioned and paid to any State for the purpose of this section shall be disbursed by the State educational agency to schools selected by the State educational agency to assist those schools in operating a breakfast program.''.

(d) NO COLLECTION OF DEBT.—

(1) IN GENERAL.—Notwithstanding any other provision of the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) or any other provision of law, effective beginning on the date of enactment of this Act, as a condition of participation in the breakfast program under section 4 of that Act (42 U.S.C. 1773), a school—

(A) shall not collect any debt owed to the school for unpaid meal charges; and

(B) shall continue to accrue debt for unpaid meal charges—

(i) for the purpose of receiving reimbursement under section 5715; and

(ii) until the effective date specified in section 5702.

(2) CHILD NUTRITION ACT OF 1966.—

(A) IN GENERAL.—Section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773) is

amended by striking subsection (d) and inserting the following:

''(d) NO COLLECTION OF DEBT.—A school participating in the free breakfast program under this section shall not collect any debt owed to the school for unpaid meal charges.''.

(B) CONFORMING AMENDMENT.—Section 23(a) of the Child Nutrition Act of 1966 (42 U.S.C. 1793(a)) is amended by striking ''school in severe need, as described in section 4(d)(1)'' and inserting the following: ''school—

''(1) that has a free breakfast program under section 4 or seeks to initiate a free breakfast program under that section; and

''(2) of which not less than 40 percent of the students are identified students (as defined in paragraph (8) of section 1113(a) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a)))''.

(e) NUTRITIONAL AND OTHER PROGRAM REQUIREMENTS.—Section 4(e) of the Child Nutrition Act of 1966 (42 U.S.C. 1773(e)) is amended—

(1) in paragraph (1)(A), in the second sentence, by striking ''free or'' and all that follows through the period at the end and inserting ''free to all chil-

dren enrolled at a school participating in the school breakfast program.''; and

(2) in paragraph (2), in the second sentence, by striking ''the full charge to the student for a breakfast meeting the requirements of this section or''.

(f) PROHIBITION ON BREAKFAST SHAMING, MEAL DENIAL.—

(1) IN GENERAL.—Effective beginning on the date of enactment of this Act, a school or school food authority—

(A) shall not—

(i) physically segregate or otherwise discriminate against any child participating in the breakfast program under section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773); or

(ii) overtly identify a child described in clause (i) by a special token or ticket, an announced or published list of names, or any other means; and

(B) shall provide the program meal to any child eligible under the program.

(2) CHILD NUTRITION ACT OF 1966.—Section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773) is amended by adding at the end the following:

''(f) PROHIBITION ON BREAKFAST SHAMING.—A school or school food authority shall not—

''(1) physically segregate or otherwise discriminate against any child participating in the free breakfast program under this section; or

''(2) overtly identify a child described in paragraph (1) by a special token or ticket, an announced or published list of names, or any other means.''.

(g) DEPARTMENT OF DEFENSE OVERSEAS DEPENDENTS' SCHOOLS.—Section 20(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1789(b)) is amended—

(1) by striking ''and reduced-price''; and

(2) by striking ''and shall'' and all that follows through ''section''.

(h) CONFORMING AMENDMENTS.—The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) is amended—

(1) by striking ''or reduced price'' each place it appears;

(2) by striking ''and reduced price'' each place it appears; and

(3) by striking ''a reduced price'' each place it appears.

SEC. 5704. APPORTIONMENT TO STATES.

Section 4(b) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1753(b)) is amended—

(1) by striking paragraph (2) and inserting the following:

"(2) PAYMENT AMOUNTS.—

"(A) IN GENERAL.—The national average payment for each free lunch shall be $3.81, adjusted annually for inflation in accordance with subparagraph (C) and rounded in accordance with subparagraph (D).

"(B) ADDITIONAL PAYMENT FOR LOCAL FOOD.—

"(i) DEFINITION OF LOCALLY-SOURCED FARM PRODUCT.—In this subparagraph, the term 'locally-sourced farm product' means a farm product that—

"(I) is marketed to consumers—

"(aa) directly; or

"(bb) through intermediated channels (such as food hubs and cooperatives); and

"(II) with respect to the school food authority purchasing the farm product, is produced and distributed—

"(aa) in the State in which the school food authority is located; or

"(bb) not more than 250 miles from the location of the school food authority.

"(ii) ADDITIONAL PAYMENT ELIGIBILITY.—During a school year, a school food authority shall receive an additional payment described in clause (iii) if the State certifies that the school food authority served meals (including breakfasts, lunches, suppers, and supplements) during the last school year of which not less than 25 percent were made with locally-sourced farm products.

"(iii) PAYMENT AMOUNT.—

"(I) IN GENERAL.—The additional payment amount under this subparagraph shall be—

"(aa) $0.30 for each free lunch and supper;

"(bb) $0.21 for each free breakfast; and

"(cc) $0.08 for each free supplement.

"(II) ADJUSTMENTS.—Each additional payment amount under subclause (I) shall be adjusted annually in accordance with subparagraph (C) and rounded in accordance with subparagraph (D).

"(iv) DISBURSEMENT.—The State agency shall disburse funds made available under this clause to school food authorities eligible to receive additional reimbursement.

"(C) INFLATION ADJUSTMENT.—

"(i) IN GENERAL.—The annual inflation adjustment under subparagraphs (A) and (B)(iii) shall reflect changes in the cost of operating the free lunch program under this Act, as indicated by the change in the Consumer Price Index for food away from home for all urban consumers.

"(ii) BASIS.—Each annual inflation adjustment under subparagraphs (A) and (B)(iii) shall reflect the changes in the Consumer Price Index for food away from

home for the most recent 12-month period for which that data is available.

''(D) ROUNDING.—On July 1, 2022, and annually thereafter, the national average payment rate for free lunch and the additional payment amount for free breakfast, lunch, supper, and supplement under subparagraph (B) shall be—

''(i) adjusted to the nearest lower-cent increment; and

''(ii) based on the unrounded amounts for the preceding 12-month period.''; and

(2) by striking paragraph (3).

SEC. 5705. NUTRITIONAL AND OTHER PROGRAM REQUIREMENTS.

(a) ELIMINATION OF FREE LUNCH ELIGIBILITY REQUIREMENTS.—

(1) IN GENERAL.—Section 9 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758) is amended by striking subsection (b) and inserting the following:

''(b) ELIGIBILITY.—All children enrolled in a school that participates in the school lunch program under this Act shall be eligible to receive free lunch under this Act.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 9 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758) is amended—

(i) in subsection (c), in the third sentence, by striking ''or at a reduced cost''; and

(ii) in subsection (e), by striking '', reduced price,''.

(B) Section 18 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1769) is amended—

(i) by striking subsection (j); and

(ii) by redesignating subsection (k) as subsection (j).

(C) Section 28(b)(4) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1769i(b)(4)) is amended—

(i) by striking subparagraph (B); and

(ii) in subparagraph (A), by striking the subparagraph designation and heading and all that follows through ''the Secretary'' and inserting ''The Secretary''.

(D) Section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) is amended—

(i) in subsection (d)(2)(A)—

(I) by striking clause (i); and

(II) by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively; and

(ii) in subsection (f)(17), by striking ''Notwithstanding subsection (d)(2)(A)(i), not later'' and inserting ''Not later''.

(E) Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking paragraph (7) and inserting the following:

''(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;''.

(F) Section 1154(a)(2)(A)(i) of title 10, United States Code, is amended by striking ''in accordance with section 9(b)(1) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(1)''.

(G) Section 4301 of the Food, Conservation, and Energy Act of 2008 (42 U.S.C. 1758a) is repealed.

(b) NO COLLECTION OF DEBT.—

(1) IN GENERAL.—Notwithstanding any other provision of the Richard B. Russell National School

Lunch Act (42 U.S.C. 1751 et seq.) or any other provision of law, effective beginning on the date of enactment of this Act, as a condition of participation in the school lunch program under that Act, a school—

(A) shall not collect any debt owed to the school for unpaid meal charges; and

(B) shall continue to accrue debt for unpaid meal charges—

(i) for the purpose of receiving reimbursement under section 5715; and

(ii) until the effective date specified in section 5702.

(2) NATIONAL SCHOOL LUNCH ACT.—Section 9 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758) is amended by striking subsection (d) and inserting the following:

''(d) NO COLLECTION OF DEBT.—A school participating in the school lunch program under this Act shall not collect any debt owed to the school for unpaid meal charges.''.

SEC. 5706. SPECIAL ASSISTANCE PROGRAM.

(a) IN GENERAL.—Section 11 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1759a) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 6 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1755) is amended—

(A) in subsection (a)(2), by striking ''sections 11 and 13'' and inserting ''section 13''; and

(B) in subsection (e)(1), in the matter preceding subparagraph (A), by striking ''section 4, this section, and section 11'' and inserting ''this section and section 4''.

(2) Section 7(d) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1756(d)) is amended by striking ''or 11''.

(3) Section 8(g) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1757(g)) is amended by striking ''and under section 11 of this Act''.

(4) Section 12(f) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760(f)) is amended by striking ''11,''.

(5) Section 7(a) of the Child Nutrition Act of 1966 (42 U.S.C. 1766(a)) is amended—

(A) in paragraph (1)(A), by striking ''4, 11, and 17'' and inserting ''4 and 17''; and

(B) in paragraph (2)(A), by striking ''sections 4 and 11'' and inserting ''section 4''.

SEC. 5707. PRICE FOR A PAID LUNCH.

Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1760) is amended—

(1) by striking subsection (p); and

(2) by redesignating subsections (q) and (r) as subsections (p) and (q), respectively.

SEC. 5708. SUMMER FOOD SERVICE PROGRAM FOR CHILDREN.

Section 13 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1761) is amended—

(1) in subsection (a)—

(A) in paragraph (2), by adding at the end the following:

''(C) WAIVER.—If the Secretary determines that a program requirement under this section limits the access of children to meals served under this section, the Secretary may waive that program requirement.

''(D) ELIGIBILITY.—All children shall be eligible to participate in the program under this section.''; and

(B) in paragraph (5), by striking ''only for'' and all that follows through the period at

the end and inserting ''for meals served to all children.'';

(2) in subsection (b)(2), by striking ''may only serve'' and all that follows through ''migrant children'';

(3) by striking subsection (c) and inserting the following:

''(c) PAYMENTS.—

''(1) IN GENERAL.—Payments shall be made to service institutions for meals served—

''(A) during the months of May through September;

''(B) during school vacation at any time during an academic school year;

''(C) during a teacher in-service day; and

''(D) on days that school is closed during the months of October through April due to a natural disaster, building repair, court order, or similar cause, as determined by the Secretary.

''(2) LIMITATION ON PAYMENTS.—A service institution shall receive payments under this section for not more than 3 meals and 1 supplement per child per day.''; and

(4) in subsection (f)(3), by striking '', except that'' and all that follows through ''section''.

SEC. 5709. SUMMER ELECTRONIC BENEFIT TRANSFER FOR CHILDREN PROGRAM.

Section 13(a) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1761(a)) is amended by adding at the end the following:

''(13) SUMMER ELECTRONIC BENEFIT TRANSFER FOR CHILDREN PROGRAM.—

''(A) DEFINITIONS.—In this paragraph:

''(i) EBT CARD.—The term 'EBT card' means an electronic benefit transfer card.

''(ii) ELIGIBLE HOUSEHOLD.—The term 'eligible household' means a household with—

''(I) an income that does not exceed 200 percent of the poverty line (as defined in section 673 of the Community Services Block Grant Act (42 U.S.C. 9902)); and

''(II) 1 or more children.

''(iii) PROGRAM.—The term 'Program' means the Summer Electronic Benefit Transfer for Children Program established under subparagraph (B).

''(B) ESTABLISHMENT.—The Secretary shall establish a national program, to be known

as the 'Summer Electronic Benefit Transfer for Children Program', under which the Secretary shall issue EBT cards to eligible households to provide food assistance during the summer months.

''(C) EBT AMOUNT.—

''(i) IN GENERAL.—The value of an EBT card provided under the Program to an eligible household shall be $60 per month per child (adjusted for inflation).

''(ii) ANNUAL LIMITATION.—No eligible household shall receive benefits under the Program for more than 3 months in a calendar year.

''(D) ADMINISTRATION.—

''(i) IN GENERAL.—Except as provided under this paragraph, the Program shall be based on the summer electronic benefit transfer for children demonstration program carried out pursuant to section 749(g) of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2010 (Public Law 111–80; 123 Stat. 2132).

''(ii) SNAP OR WIC.—

"(I) IN GENERAL.—Subject to subclause (II), a State shall administer the Program through the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

"(II) WIC OPTION.—If a State has participated in the demonstration program described in clause (i) before the effective date specified in section 5702 of the Universal School Meals Program Act of 2022, the State may elect to administer the Program through the special supplemental nutrition program for women, infants, and children established by section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786).

"(E) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this paragraph such sums as are necessary for fiscal year 2022 and each fiscal year thereafter.".

SEC. 5710. CHILD AND ADULT CARE FOOD PROGRAM.

Section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766) is amended—

(1) in subsection (a)(2), by striking subparagraph (B) and inserting the following:

''(B) any other private organization providing nonresidential child care or day care outside school hours for school children;'';

(2) by striking subsection (c) and inserting the following:

''(c) FREE MEALS.—Notwithstanding any other provision of law—

''(1) all meals and supplements served under the program authorized under this section shall be provided for free to participants of the program; and

''(2) an institution that serves those meals and supplements shall be reimbursed—

''(A) in the case of breakfast, at the rate established for free breakfast under section 4(b)(1)(B)(i) of the Child Nutrition Act of 1966 (42 U.S.C. 1773(b)(1)(B)(i));

''(B) in the case of lunch, at the rate established for free lunch under section 4(b)(2)(A); and

"(C) in the case of a supplemental meal, $0.96, adjusted for inflation in accordance with section 4(b)(2)(C).";

(3) in subsection (f)—

(A) in paragraph (2), by striking subparagraph (B) and inserting the following:

"(B) LIMITATION TO REIMBURSEMENTS.—An institution may claim reimbursement under this paragraph for not more than 3 meals and 1 supplement per day per child.";

(B) by striking paragraph (3); and

(C) by redesignating paragraph (4) as paragraph (3); and

(4) in subsection (r)—

(A) in the subsection heading, by striking "PROGRAM FOR AT-RISK SCHOOL CHILDREN" and inserting "AFTERSCHOOL MEAL AND SNACK PROGRAM";

(B) by striking "at-risk school" each place it appears and inserting "eligible";

(C) in paragraph (1)—

(i) in the paragraph heading, by striking "AT-RISK SCHOOL" and inserting "ELIGIBLE"; and

(ii) in subparagraph (B), by striking ''operated'' and all that follows through the period at the end and inserting a period; and

(D) in paragraph (4)(A), by striking ''only for'' and all that follows through the period at the end and inserting the following: ''for—

''(i) not more than 1 meal and 1 supplement per child per day served on a regular school day; and

''(ii) not more than 3 meals and 1 supplement per child per day served on any day other than a regular school day.''.

SEC. 5711. MEALS AND SUPPLEMENTS FOR CHILDREN IN AFTERSCHOOL CARE.

Section 17A of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766a) is amended—

(1) in the section heading, by striking ''**MEAL SUPPLEMENTS**'' and inserting ''**MEALS AND SUPPLEMENTS**'';

(2) in subsection (a)(1), by striking ''meal supplements'' and inserting ''free meals and supplements'';

(3) in subsection (b), by inserting ''meals and'' before ''supplements''; and

(4) by striking subsection (c) and inserting the following:

''(c) REIMBURSEMENT.—

''(1) IN GENERAL.—

''(A) MEALS.—A free meal provided under this section to a child shall be reimbursed at a rate of $3.81, adjusted annually for inflation in accordance with paragraph (3)(A) and rounded in accordance with paragraph (3)(B).

''(B) SUPPLEMENTS.—A free supplement provided under this section to a child shall be reimbursed at the rate at which free supplements are reimbursed under section 17(c)(2)(C).

''(2) LIMITATION TO REIMBURSEMENTS.—An institution may claim reimbursement under this section for not more than 1 meal and 1 supplement per day per child served on a regular school day.

''(3) INFLATION; ROUNDING.—

''(A) INFLATION ADJUSTMENT.—

''(i) IN GENERAL.—The annual inflation adjustment under paragraph (1)(A) shall reflect changes in the cost of operating the program under this section, as indicated by the change in the Consumer

Price Index for food away from home for all urban consumers.

''(ii) BASIS.—Each inflation annual adjustment under paragraph (1)(A) shall reflect the changes in the Consumer Price Index for food away from home for the most recent 12-month period for which that data is available.

''(B) ROUNDING.—On July 1, 2022, and annually thereafter, the reimbursement rate for a free meal under this section shall be—

''(i) adjusted to the nearest lower-cent increment; and

''(ii) based on the unrounded amounts for the preceding 12-month period.''.

SEC. 5712. ACCESS TO LOCAL FOODS: FARM TO SCHOOL PROGRAM.

Section 18(g)(5) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1769(g)(5)) is amended by striking subparagraph (B) and inserting the following:

''(B) serve a high proportion of identified students (as defined in paragraph (8) of section 1113(a) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a)));''.

SEC. 5713. FRESH FRUIT AND VEGETABLE PROGRAM.

Section 19(d) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1769a(d)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking ''paragraph (2) of this subsection and'';

(B) in subparagraph (A), in the matter preceding clause (i), by striking ''school—'' and all that follows through ''submits'' in clause (ii) and inserting ''school that submits'';

(C) in subparagraph (B), by striking ''schools'' and all that follows through ''Act'' and inserting ''high-need schools (as defined in section 2211(b) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6631(b)))''; and

(D) in subparagraph (D)—

(i) by striking clause (i); and

(ii) by redesignating clauses (ii) through (iv) as clauses (i) through (iii), respectively; and

(2) by striking paragraphs (2) and (3) and inserting the following:

''(2) OUTREACH TO HIGH-NEED SCHOOLS.—Prior to making decisions regarding school participa-

tion in the program, a State agency shall inform high-need schools (as defined in section 2211(b) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6631(b))), including Tribal schools, of the eligibility of the schools for the program.''.

SEC. 5714. TRAINING, TECHNICAL ASSISTANCE, AND FOOD SERVICE MANAGEMENT INSTITUTE.

Section 21(a)(1)(B) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1769b–1(a)(1)(B)) is amended in the matter preceding clause (i) by striking ''certified to receive free or reduced price meals'' and inserting ''who are identified students (as defined in paragraph (8) of section 1113(a) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a))''.

SEC. 5715. REIMBURSEMENT OF SCHOOL MEAL DELINQUENT DEBT PROGRAM.

(a) DEFINITIONS.—In this section:

(1) DELINQUENT DEBT.—The term ''delinquent debt'' means the debt owed by a parent or guardian of a child to a school—

(A) as of the effective date specified in section 5702; and

(B) for meals served by the school under—

(i) the school breakfast program under section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773);

(ii) the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.); or

(iii) both of the programs described in clauses (i) and (ii).

(2) PROGRAM.—The term ''program'' means the program established under subsection (b)(1).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Agriculture.

(b) REIMBURSEMENT PROGRAM.—

(1) ESTABLISHMENT.—Not later than 60 days after the effective date specified in section 5702, the Secretary shall establish a program under which the Secretary shall reimburse each school participating in a program described in clause (i) or (ii) of subsection (a)(1)(B) for all delinquent debt.

(2) FORM FOR REIMBURSEMENT.—To carry out the program, the Secretary shall design and distribute a form to State agencies to collect data on all delinquent debt in applicable schools in the State, grouped by school food authority.

(3) COMPLETION DATE.—The Secretary shall provide all reimbursements under the program not later than 180 days after the effective date specified in section 5702.

(c) REPORT.—Not later than 2 years after the effective date specified in section 5702, the Comptroller General of the United States shall submit to Congress and make publicly available a report that describes the successes and challenges of the program.

SEC. 5716. CONFORMING AMENDMENTS.

The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) is amended—

(1) by striking ''or reduced price'' each place it appears;

(2) by striking ''or a reduced price'' each place it appears;

(3) by striking ''and reduced price'' each place it appears; and

(4) by striking ''a reduced price'' each place it appears.

SEC. 5717. MEASURE OF POVERTY.

Section 1113(a) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a)) is amended—

(1) in paragraph (5)(A), by striking ''the number of children eligible for a free or reduced price

lunch under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.)'' and inserting ''the number of identified students''; and

(2) by adding at the end the following:

''(8) IDENTIFIED STUDENTS DEFINED.—

''(A) IN GENERAL.—In this subsection, the term 'identified students' means the number of students—

''(i) who are—

''(I) homeless children and youths, as defined under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2));

''(II) runaway and homeless youth served by programs established under the Runaway and Homeless Youth Act (34 U.S.C. 11201 et seq.);

''(III) migratory children, as defined under section 1309; or

''(IV) foster children;

''(ii) who are eligible for and receiving medical assistance under the program of medical assistance established under title

XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

''(iii) who participate (or who are part of a household that participates) in at least one of the following:

''(I) The supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

''(II) A State program funded under the program of block grants to States for temporary assistance for needy families established under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

''(III) The food distribution program on Indian reservations established under section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)).

''(IV) A Head Start program authorized under the Head Start Act (42 U.S.C. 9831 et seq.) or a comparable State-funded Head Start or pre-kindergarten program.

"(B) MULTIPLIER.—In determining the number of identified students under subparagraph (A), the local educational agency shall multiply the number determined under such subparagraph by 1.6.".

SEC. 5718. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.

(a) AGREEMENT FOR DIRECT CERTIFICATION.—

(1) IN GENERAL.—Section 11 of the Food and Nutrition Act of 2008 (7 U.S.C. 2020) is amended—

(A) by striking subsection (u); and

(B) by redesignating subsections (v) through (x) as subsections (u) through (w), respectively.

(2) CONFORMING AMENDMENTS.—Section 11(e) of the Food and Nutrition Act of 2008 (7 U.S.C. 2020(e)) is amended—

(A) in paragraph (8)(F), by striking "or subsection (u)"; and

(B) in paragraph (26)(B), by striking "(x)" and inserting "(w)".

(b) NUTRITION EDUCATION AND OBESITY PREVENTION GRANT PROGRAM.—Section 28(a) of the Food and

Nutrition Act of 2008 (7 U.S.C. 2036a(a)) is amended by striking paragraph (1) and inserting the following:

"(1) an individual eligible for benefits under this Act;".

SEC. 5719. HIGHER EDUCATION ACT OF 1965.

(a) TEACHER QUALITY ENHANCEMENT.—Subparagraph (A) of section 200(11) of the Higher Education Act of 1965 (20 U.S.C. 1021(11)) is amended to read as follows:

"(A) IN GENERAL.—The term 'high-need school' means a school that is in the highest quartile of schools in a ranking of all schools served by a local educational agency, ranked in descending order by percentage of students from low-income families enrolled in such schools, as determined by the local educational agency based on one of the following measures of poverty:

"(i) The percentage of students aged 5 through 17 in poverty counted in the most recent census data approved by the Secretary.

"(ii) The percentage of students in families receiving assistance under the State program funded under the program

of block grants to States for temporary assistance for needy families established under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

''(iii) The percentage of students eligible to receive medical assistance under the program of medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

''(iv) A composite of two or more of the measures described in clauses (i) through (iii).''.

(b) GEAR UP.—Subparagraph (A) of section 404B(d)(1) of the Higher Education Act of 1965 (20 U.S.C. 1070a–22(d)(1)) is amended to read as follows:

''(A) provide services under this chapter to at least one grade level of students, beginning not later than 7th grade, in a participating school—

''(i) that has a 7th grade; and

''(ii) in which—

''(I) at least 50 percent of the students enrolled are identified students (as described in clause (i), (ii), or (iii) of section 1113(a)(8)(A) of the

Elementary and Secondary Education Act of 1965); or

"(II) if an eligible entity determines that it would promote the effectiveness of a program, an entire grade level of students, beginning not later than the 7th grade, reside in public housing, as defined in section 3(b)(1) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(1)).".

(c) SIMPLIFIED NEEDS TEST.—Section 479(d)(2) of the Higher Education Act of 1965 (20 U.S.C. 1087ss(d)(2)) is amended—

(1) by striking subparagraph (C); and

(2) by redesignating subparagraphs (D) through (F) as subparagraphs (C) through (E), respectively.

(d) EARLY FEDERAL PELL GRANT COMMITMENT DEMONSTRATION PROGRAM.—Section 894(b) of the Higher Education Act of 1965 (20 U.S.C. 1161y(b)) is amended—

(1) in paragraph (1)(B), by striking "qualify for a free or reduced price school lunch under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the Child Nutrition Act of

1966 (42 U.S.C. 1771 et seq.)'' and inserting ''are identified students (as described in clause (i), (ii), or (iii) of section 1113(a)(8)(A) of the Elementary and Secondary Education Act of 1965)''; and

(2) in paragraph (5), by striking ''eligible for a free or reduced price school lunch under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.)'' and inserting ''identified students (as described in clause (i), (ii), or (iii) of section 1113(a)(8)(A) of the Elementary and Secondary Education Act of 1965)''.

SEC. 5720. ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965.

(a) LITERACY EDUCATION FOR ALL.—Section 2221(b)(3)(B) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6641(b)(3)(B)) is amended—

(1) by striking clause (i); and

(2) by redesignating clauses (ii) and (iii) as clauses (i) and (ii), respectively.

(b) GRANTS FOR EDUCATION INNOVATION AND RESEARCH.—Section 4611(d)(2) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7261(d)(2)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

(c) ELIGIBILITY FOR HEAVILY IMPACTED LOCAL EDUCATIONAL AGENCIES.—Item (bb) of section 7003(b)(2)(B)(i)(III) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7703(b)(2)(B)(i)(III)) is amended to read as follows:

> ''(bb) has an enrollment of children described in subsection (a)(1) that constitutes a percentage of the total student enrollment of the agency that is not less than 30 percent; or''.

SEC. 5721. AMERICA COMPETES ACT.

Section 6122(3) of the America COMPETES Act (20 U.S.C. 9832(3)) is amended by striking ''data on children eligible for free or reduced-price lunches under the Richard B. Russell National School Lunch Act,''.

SEC. 5722. WORKFORCE INNOVATION AND OPPORTUNITY ACT.

Section 3(36)(A) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102(36)(A)) is amended—

(1) by striking clause (iv); and

(2) by redesignating clauses (v) and (vi) as clauses (iv) and (v), respectively.

SEC. 5723. NATIONAL SCIENCE FOUNDATION AUTHORIZATION ACT OF 2002.

Section 4(8) of the National Science Foundation Authorization Act of 2002 (42 U.S.C. 1862n note) is amended—

(1) by striking subparagraph (A); and

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively.

SEC. 5724. CHILD CARE AND DEVELOPMENT BLOCK GRANT.

Section 658O(b) of the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858m(b)) is amended—

(1) in paragraph (1)(B), by striking ''school lunch factor'' and inserting ''identified students factor''; and

(2) by striking paragraph (3) and inserting the following:

''(3) IDENTIFIED STUDENTS FACTOR.—The term 'identified students factor' means the ratio of the number of children who are identified students (as determined under paragraph (8) of section 1113(a) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a))) in the

State to the number of such children in all the States as determined annually by the Secretary of Education.''.

SEC. 5725. CHILDREN'S HEALTH ACT OF 2000.

Section 1404(b) of the Children's Health Act of 2000 (42 U.S.C. 9859c(b)) is amended—

(1) in paragraph (1)(B), by striking ''school lunch factor'' and inserting ''identified students factor''; and

(2) by amending paragraph (3) to read as follows:

''(3) IDENTIFIED STUDENTS FACTOR.—In this subsection, the term 'identified students factor' means the ratio of the number of children who are identified students (as determined under paragraph (8) of section 1113(a) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6313(a))) in the State to the number of such children in all the States as determined annually by the Secretary of Education.''.

SEC. 5726. JUVENILE JUSTICE AND DELINQUENCY PREVENTION.

Section 252(i) of the Juvenile Justice and Delinquency Prevention Act of 1974 (34 U.S.C. 11162(i)) is amended to read as follows:

''(i) FREE SCHOOL LUNCHES FOR INCARCERATED JUVENILES.—

''(1) ELIGIBLE JUVENILE DETENTION CENTER DEFINED.—In this subsection, the term 'eligible juvenile detention center' does not include any private, for-profit detention center.

''(2) ELIGIBILITY FOR FREE LUNCH.—A juvenile who is incarcerated in an eligible juvenile detention center is eligible to receive free lunch under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

''(3) GUIDANCE.—Not later than 1 year after the date of enactment of the Universal School Meals Program Act of 2022, the Attorney General, in consultation with the Secretary of Agriculture, shall provide guidance to States relating to the options for school food authorities in the States to apply for reimbursement for free lunches under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) for juveniles who are incarcerated.''.

Subtitle I—Elder Care

SEC. 5801. EXPENSES FOR HOUSEHOLD AND ELDER CARE SERVICES NECESSARY FOR GAINFUL EMPLOYMENT.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 25D the following new section:

"SEC. 25E. EXPENSES FOR HOUSEHOLD AND ELDER CARE SERVICES NECESSARY FOR GAINFUL EMPLOYMENT.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—In the case of an individual for which there are one or more qualifying individuals (as defined in subsection (b)(1)) with respect to such individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the employment-related expenses (as defined in subsection (b)(3)) paid by such individual during the taxable year.

''(2) APPLICABLE PERCENTAGE DEFINED.—For purposes of paragraph (1), the term 'applicable percentage' means 35 percent reduced (but not below 20 percent) by 1 percentage point for each $2,000

(or fraction thereof) by which the taxpayer's adjusted gross income for the taxable year exceeds $15,000.

''(b) DEFINITIONS OF QUALIFYING INDIVIDUAL AND EMPLOYMENT-RELATED EXPENSES.—For purposes of this section—

''(1) QUALIFYING INDIVIDUAL.—The term 'qualifying individual' means an individual who—

''(A) has attained age 50, and

''(B) satisfies the requirements of any of the following clauses:

''(i) An individual who bears a relationship to the taxpayer described in subparagraph (C) or (D) of section 152(d)(2) (relating to fathers, mothers, and ancestors).

''(ii) An individual who would be a dependent of the taxpayer (as defined in section 152, determined without regard to subsections (b)(1) and (b)(2)) as a qualifying relative described in section 152(d)(1) if—

''(I) in lieu of the requirements under subparagraphs (B) and (C) of

such section, with respect to such individual—

"(aa) the taxpayer has provided over one-half of the individual's support for the calendar year in which such taxable year begins and each of the preceding 4 taxable years, and

"(bb) the individual's modified adjusted gross income for the calendar year in which such taxable year begins is less than the exemption amount (as defined in section 151(d)),

"(II) the individual is physically or mentally incapable of caring for himself or herself, and

"(III) the individual has the same principal place of abode as the taxpayer for more than one-half of such taxable year.

"(iii) The spouse of the taxpayer, if such spouse is physically or mentally incapable of caring for himself or herself.

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income determined without regard to section 86.

''(3) EMPLOYMENT-RELATED EXPENSES.—

''(A) IN GENERAL.—The term 'employment-related expenses' means amounts paid for the following expenses, but only if such expenses are incurred to enable the taxpayer to be gainfully employed for any period for which there are one or more qualifying individuals with respect to the taxpayer:

''(i) Expenses for household services with respect to the qualifying individual.

''(ii) Expenses for the care of a qualifying individual, including expenses for respite care and hospice care.

''(B) EXCEPTION.—The term 'employment-related expenses' shall not include services provided outside the taxpayer's household unless such expenses are incurred for the care of—

''(i) a qualifying individual described in paragraph (1)(A), or

"(ii) a qualifying individual (not described in paragraph (1)(A)) who regularly spends at least 8 hours each day in the taxpayer's household.

"(C) DEPENDENT CARE CENTERS.—The term 'employment-related expenses' shall not include services provided outside the taxpayer's household by a dependent care center (as defined in subparagraph (D)) unless—

"(i) such center complies with all applicable laws and regulations of the State and local government in which such center is located, and

"(ii) the requirements of subparagraph (B) are met.

"(D) DEPENDENT CARE CENTER DEFINED.—For purposes of this paragraph, the term 'dependent care center' means any facility which—

"(i) provides care for more than 6 individuals (other than individuals who reside at the facility), and

"(ii) receives a fee, payment, or grant for providing services for any of the indi-

viduals (regardless of whether such facility is operated for profit).

''(c) DOLLAR LIMIT ON AMOUNT CREDITABLE.—The amount of the employment-related expenses incurred during any taxable year which may be taken into account under subsection (a) shall not exceed—

''(1) if there is 1 qualifying individual with respect to the taxpayer for such taxable year, $3,000, or

''(2) if there are 2 or more qualifying individuals with respect to the taxpayer for such taxable year, $6,000.

The amount determined under this subsection shall be reduced by the aggregate amount excludable from gross income under section 129 for the taxable year.

''(d) EARNED INCOME LIMITATION.—The amount of the employment-related expenses incurred during any taxable year which may be taken into account under subsection (a) shall not exceed—

''(1) in the case of an individual who is not married at the close of such year, such individual's earned income for such year, or

''(2) in the case of an individual who is married at the close of such year, the lesser of such individ-

ual's earned income or the earned income of his spouse for such year.

''(e) SPECIAL RULES.—For purposes of this section—

''(1) PLACE OF ABODE.—An individual shall not be treated as having the same principal place of abode of the taxpayer if at any time during the taxable year of the taxpayer the relationship between the individual and the taxpayer is in violation of local law.

''(2) MARRIED COUPLES MUST FILE JOINT RETURN.—In the case of an individual who is married as of the close of the taxable year, the credit shall be allowed under subsection (a) only if a joint return is filed for the taxable year under section 6013.

''(3) MARITAL STATUS.—An individual legally separated from his or her spouse under a decree of divorce or of separate maintenance shall not be considered as married.

''(4) CERTAIN MARRIED INDIVIDUALS LIVING APART.—In the case of an individual who is married and does not file a joint return for the taxable year, if—

''(A) such individual—

''(i) maintains as his or her home a household which constitutes for more than one-half of the taxable year the principal place of abode of a qualifying individual,

''(ii) furnishes over half of the cost of maintaining such household during the taxable year, and

''(B) during the last 6 months of such taxable year, such individual's spouse is not a member of such household,

such individual shall not be considered as married.

''(5) PAYMENTS TO RELATED INDIVIDUALS.—No credit shall be allowed under subsection (a) for any amount paid by the taxpayer to an individual—

''(A) with respect to whom, for the taxable year, a deduction under section 151(c) (relating to deduction for personal exemptions for dependents) is allowable either to the taxpayer or the taxpayer's spouse, or

''(B) who—

''(i) is a child of the taxpayer (within the meaning of section 152(f)(1)), and

''(ii) has not attained the age of 19 at the close of the taxable year.

For purposes of this paragraph, the term 'taxable year' means the taxable year of the taxpayer in which the service (as described in clause (i) of subsection (b)(3)(A)) is performed or the care (as described in clause (ii) of such subsection) is provided.

''(6) IDENTIFYING INFORMATION REQUIRED WITH RESPECT TO SERVICE PROVIDER.—No credit shall be allowed under subsection (a) for any amount paid to any person unless—

''(A) the name, address, and taxpayer identification number of such person are included on the return of tax for the taxable year in which the credit under this section is being claimed, or

''(B) if such person is an organization described in section 501(c)(3) and exempt from tax under section 501(a), the name and address of such person are included on the return of tax for the taxable year in which the credit under this section is being claimed.

In the case of a failure to provide the information required under the preceding sentence, the preceding sentence shall not apply if it is shown that the taxpayer exercised due diligence in attempting to provide the information so required.

''(7) IDENTIFYING INFORMATION REQUIRED WITH RESPECT TO QUALIFYING INDIVIDUALS.—No credit shall be allowed under this section with respect to any qualifying individual unless the TIN of such individual is included on the return of tax for the taxable year in which the credit under this section is being claimed.

''(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Expenses for household and elder care services necessary for gainful employment.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

Subtitle J—Miscellaneous Provisions

SEC. 5901. CLARIFICATION SUPPORTING PERMISSIBLE USE OF FUNDS FOR STILLBIRTH PREVENTION ACTIVITIES.

Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended—

(1) in paragraph (1)(B), by inserting ''to reduce the incidence of stillbirth,'' after ''among children,''; and

(2) in paragraph (2), by inserting after ''follow-up services'' the following: '', and for evidence-based programs and activities and outcome research to reduce the incidence of stillbirth (including tracking and awareness of fetal movements, improvement of birth timing for pregnancies with risk factors, initiatives that encourage safe sleeping positions during pregnancy, screening and surveillance for fetal growth restriction, efforts to achieve smoking cessation during pregnancy, community-based programs that provide home visits or other types of support, and any other research or evidence-based programming to prevent stillbirths)''.

TITLE VI—MENTAL HEALTH AND SUBSTANCE USE DISORDERS

SEC. 6001. MENTAL HEALTH FINDINGS.

Congress finds the following:

(1) Despite the existence of effective treatments, inequities lie in the availability, accessibility, and quality of mental health services for racial and ethnic minorities and people with disabilities.

(2) These inequities have powerful significance for minority groups and for society as a whole.

(3) Racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity.

(4) Improving community conditions and one's home environment, paired with high-quality, accessible, and culturally and linguistically tailored mental health services, can reduce the likelihood, frequency, and intensity of challenges to one's mental health.

(5) The presence of strong social connections and trust, opportunities to experience and share cultural identity, safe gathering places, and economic opportunity are community factors that benefit mental health.

(6) The social, physical, economic, and other conditions, otherwise known as social determinants of health, in communities can have tremendous influence on daily stressors that shape mental health outcomes.

(7) Significant barriers include the cost of and access to quality care, societal stigma, mental health workforce shortages, the fragmented organization of services and needed social supports, and the history of racism and discrimination in the mental health system.

(8) People with severe and persistent mental illness who are racial or ethnic minorities often have co-occurring health and mental health conditions and experience direct inequities in access to necessary supports, resources, and services which, without proper accommodations and support, further stigmatize them and limit their participation in society.

(9) African-American, Latinx, Asian American, Pacific Islander, Native, Middle Eastern and North African (MENA), and other people of color communities are more likely to experience systemic discrimination by health care and social service pro-

viders and may be reluctant to seek mental health care and other health interventions.

(10) Mental health conditions and substance abuse disorders retain considerable stigma in many communities of color and seeking treatment is not always encouraged.

(11) Addressing mental health stigma and increasing access to culturally and linguistically appropriate treatments and supports in communities will help to increase utilization of mental health services for people who have functional difficulties because of mental health challenges.

(12) There is a link between a mental health diagnosis and the likelihood of an individual committing suicide.

(13) A comprehensive public health approach to behavioral health is one that fosters and finances protective factors in racial and ethnic communities that support mental health.

(14) Approaches to mental health and trauma must keep in mind the historical and present day and cultural trauma that impacts many communities of color, including trauma and loss caused by adverse weather events and structural violence.

(15) Culturally and linguistically appropriate treatments and supports must keep approaches of individual communities to mental health in mind, including by considering—

(A) approaches to cultural healing practices; and

(B) the diverse mental health professionals needed for such practices, such as peer support specialists.

(16) Approaches to mental health and addressing trauma must keep in mind the concept of intersectionality of individuals; that individuals may experience many inequities that shape the way they process and experience everyday life.

SEC. 6002. SENSE OF CONGRESS.

It is the sense of the Congress that it is imperative that a comprehensive public health approach to addressing trauma and mental health care be focused on care delivery 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));''.

(2) DEFINITIONS.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 2007(b), 4221(a), and 4251(c)(2), is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor; Substance Abuse Counselor Services; Substance Abuse Counselor; Peer Support Specialist Services; Peer Support Specialist

''(ooo)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree that qualifies for licensure or certification as a marriage and family therapist pursuant to State law, including but not limited to, clinical social workers and occupational therapists;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental health conditions and disabilities that the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(4) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree in mental health counseling or a related field, including clinical social workers and occupational therapists;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.

''(5) The term 'substance abuse counselor services' means services performed by a substance abuse counselor (as defined in paragraph (6)) for the diagnosis and treatment of substance abuse and addiction that the substance abuse counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(6) The term 'substance abuse counselor' means an individual who—

''(A) has performed at least 2 years of supervised substance abuse counselor practice;

''(B) in the case of an individual performing services in a State that provides for licensure or certification of substance abuse counselors or professional counselors, is licensed or certified as a substance abuse counselor or professional counselor in such State; or

''(C) is a drug and alcohol counselor as defined in section 40.281 of title 49, Code of Federal Regulations.

''(7) The term 'peer support specialist services' means services performed by a peer support specialist (as defined in paragraph (8)) for the well-being of individuals needing mental health support that the peer support specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(8) The term 'peer support specialist' means an individual who—

''(A) is an individual living in recovery with mental illness, addiction, or systems involvement;

''(B) has skills learned in formal training;

''(C) uses assets-based framing in speaking about mental health, recovery, and well-being; and

''(D) delivers services in behavioral health settings to promote mind-body recovery and resiliency.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(A) by striking ''and'' at the end of clause (iv); and

(B) by adding at the end the following new clause:

''(v) marriage and family therapist services, mental health counselor services, substance abuse counselor services, and peer support specialist services; and''.

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4251(c)(3), is amended—

(A) by striking ''and'' before ''(EE)''; and

(B) by inserting before the semicolon at the end the following: ", and (FF) with respect to marriage and family therapist services, mental health counselor services, substance abuse counselor services, and peer support specialist services under section 1861(s)(2)(JJ), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES, MENTAL HEALTH COUNSELOR SERVICES, AND PEER SUPPORT SPECIALIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "marriage and family therapist services (as defined in section 1861(nnn)(1)), mental health counselor services (as defined in section 1861(nnn)(3)), and peer support specialist services (as defined in section 1861(nnn)(7)),'' after "qualified psychologist services,".

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS, MENTAL HEALTH COUNSELORS, AND

SUBSTANCE ABUSE COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

''(vii) A marriage and family therapist (as defined in section 1861(nnn)(2)).

''(viii) A mental health counselor (as defined in section 1861(nnn)(4)).

''(ix) A substance abuse counselor (as defined in section 1861(nnn)(6)).

''(x) A peer support specialist (as defined in section 1861(nnn)(8)).''.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (nnn)(2)), or by a mental health counselor (as defined in subsection (nnn)(4)), or by a substance

abuse counselor (as defined in section 1861 (nnn)(6)), or by a peer support specialist (as defined in section 1861(nnn)(8)).''.

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ''or one marriage and family therapist (as defined in subsection (nnn)(2))'' after ''social worker''.

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POSTHOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting ''marriage and family therapist (as defined in subsection (nnn)(2)),'' after ''social worker,''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2023.

SEC. 6012. REAUTHORIZATION OF MINORITY FELLOWSHIP PROGRAM.

Section 597(c) of the Public Health Service Act (42 U.S.C. 297ll(c)) is amended by striking ''$12,669,000 for each of fiscal years 2018 through 2022'' and inserting ''$25,000,000 for each of fiscal years 2023 through 2027''.

SEC. 6013. ADDITIONAL FUNDS FOR NATIONAL INSTITUTES OF HEALTH.

(a) IN GENERAL.—In addition to amounts otherwise authorized to be appropriated to the National Institutes of Health, there is authorized to be appropriated to such Institutes $100,000,000 for each of fiscal years 2023 through 2027 to build relations with communities and conduct or support clinical research, including clinical research on racial or ethnic disparities in physical and mental health.

(b) DEFINITION.—In this section, the term ''clinical research'' has the meaning given to such term in section 409 of the Public Health Service Act (42 U.S.C. 284d).

SEC. 6014. ADDITIONAL FUNDS FOR NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.

In addition to amounts otherwise authorized to be appropriated to the National Institute on Minority Health and Health Disparities, there is authorized to be appropriated to such Institute $650,000,000 for each of fiscal years 2023 through 2027.

SEC. 6015. GRANTS FOR INCREASING RACIAL AND ETHNIC MINORITY ACCESS TO HIGH-QUALITY TRAUMA SUPPORT SERVICES AND MENTAL HEALTH CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Assistant Secretary for Mental Health and Substance Use, shall award grants to eligible entities to establish or expand programs for the purpose of increasing racial and ethnic minority access to high-quality trauma support services and mental health care.

(b) ELIGIBLE ENTITIES.—To seek a grant under this section, an entity shall be a community-based program or organization that—

(1) provides culturally and linguistically appropriate programs and resources that are aligned with evidence-based practices for trauma-informed care; and

(2) has demonstrated expertise in serving communities of color or can partner with a program that has such demonstrated expertise.

(c) USE OF FUNDS.—As a condition on receipt of a grant under this section, a grantee shall agree to use the grant to increase racial and ethnic minority access to high-

quality trauma support services and mental health care, such as by—

(1) establishing and maintaining community-based programs providing evidence-based services in trauma-informed care and culturally specific services and other resources;

(2) developing innovative, culturally-specific strategies and projects to enhance access to trauma-informed care and resources for racial and ethnic minorities who face obstacles to using more traditional services and resources (such as obstacles in geographic access to providers, insurance coverage, and access to audio and video technologies);

(3) working with State and local governments and social service agencies to develop and enhance effective strategies to provide culturally-specific services to racial and ethnic minorities;

(4) increasing communities' capacity to provide culturally-specific resources and support for communities of color;

(5) working in cooperation with the community to develop education and prevention strategies highlighting culturally-specific issues and resources regarding racial and ethnic minorities;

(6) providing culturally-specific programs for racial and ethnic minorities exposed to law enforcement violence; and

(7) examining the dynamics of culture and its impact on victimization and healing.

(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities proposing to serve communities that have faced high rates of community trauma, including from exposure to law enforcement violence, intergenerational poverty, civil unrest, discrimination, or oppression.

(e) GRANT PERIOD.—The period of a grant under this section shall be 4 years.

(f) EVALUATION.—Not later than 6 months after the end of the period of all grants under this section, the Secretary shall—

(1) conduct an evaluation of the programs funded by a grant under this section;

(2) include in such evaluation an assessment of the outcomes of each such program; and

(3) submit a report on the results of such evaluation to the Congress.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2023 through 2027.

SEC. 6016. GRANTS FOR UNARMED 9-1-1 RESPONSE PROGRAMS.

Part D of title V of the Public Health Service Act, as amended by sections 6022, 6023, and 6052, is further amended by adding at the end the following new section:

"SEC. 556. GRANTS FOR UNARMED 9-1-1 RESPONSE PROGRAMS.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, may award grants to States, territories, political subdivisions of States and territories, Tribal governments, and consortia of Tribal governments to establish an unarmed 9-1-1 response program under which nonviolent 9-1-1 calls are referred to unarmed professional service providers for response, instead of to a law enforcement agency.

''(b) PROGRAM REQUIREMENTS.—An unarmed 9-1-1 response program funded under this section shall—

''(1) dispatch unarmed professional service providers in groups of two or more in a timely manner;

''(2) be capable of providing screening, assessment, de-escalation, trauma-informed culturally and linguistically appropriate services, referrals to treatment providers, and transportation to immediately necessary treatment;

''(3) when necessary, coordinate with health or social services;

''(4) not be subject to oversight of State or local law enforcement agencies; and

''(5) clearly outline the scope of calls that must or may be referred to the unarmed 9-1-1 response program.

''(c) USES OF FUNDS.—A grant under this section may be used for—

''(1) hiring unarmed professional service providers and 9-1-1 dispatchers;

''(2) training unarmed professional service providers to respond to 9-1-1 calls by identifying, understanding, and responding to signs of mental illnesses, developmental or intellectual disabilities, and substance use disorders, including by means of—

''(A) de-escalation;

''(B) crisis intervention; and

''(C) connecting individuals to local social service providers, health care providers, community-based organizations, and the full range of other available providers and resources, with a focus on culturally and linguistically appropriate service providers;

''(3) updating 9-1-1 response systems to enable triage between nonviolent 9-1-1 calls and those that require a response from law enforcement;

''(4) training 9-1-1 dispatchers on call diversion;

''(5) building the capacity—

''(A) to coordinate with local social service providers, health care providers, suicide hotline operators, and community-based organizations; and

''(B) to provide multilingual and culturally and linguistically appropriate services; and

''(6) collecting data for reports to the Secretary.

''(d) APPLICATION.—An applicant seeking a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may reasonably require, including the applicant's plan to train 9-1-1 dispatchers to determine when a call should be diverted to the unarmed 9-1-1 response program.

''(e) REPORTS TO SECRETARY.—A recipient of a grant under this section shall submit to the Secretary, on a biannual basis, a report on the following:

''(1) The number of calls placed to 9-1-1 that were diverted to the grantee's unarmed 9-1-1 response program.

''(2) Demographic information on the individuals served by the grantee's unarmed 9-1-1 response program, disaggregated by race, ethnicity, age, sex, sexual orientation, gender identity, and location.

''(3) The effects of the grantee's unarmed 9-1-1 response program on emergency room visits, hospitalizations, use of ambulances, and involvement of law enforcement in mental health or substance use disorder crises.

''(4) An assessment of the types of events and crises to which the grantee's unarmed 9-1-1 response program responded and the services provided, including—

''(A) the number of individuals to whom services were provided who were involuntarily committed for treatment;

''(B) the number of individuals successfully transferred to an alternative destination;

''(C) the time between notification by a 9-1-1 dispatcher and arrival at the scene by a provider; and

''(D) the time spent by providers at scene.

''(5) A cost analysis of the grantee's unarmed 9-1-1 response program.

''(6) An assessment of data sharing limitations or problems associated with adherence to—

''(A) Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

''(B) part 2 of title 42, Code of Federal Regulations.

''(f) REPORTS TO CONGRESS.—The Secretary shall submit to the Congress, on a biannual basis, a report on the program under this section, including a summary of the reports submitted by grantees pursuant to subsection (e).

''(g) GRANT AMOUNT.—The Secretary may make grants to applicants that do not meet all of the criteria under subsection (b), but applicants that do not meet all such criteria may not receive the full grant amount.

''(h) DEFINITIONS.—In this section:

''(1) The term 'alternative destination'—

''(A) means any service- or care-providing site other than a hospital emergency department or jail; and

"(B) includes a clinic, primary care office, crisis center, and community care center.

"(2) The term 'nonviolent 9-1-1 call' means a 9-1-1 call that—

"(A) relates to mental health, homelessness, addiction problems, social services, truancy, intellectual and developmental disabilities, or public intoxication; and

"(B) does not involve obvious violent behavior.

"(3) The term 'unarmed professional service provider' means a professional (which may include a nurse, social worker, emergency medical technician, counselor, community health worker, trauma-informed personnel, social service provider, or peer support specialist) who—

"(A) is trained to deal with mental health or substance abuse crises or intellectual and developmental disabilities; and

"(B) does not carry a firearm.".

Subtitle B—Interprofessional Care

SEC. 6021. HEALTH PROFESSIONS COMPETENCIES TO ADDRESS RACIAL AND ETHNIC MENTAL HEALTH INEQUITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, shall award grants to qualified national organizations for the purposes of—

(1) developing, and disseminating to health professional educational programs, culturally and linguistically appropriate curricula or core competencies addressing mental health inequities among racial and ethnic minority groups for use in the training of students in the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, peer support, and substance abuse counseling; and

(2) certifying community health workers and peer wellness specialists with respect to such curricula and core competencies and integrating and expanding the use of such workers and specialists into health care and community-based settings to address mental health inequities among racial and ethnic minority groups.

(b) CURRICULA; CORE COMPETENCIES.—Organizations receiving funds under subsection (a) may use the funds to engage in the following activities related to the development and dissemination of curricula or core competencies described in subsection (a)(1):

(1) Formation of committees or working groups comprised of experts from accredited health professions schools to identify core competencies relating to mental health inequities among racial and ethnic minority groups.

(2) Planning of workshops in collaboration with community-based organizations and communities of color in national fora to directly facilitate public input, including input from communities of color with lived experience, into the educational needs associated with mental health inequities among racial and ethnic minority groups.

(3) Dissemination and promotion of the use of curricula or core competencies in undergraduate and graduate health professions training programs nationwide.

(4) Establishing external stakeholder advisory boards to provide meaningful input into policy and program development and best practices to reduce mental health inequities among racial and ethnic

groups, including participation and leadership from communities of color with lived experience of the impacts of mental health inequities.

(c) DEFINITIONS.—In this section:

(1) QUALIFIED NATIONAL ORGANIZATION.—The term ''qualified national organization'' means a national organization that focuses on the education of students in programs of social work, occupational therapy, psychology, psychiatry, substance use counseling, and marriage and family therapy.

(2) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given to such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)), as amended by title I of this Act.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

SEC. 6022. INTERPROFESSIONAL HEALTH CARE TEAMS FOR BEHAVIORAL HEALTH CARE.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

"SEC. 553. INTERPROFESSIONAL HEALTH CARE TEAMS FOR PROVISION OF BEHAVIORAL HEALTH CARE IN PRIMARY CARE SETTINGS.

"(a) GRANTS.—The Secretary, acting through the Assistant Secretary, shall award grants to eligible entities for the purpose of establishing interprofessional health care teams that provide behavioral health care.

"(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), rural health clinic, women's health clinic, or behavioral health program (including any such program operated by a community-based organization) serving a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).

"(c) LOAN FORGIVENESS.—To encourage qualified and diverse allied health professionals to enter the mental health field, an eligible entity receiving a grant under this section shall agree to use not less than $10,000 of the grant funds on a loan forgiveness program for practitioners who commit to working in the mental health field for a period of 2 years.

"(d) SCIENTIFICALLY AND CULTURALLY BASED.—Integrated health care funded through this section shall be scientifically and culturally based, taking into consider-

ation the results of the most recent peer-reviewed research available, including information on language accessibility, cultural humility, diversity of practitioners, and consideration of social determinants of health.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2023 through 2027.''.

SEC. 6023. INTEGRATED HEALTH CARE DEMONSTRATION PROGRAM.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by sections 6022 and 6052, is further amended by adding at the end the following:

''SEC. 555. INTERPROFESSIONAL HEALTH CARE TEAMS FOR PROVISION OF BEHAVIORAL HEALTH CARE IN PRIMARY CARE SETTINGS.

''(a) GRANTS.—The Secretary shall award grants to eligible entities for the purpose of establishing interprofessional health care teams that provide behavioral health care.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), rural health clinic, or behavioral

health program, serving a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)).

''(c) SCIENTIFICALLY BASED.—Integrated health care funded through this section shall be scientifically based, taking into consideration the results of the most recent peer-reviewed research available.

''(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $20,000,000 for each of the first 5 fiscal years following the date of enactment of the Health Equity and Accountability Act.''.

Subtitle C—Workforce Development

SEC. 6031. BUILDING AN EFFECTIVE WORKFORCE IN MENTAL HEALTH.

(a) IN GENERAL.—The Secretary of Health and Human Services, in coordination with the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, the Secretary of Labor, and advocacy and behavioral and mental health organizations serving vulnerable populations, including youth and young adults, people with low incomes, and people of color, shall—

(1) develop, strengthen, and implement strategies to bolster career pathways for diverse mental health professionals;

(2) identify the breadth of settings where mental health care and behavioral health care can take place; and

(3) identify current mental health professional workforce shortages, inclusive of shortages of diverse mental health professionals.

(b) CONTENTS.—Strategies under subsection (a) shall include—

(1) the variety of settings where mental health professionals are needed, including community-based organizations, women's centers, shelters, organizations focused on youth development, workforce agencies, job placement and development centers, emergency rooms, the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), food banks, legal aid, and benefit issuers as defined in section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012);

(2) defining career pathways in mental and behavioral health, to help diverse communities under-

stand the variety of careers in mental and behavioral health that are available;

(3) building career pathways in mental and behavioral health as part of the curriculum at the postsecondary education level;

(4) providing accessible training and certification pathways for diverse lay health workers such as community health workers and other peer support specialists to ensure that careers pay a living wage;

(5) creating incentives for students in the fields of occupational therapy, social work, psychology, medicine, and nursing to learn more about mental health, and to include a mental health rotation, with a particular focus in racially and ethnically diverse communities, as a part of the health professional curricula;

(6) including training and education for teachers about the basics of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and individualized education programs (as defined in section 614(d) of the Individuals with Disabilities Education Act (20 U.S.C. 1414(d)));

(7) researching, developing, and implementing programs for mental and behavioral health professionals to prevent burnout; and

(8) finding better and increased avenues to ensure equity by providing better loan forgiveness programs, including a focus area within the National Health Service Corps focused on community trauma.

(c) USE OF FUNDS.—Programs and activities funded under this section shall be consistent with subsection (a)(1) and shall include the following:

(1) Subgrants to entities serving youth and young adults which demonstrate a need for an increased mental health workforce, using strategies mentioned in subsection (a)(1).

(2) Funding towards the Health Resources and Services Administration's Behavioral Health Workforce Education and Training Program.

(3) Funding towards the development and implementation of a National Health Service Corps program focused on community trauma.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2023 through 2033.

SEC. 6032. PILOT PROGRAM TO INCREASE LANGUAGE ACCESS AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) LOAN REPAYMENTS TO QUALIFIED HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—For the purpose of increasing language access to mental health services, the Secretary shall carry out a demonstration project under which—

(A) the Secretary matches qualified mental health professionals with Federally qualified health centers;

(B) the qualified mental health professionals each agree to a period of obligated service at a Federally qualified health center with which they are so matched; and

(C) the Secretary agrees to make loan repayments under section 338B of the Public Health Service Act (42 U.S.C. 254l–1) on behalf of such qualified mental health professionals.

(2) PREFERENCE.—In matching qualified mental health professionals with Federally qualified health centers under paragraph (1), the Secretary shall give preference to placement at Federally qualified health centers at which at least 20 percent of the patients are best served in a language other than English, as indicated by data in the Uniform Data System (or any successor database).

(3) ENHANCED COMPENSATION.—For each year of obligated service that a qualified mental health professional contracts to serve under paragraph (1) at a Federally qualified health center at which at least 20 percent of the patients are best served in a language other than English, as indicated by data in the Uniform Data System (or any successor database), the Secretary may pay the higher of—

(A) $10,000 above the maximum amount otherwise applicable under section 338B(g)(2)(A) of the Public Health Service Act (42 U.S.C. 254l–1(g)(2)(A)); or

(B) if the qualified health professional is fluent in a language other than English that is needed by such Federally qualified health center, $15,000 above such maximum amount.

(4) ACHIEVING FLUENCY.—A qualified mental health professional eligible to receive the enhanced pay amount specified in paragraph (3)(A) at the beginning of the professional's period of obligated service may transition to being eligible to receive the enhanced higher pay amount specified in paragraph (3)(B) if the professional is determined by the Federally qualified health center at which the profes-

sional serves to have achieved fluency in a language other than English needed by that health center.

(b) GRANTS TO HEALTH CENTERS.—

(1) IN GENERAL.—The Secretary shall carry out a demonstration program consisting of awarding grants under section 330 of the Public Health Service Act (42 U.S.C. 254b) to Federally qualified health centers to recruit, hire, employ, and supervise qualified mental health professionals who are fluent in a language other than English to provide mental health services in such other language.

(2) PREFERENCE.—In selecting grant recipients under paragraph (1), the Secretary shall give preference to Federally qualified health centers at which at least 20 percent of the patients are best served in a language other than English, as indicated by data in the Uniform Data System (or any successor database).

(3) MARKETING.—A Federally qualified health center receiving a grant under this subsection shall use a portion of the grant funds to disseminate information about, and otherwise market, the mental health services supported through the grant.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than 6 months after awarding loan repayment agreements under subsection (a) and grants under subsection (b), the Secretary shall submit to the Committees on Appropriations of the House of Representatives and the Senate, and to other appropriate congressional committees, a report on the implementation of the programs under this section. Such report shall include—

(A) the languages spoken by the qualified mental health professionals receiving loan repayments pursuant to subsection (a) or recruited pursuant to a grant under subsection (b);

(B) the Federally qualified health centers at which such professionals were placed;

(C) how many Federally qualified health centers received funding through the grant program under subsection (b);

(D) an analysis, conducted in consultation with the Federally qualified health centers receiving grants under section (b), of the effectiveness of such grants at increasing language access to mental health services; and

(E) best practices, developed in consultation with Federally qualified health centers receiving grants under section (b), for the recruitment and retention of mental health professionals at Federally qualified health centers.

(2) FINAL REPORT.—Not later than the end of fiscal year 2027, the Secretary shall submit to the Committees on Appropriations of the House of Representatives and the Senate, and to other appropriate congressional committees, a final report on the implementation of the programs under this section, including the information, analysis, and best practices listed in subparagraphs (A) through (E) of paragraph (1).

(d) DEFINITIONS.—In this section:

(1) The term ''Federally qualified health center'' has the meaning given the term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

(2) The term ''qualified mental health professional'' means—

(A) physicians, allopathic physicians, osteopathic physicians, nurse practitioners, and physician assistants with a specialty in mental health and psychiatry;

(B) health service psychologists;

(C) licensed clinical social workers;

(D) psychiatric nurse specialists;

(E) marriage and family therapists;

(F) licensed professional counselors;

(G) substance use disorder counselors;

(H) occupational therapists; and

(I) other individuals who—

(i) have not yet been licensed or certified to serve as a professional listed in any of subparagraphs (A) through (H); and

(ii) will serve at the Federally qualified health center under the supervision of a licensed individual or certified professional so listed.

(3) The term ''Secretary'' means the Secretary of Health and Human Services.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $75,000,000 for each of fiscal years 2023 through 2027.

(2) SUPPLEMENT NOT SUPPLANT.—Amounts made available to carry out this section shall be in addition to amounts otherwise available to provide

mental health services at Federally qualified health centers pursuant to sections 338B and 330 of the Public Health Service Act (42 U.S.C. 254l–1, 254b).

SEC. 6033. HEALTH PROFESSIONS COMPETENCIES TO ADDRESS RACIAL AND ETHNIC MINORITY MENTAL HEALTH DISPARITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services may award grants to qualified national organizations for the purposes of—

(1) developing, and disseminating to health professional educational programs, best practices or core competencies addressing mental health disparities among racial and ethnic minority groups for use in the training of students in the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, and substance abuse counseling; and

(2) certifying community health workers and peer wellness specialists with respect to such best practices and core competencies and integrating and expanding the use of such workers and specialists into health care to address mental health disparities among racial and ethnic minority groups.

(b) BEST PRACTICES; CORE COMPETENCIES.—Organizations receiving funds under subsection (a) may use the

funds to engage in the following activities related to the development and dissemination of best practices or core competencies described in subsection (a)(1):

(1) Formation of committees or working groups comprised of experts from accredited health professions schools to identify best practices and core competencies relating to mental health disparities among racial and ethnic minority groups.

(2) Planning of workshops at the national level to allow for public input into the educational needs associated with mental health disparities among racial and ethnic minority groups.

(3) Dissemination and promotion of the use of best practices or core competencies for culturally and linguistically appropriate mental health services in undergraduate and graduate health professions training programs nationwide.

(4) Establishing external stakeholder advisory boards to provide meaningful input into policy and program development and best practices to reduce mental health disparities among racial and ethnic minority groups.

(c) DEFINITIONS.—In this section:

(1) QUALIFIED NATIONAL ORGANIZATION.—The term ''qualified national organization'' means a na-

tional organization that focuses on the education of students in one or more of the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, and substance misuse counseling.

(2) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given to such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

Subtitle D—Children's Mental Health

SEC. 6041. PEDIATRIC BEHAVIORAL HEALTH CARE.

Subpart V of part D of title III of the Public Health Service Act (42 U.S.C. 256 et seq.) is amended by adding at the end the following:

''SEC. 340A–1. GRANTS TO SUPPORT PEDIATRIC BEHAVIORAL HEALTH CARE INTEGRATION AND COORDINATION.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities for the purpose of supporting pediatric behavioral health care integration and coordination within communities to meet local community needs.

''(b) ELIGIBLE ENTITIES.—Entities eligible for grants under subsection (a) include—

''(1) pediatricians;

''(2) children's hospitals;

''(3) pediatric behavioral health providers with the capacity to organize and implement activities working with community organizations and providers; and

''(4) other entities as determined appropriate by the Secretary.

''(c) PRIORITIZATION.—In awarding grants under subsection (a), the Secretary shall prioritize applicants that demonstrate the highest needs at the local level along the care continuum for strengthening children's behavioral health crisis care and access.

''(d) USE OF FUNDS.—Activities that may be funded through a grant under subsection (a) include—

''(1) the recruitment and retention of community health workers or navigators to coordinate family access to pediatric mental, emotional, and behavioral health services;

''(2) training the pediatric mental, emotional, and behavioral health care workforce, relevant stakeholders, and community members;

''(3) expanding evidence-based, integrated models of care for pediatric mental, emotional, and behavioral health services;

''(4) pediatric practice integration for the provision of pediatric mental, emotional, and behavioral health services;

''(5) addressing surge capacity for pediatric mental, emotional, and behavioral health needs;

''(6) providing pediatric mental, emotional, and behavioral health services to children as delivered by behavioral, emotional, and mental health professionals utilizing telehealth services;

''(7) establishing or maintaining initiatives to decompress emergency departments, including partial hospitalization, step down residency programs, and intensive outpatient programs;

''(8) supporting, enhancing, or expanding pediatric mental, emotional, and behavioral health preventive and crisis intervention services;

''(9) establishing or maintaining pediatric mental, emotional, and behavioral health urgent care;

''(10) establishing or maintaining community-based initiatives, such as school-based partnerships; and

''(11) addressing other access and coordination gaps to mental, emotional, and behavioral health services in the community for children.

''(e) FUNDING.—To carry out this section, there is hereby appropriated, out of amounts in the Treasury not otherwise obligated, $500,000,000 for each of fiscal years 2023 through 2027.

"SEC. 340A–2. PEDIATRIC BEHAVIORAL HEALTH WORKFORCE TRAINING PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities for the purpose of supporting evidence-based pediatric behavioral health workforce training.

''(b) ELIGIBLE ENTITIES.—Entities eligible for grants under subsection (a) include—

''(1) children's hospitals; and

''(2) other pediatric health care providers as determined appropriate by the Secretary.

''(c) USE OF FUNDS.—The training that may be supported through a grant under subsection (a) includes expanded training in pediatric behavioral health for physicians and nonphysician practitioners, including the following practitioner types:

''(1) Child and adolescent psychiatrists.

''(2) Psychiatric nurses.

''(3) Psychologists.

''(4) Advanced practice nurses.

''(5) Family therapists.

''(6) Social workers.

''(7) Mental health counselors.

''(8) Other practitioner types as determined appropriate by the Secretary.

''(d) FUNDING.—To carry out this section, there is hereby appropriated, out of amounts in the Treasury not otherwise obligated, $100,000,000 for each of fiscal years 2023 through 2027.''.

SEC. 6042. MENTAL HEALTH IN SCHOOLS.

(a) PURPOSE.— It is the purpose of this section to—

(1) revise, increase funding for, and expand the scope of the Project AWARE State Educational Agency Grant Program carried out by the Secretary of Health and Human Services, in order to provide access to more comprehensive school-based mental health services and supports;

(2) provide for comprehensive staff development for school and community service personnel working in the school;

(3) provide for comprehensive training to improve health and academic outcomes for children

with, or who have a high likelihood of developing, mental health conditions, for parents or guardians, siblings, and other family members of such children, and for concerned members of the community;

(4) provide for comprehensive, universal, evidence-based screening to identify children and adolescents with potential mental health conditions or unmet emotional health needs;

(5) recognize best practices for the delivery of mental health care in school-based settings, including school-based health centers;

(6) provide for comprehensive training for parents or guardians, siblings, other family members, and concerned members of the community on behalf of children and adolescents experiencing mental health trauma, disorders, cooccurring conditions, or disabilities; and

(7) establish formal working relationships among health, human service, and educational entities that support the mental and emotional health of children and adolescents in the school setting or that have a child or youth focus.

(b) TECHNICAL AMENDMENTS.—The second part G (relating to services provided through religious organiza-

tions) of title V of the Public Health Service Act (42 U.S.C. 290kk et seq.) is amended—

(1) by redesignating such part as part J; and

(2) by redesignating sections 581 through 584 as sections 596 through 596C, respectively.

(c) SCHOOL-BASED MENTAL HEALTH AND CHILDREN AND VIOLENCE.—Section 581 of the Public Health Service Act (42 U.S.C. 290hh) (relating to children and violence) is amended to read as follows:

"SEC. 581. SCHOOL-BASED MENTAL HEALTH; CHILDREN AND ADOLESCENTS.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Education, shall, through grants, contracts, or cooperative agreements awarded to eligible entities described in subsection (b), provide comprehensive school-based mental health services and supports to assist children in local communities and schools (including schools funded by the Bureau of Indian Education) dealing with traumatic experiences, grief, bereavement, risk of suicide, and the risk of experiencing community or interpersonal violence, such as abuse or neglect. All services and supports provided under such a grant, contract, or cooperative agreement shall—

''(1) be developmentally, linguistically, and culturally appropriate;

''(2) be trauma-informed; and

''(3) incorporate positive behavioral interventions and supports.

''(b) ACTIVITIES.—Grants, contracts, or cooperative agreements awarded under subsection (a), shall, as appropriate, be used for—

''(1) implementation of school and community-based mental health programs that—

''(A) build awareness of individual trauma and the intergenerational continuum of impacts of trauma on populations;

''(B) train appropriate staff to identify, and screen for, signs of trauma exposure, mental health and cooccurring conditions, or risk of suicide; and

''(C) incorporate positive behavioral interventions, family engagement, student treatment, and multigenerational supports to foster the health and development of children, prevent mental health disorders, and ameliorate the impact of trauma;

''(2) technical assistance to local communities with respect to the development of programs described in paragraph (1);

''(3) facilitating diverse community partnerships among families, students, educational agencies, mental health and substance use disorder service systems, family-based mental health service systems, child welfare agencies, health care providers (including primary care physicians, mental health professionals, and other professionals who specialize in children's mental health such as child and adolescent psychiatrists), institutions of higher education, faith-based programs, trauma networks, and other community-based systems to address child and adolescent trauma, as well as unmet mental health needs; and

''(4) establishing and promoting best practices that are either evidence-based or culturally-based for children and adolescents to share their experiences of individual and community trauma, including their exposure to community and domestic violence, with trusted adults.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall be a partnership that includes—

''(A) a State educational agency, as defined in section 8101 of the Elementary and

Secondary Education Act of 1965, in coordination with one or more local educational agencies, as defined in section 8101 of the Elementary and Secondary Education Act of 1965, or a consortium of any entities described in subparagraph (B), (C), (D), or (E) of section 8101(30) of such Act; and

''(B) at least 1 community-based mental health provider, including a public or private mental health entity, health care entity, family-based mental health entity, trauma network, or other community-based entity, as determined by the Secretary (and which may include additional entities such as a human services agency, child welfare agency, an institution of higher education, or another entity, as determined by the Secretary).

''(2) COMPLIANCE WITH HIPAA.—Any patient records developed by covered entities through activities under the grant shall meet the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(3) COMPLIANCE WITH FERPA.—Section 444 of the General Education Provisions Act (commonly known as the 'Family Educational Rights and Pri-

vacy Act of 1974') shall apply to any entity that is a member of the partnership in the same manner that such section applies to an educational agency or institution (as that term is defined in such section).

''(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts, or cooperative agreements under subsection (a) will be distributed equitably among the regions of the country and among urban and rural areas.

''(e) DURATION OF AWARDS.—With respect to a grant, contract, or cooperative agreement under subsection (a), the period during which payments under such an award will be made to the recipient shall be 5 years, with options for renewal.

''(f) EVALUATION AND MEASURES OF OUTCOMES.—

''(1) DEVELOPMENT OF PROCESS.—The Assistant Secretary shall develop a fiscally appropriate process for evaluating activities carried out under this section. Such process shall include—

''(A) the development of guidelines for the submission of program data by grant, contract, or cooperative agreement recipients;

''(B) the development of measures of outcomes (in accordance with paragraph (2)) to be

applied by such recipients in evaluating programs carried out under this section; and

''(C) the submission of annual reports by such recipients concerning the effectiveness of programs carried out under this section.

''(2) MEASURES OF OUTCOMES.—The Assistant Secretary shall develop measures of outcomes to be applied by recipients of assistance under this section to evaluate the effectiveness of programs carried out under this section, including outcomes related to the student, family, and local educational systems supported by this section.

''(3) SUBMISSION OF ANNUAL DATA.—An eligible entity described in subsection (c) that receives a grant, contract, or cooperative agreement under this section shall annually submit to the Assistant Secretary a report that includes data to evaluate the success of the program carried out by the entity based on whether such program is achieving the purposes of the program. Such reports shall utilize the measures of outcomes under paragraph (2) in a reasonable manner to demonstrate the progress of the program in achieving such purposes.

''(4) EVALUATION BY ASSISTANT SECRETARY.—Based on the data submitted under paragraph (3),

the Assistant Secretary shall annually submit to Congress a report concerning the results and effectiveness of the programs carried out with assistance received under this section.

''(5) LIMITATION.—An eligible entity shall use not more than 20 percent of amounts received under a grant under this section to carry out evaluation activities under this subsection.

''(g) INFORMATION AND EDUCATION.—The Secretary shall disseminate best practices based on findings made pursuant to this section.

''(h) AMOUNT OF GRANTS AND AUTHORIZATION OF APPROPRIATIONS.—

''(1) AMOUNT OF GRANTS.—A grant under this section shall be in an amount that is not more than $2,000,000 for each of the first 5 fiscal years following the date of enactment of this section. The Secretary shall determine the amount of each such grant based on the population of children up to age 21 of the area to be served under the grant.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $130,000,000 for each of fiscal years 2023 through 2026.''.

(d) CONFORMING AMENDMENT.—Part G of title V of the Public Health Service Act (42 U.S.C. 290hh et seq.), as amended by this section, is further amended, in the part heading by striking "**PROJECTS FOR CHILDREN AND VIOLENCE**" and inserting the following: "**SCHOOL-BASED MENTAL HEALTH**".

(e) SCHOOL-BASED MENTAL HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary of Education shall award grants to State educational agencies to support services provided by school-based mental health services providers at schools receiving funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.).

(2) USE OF FUNDS.—Grants under this subsection shall be used to help meet the recommended ratios of—

(A) 250 students per school counselor;

(B) 500 students per school psychologist; and

(C) 250 students per school social worker.

(3) CONDITION.—The Secretary shall ensure that funds made available under this subsection are used to provide services that are developmentally, linguistically, and culturally appropriate, are trau-

ma-informed, and incorporate positive behavioral interventions and supports.

(4) DEFINITIONS.—For purposes of this subsection:

(A) The term ''school-based mental health services provider'' has the meaning given such term in section 4102 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7112).

(B) The term ''State educational agency'' has the meaning given such term in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

SEC. 6043. ADDITIONAL SUPPORT FOR YOUTH AND YOUNG ADULT MENTAL HEALTH SERVICE PROVISION.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

''(cc) YOUTH AND YOUNG ADULT INTERVENTION SERVICES.—

''(1) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to Statewideness), section 1902(a)(10)(B) (relating to comparability), section 1902(a)(23)(A) (relating to freedom of choice of

providers), or section 1902(a)(27) (relating to provider agreements), a State may, during the 5-year period beginning on the first day of the fiscal year quarter that begins on or after January 1, 2024, provide medical assistance for qualifying youth and young adult mental health and substance use intervention services (as defined in paragraph (2)(C)) under a State plan amendment or waiver approved under section 1115 or 1915(c).

''(2) DEFINITIONS.—For the purposes of this subsection:

''(A) PRIORITY SERVICE.—The term 'priority service' means any of the following if voluntarily received and provided in a manner that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements:

''(i) Community based mobile crisis intervention services, as defined in section 1947.

''(ii) Telehealth.

''(iii) Youth peer support.

''(iv) Screening for adverse childhood experiences.

''(v) Trauma responsive care.

"(vi) Other priority services for youth, as defined by the Secretary.

"(B) QUALIFIED MENTAL HEALTH PROVIDERS.—The term 'qualified mental health providers' means a behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in youth and young adult behavioral health or mental health, including social workers, peer support specialists, recovery coaches, community health workers, mental health clinicians, and others, as designated by the State and approved by the Secretary.

"(C) QUALIFYING YOUTH AND YOUNG ADULT MENTAL HEALTH AND SUBSTANCE USE INTERVENTION SERVICES DEFINED.—The term 'qualifying youth and young adult mental health and substance use intervention services' means, with respect to a State, items and services for which medical assistance is available under the State plan under this title or a waiver of such plan, that are—

"(i) furnished to an individual 16 to 25 years of age who is—

"(I) experiencing a mental health or substance use disorder crisis;

"(II) subject to the juvenile or adult justice system as defined in section 3102 of title 29, United States Code;

"(III)(aa) experiencing homelessness (as defined in section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)));

"(bb) a homeless child or youth (as defined in section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)));

"(cc) a runaway, in foster care, or has aged out of the foster care system;

"(dd) a child eligible for assistance under section 477 of the Social Security Act (42 U.S.C. 677); or

"(ee) in an out-of-home placement;

"(IV) pregnant or parenting as defined in section 3102 of title 29, United States Code;

"(V) a youth who is an individual with a disability as defined in section 3102 of title 29, United States Code;

"(VI) a low income youth requiring additional assistance to enter or complete an educational program or to secure or hold employment as defined in section 3102 of title 29, United States Code; or

"(VII) living in a community that has faced acute or long-term exposure to substantial discrimination, historical oppression, intergenerational poverty, civil unrest, or a high rate of violence or drug overdose deaths;

"(ii) furnished by qualified mental health providers; and

"(iii) a priority service.

"(D) TELEHEALTH.—The term 'telehealth' means use of electronic information and telecommunications technologies, including voice only audio, text, remote patient monitoring, and

mHealth via applications, to support clinical mental health care, patient and professional health-related education, public health, and health administration.

''(3) PAYMENTS.—Notwithstanding section 1905(b), beginning January 1, 2024, during each of the first 20 fiscal quarters that a State meets the requirements described in paragraph (4), the Federal medical assistance percentage applicable to amounts expended by the State for medical assistance for qualifying youth and young adult mental health and substance use intervention services furnished during such quarter shall be equal to 100 percent.

''(4) REQUIREMENTS.—The requirements described in this paragraph are the following:

''(A) The State demonstrates, to the satisfaction of the Secretary—

''(i) that it will be able to support the provision of qualifying youth and young adult mental health and substance use intervention services that meet the conditions specified in paragraphs (1) and (2)); and

"(ii) how it will support coordination between qualified mental health providers and substance use teams and community partners, including health care providers, to enable the provision of services, needed referrals, and other activities identified by the Secretary.

"(B) The State provides assurances satisfactory to the Secretary that—

"(i) any additional Federal funds received by the State for qualifying youth and young adult mental health and substance use intervention services provided under this subsection that are attributable to the increased Federal medical assistance percentage under paragraph (3)(A) will be used to supplement, and not supplant, the level of State funds expended for such services for fiscal year 2024;

"(ii) if the State made qualifying youth and young adult mental health and substance use intervention services available in a region of the State in fiscal year 2023 the State will continue to make such services available in such region under this

subsection at the same level that the State made such services available in such fiscal year; and

''(iii) the State will conduct the evaluation and assessment, and submit the report required under paragraph (5).

''(5) STATE EVALUATION AND REPORT.—

''(A) STATE EVALUATION.—Not later than 4 fiscal quarters after a State begins providing qualifying youth and young adult mental health and substance use intervention services in accordance with this subsection, the State shall enter into a contract with an independent entity or organization to conduct an evaluation for the purposes of—

''(i) determining the effect of the provision of such services on—

''(I) emergency room visits;

''(II) use of ambulatory services;

''(III) hospitalizations;

''(IV) the involvement of law enforcement in mental health or substance use disorder crisis events; and

''(V) the diversion of individuals from jails or similar settings; and

"(ii) assessing—

"(I) the types of services provided to individuals;

"(II) the types of events responded to;

"(III) cost savings or cost-effectiveness attributable to such services;

"(IV) the experiences of individuals who receive qualifying youth and young adult mental health and substance use intervention services;

"(V) the successful connection of individuals with follow-up services; and

"(VI) other relevant outcomes identified by the Secretary.

"(B) COMPARISON TO HISTORICAL MEASURES.—The contract described in subparagraph (A) shall specify that the evaluation is based on a comparison of the historical measures of State performance with respect to the outcomes specified under such subparagraph to the State's performance with respect to such outcomes during the period beginning with the first quarter in which the State begins pro-

viding qualifying youth and young adult mental health and substance use intervention services in accordance with this subsection.

''(C) REPORT.—Not later than 2 years after a State begins to provide qualifying youth and young adult mental health and substance use intervention services in accordance with this subsection, the State shall submit a report to the Secretary on the following:

''(i) The results of the evaluation carried out under subparagraph (A).

''(ii) The number of individuals who received qualifying youth and young adult mental health and substance use intervention services.

''(iii) Demographic information regarding such individuals when available, including the race and ethnicity, age, sex, sexual orientation, gender identity, and geographic location of such individuals.

''(iv) The processes and models developed by the State to provide qualifying youth and young adult mental health and substance use intervention services under such the State plan or waiver, including

the processes developed to provide referrals for, or coordination with, follow-up care and services.

''(v) Lessons learned regarding the provision of such services.

''(D) PUBLIC AVAILABILITY.—The State shall make the report required under subparagraph (C) publicly available, including on the website of the appropriate State agency, upon submission of such report to the Secretary.

''(6) BEST PRACTICES REPORT.—

''(A) IN GENERAL.—Not later than 3 years after the first State begins to provide qualifying youth and young adult mental health and substance use intervention services in accordance with this subsection, the Secretary shall submit a report to Congress that—

''(i) identifies the States that elected to provide services in accordance with this subsection;

''(ii) summarizes the information reported by such States under paragraph (5)(C); and

''(iii) identifies best practices for the effective delivery of youth and young adult

mental health and substance use intervention services.

"(B) PUBLIC AVAILABILITY.—The report required under subparagraph (A) shall be made publicly available, including on the website of the Department of Health and Human Services, upon submission to Congress.

"(7) NONDISCRIMINATION.—

"(A) FEDERALLY FUNDED ACTIVITIES.—(i) For the purpose of applying the prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), on the basis of handicap under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), on the basis of sex under title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), or on the basis of race, color, or national origin under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), programs and activities funded in whole or in part with funds made available under this subchapter are considered to be programs and activities receiving Federal financial assistance.

"(ii) No person shall on the ground of sex or religion be excluded from participation in, be

denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title.

''(B) COMPLIANCE.—Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under section 702(c) of this title, has failed to comply with a provision of law referred to in subsection (a)(1), with subsection (a)(2), or with an applicable regulation (including one prescribed to carry out subsection (a)(2)), he shall notify the chief executive officer of the State and shall request him to secure compliance. If within a reasonable period of time, not to exceed 60 days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

''(i) refer the matter to the Attorney General with a recommendation that an appropriate civil action be instituted;

''(ii) exercise the powers and functions provided by title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), the Age Discrimination Act of 1975 (42

U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), as may be applicable; or

''(iii) take such other action as may be provided by law.

''(C) AUTHORITY OF ATTORNEY GENERAL; CIVIL ACTIONS.—When a matter is referred to the Attorney General pursuant to subsection (b)(1), or whenever he has reason to believe that the entity is engaged in a pattern or practice in violation of a provision of law referred to in subsection (a)(1) or in violation of subsection (a)(2), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.''.

SEC. 6044. EARLY INTERVENTION AND PREVENTION PROGRAMS FOR TRANSITION-AGE YOUTH.

(a) IN GENERAL.—Section 1912(b)(1) of the Public Health Service Act (42 U.S.C. 300x–1(b)(1)) is amended—

(1) by redesignating subparagraph (E) as subparagraph (F); and

(2) by inserting after subparagraph (D) the following:

''(E) EARLY INTERVENTION AND PREVENTION PROGRAMS FOR TRANSITION-AGE YOUTH.—The plan shall describe the State's plans to carry out demonstration grants or contracts for early intervention and prevention programs for transition-age youth of 16 to 25 years of age who meet one or more of the criteria specified in section 129(a)(1)(B) of the Workforce Innovation and Opportunity Act to be considered out-of-school youth.''.

(b) SET-ASIDE.—Section 1920 of the Public Health Service Act (42 U.S.C. 300x–9) is amended by adding at the end the following:

''(d) EARLY INTERVENTION AND PREVENTION PROGRAMS FOR TRANSITION-AGE YOUTH.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a State shall expend at least 15 percent of the amount of the allotment of the State pursuant to a funding agreement under section 1911 for each fiscal year to support programs described in section 1912(b)(1)(E).

''(2) STATE FLEXIBILITY.—In lieu of expending 15 percent of the amount of the allotment for a fiscal year as required by paragraph (1), a State may elect to expend not less than 30 percent of such

amount to support such programs by the end of two consecutive fiscal years.''.

SEC. 6045. STRATEGIES TO INCREASE ACCESS TO TELEHEALTH UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) GUIDANCE.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue and disseminate guidance to States to clarify strategies to overcome existing barriers and increase access to telehealth under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.). Such guidance shall include technical assistance and best practices regarding—

(1) telehealth delivery of covered services;

(2) recommended voluntary billing codes, modifiers, and place-of-service designations for telehealth and other virtual health care services;

(3) the simplification or alignment (including through reciprocity) of provider licensing, credentialing, and enrollment protocols with respect to telehealth across States, State Medicaid plans under such title XIX, and Medicaid managed care

organizations, including during national public health emergencies;

(4) existing strategies States can use to integrate telehealth and other virtual health care services into value-based health care models; and

(5) examples of States that have used waivers under the Medicaid program to test expanded access to telehealth, including during the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)).

(b) STUDIES.—

(1) TELEHEALTH IMPACT ON HEALTH CARE ACCESS.—Not later than 1 year after the date of the enactment of this Act, the Medicaid and CHIP Payment and Access Commission shall conduct a study, with respect to a minimum of 10 States across geographic regions of the United States, and submit to Congress a report, on the impact of telehealth on health care access, utilization, cost, and outcomes, broken down by race, ethnicity, sex, age, disability status, and zip code. Such report shall—

(A) evaluate cost, access, utilization, outcomes, and patient experience data from across the health care field, including States, Medicaid managed care organizations, provider organiza-

tions, and other organizations that provide or pay for telehealth under the Medicaid program and Children's Health Insurance Program;

(B) identify barriers and potential solutions to provider entry and participation in telehealth that States are experiencing, as well as barriers to providing telehealth across State lines, including during times of public health crisis or public health emergency;

(C) determine the frequency at which out-of-State telehealth is provided to patients enrolled in the Medicaid program and the potential impact on access to telehealth if State Medicaid policies were more aligned; and

(D) identify and evaluate opportunities for more alignment among such policies to promote access to telehealth across all States, State Medicaid plans under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.), and Medicaid managed care organizations, including the potential for regional compacts or reciprocity agreements.

(2) FEDERAL AGENCY TELEHEALTH COLLABORATION.—Not later than 1 year after the date of the

enactment of this Act, the Comptroller General of the United States shall conduct a study and submit to Congress a report evaluating collaboration between Federal agencies with respect to telehealth services furnished under the Medicaid or CHIP program to individuals under the age of 18, including such services furnished to such individuals in early care and education settings. Such report shall include recommendations on—

(A) opportunities for Federal agencies to improve collaboration with respect to such telehealth services; and

(B) opportunities for collaboration between Federal agencies to expand telehealth access to such individuals enrolled under the Medicaid or CHIP program, including in early care and education settings.

SEC. 6046. YOUTH AND YOUNG ADULT MENTAL HEALTH PROMOTION, PREVENTION, INTERVENTION, AND TREATMENT.

Title III of the Public Health Service Act is amended by inserting after section 399Z–3, as added by section 5001, the following:

"SEC. 399Z–4. YOUTH AND YOUNG ADULT MENTAL HEALTH PROMOTION, PREVENTION, INTERVENTION, AND TREATMENT.

''(a) GRANTS.—The Secretary shall—

''(1) award grants to eligible entities to develop, maintain, or enhance youth and young adult mental health promotion, prevention, intervention, and treatment programs, including—

''(A) programs for youth and young adults who may be likely to develop, are showing early signs of, or have been diagnosed with a mental health condition, including a serious emotional disturbance; and

''(B) infrastructure and organization change at a State, tribal, or territorial level to improve cross-system collaboration, service capacity, and expertise related to youth and young adults; and

''(2) ensure that programs funded through grants under this section use community-driven, evidence-informed, or evidence-based models, practices, and methods that are, as appropriate, culturally and linguistically appropriate, and can be replicated in other appropriate settings.

''(b) ELIGIBLE TRANSITION AGE YOUTH AND ENTITIES.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a local educational agency;

''(B) a State educational agency;

''(C) an institution of higher education (or consortia of such institutions), which may include a recovery program at an institution of higher education;

''(D) a local board, or a one-stop operator, as defined in section 3 of the Workforce Innovation and Opportunity Act;

''(E) a nonprofit organization with appropriate expertise in providing services or programs for children, adolescents, or young adults, excluding a school;

''(F) a State, political subdivision of a State, Indian tribe, or tribal organization; or

''(G) a high school or dormitory serving high school students that receives funding from the Bureau of Indian Education.

''(2) ELIGIBLE TRANSITION AGE YOUTH.—The term 'eligible transition age youth' means a youth or young adult from age 16 to not more than 25 years of age who is—

"(A) an out-of-school youth as defined in section 129(a)(1)(B) of the Workforce Innovation and Opportunity Act;

"(B) a homeless individual (as defined in section 41403(6) of the Violence Against Women Act of 1994), a homeless child or youth (as defined in section 725(2) of the McKinney-Vento Homeless Assistance Act) a runaway, in foster care or has aged out of the foster care system, a child eligible for assistance under section 477 of the Social Security Act, or in an out-of-home placement;

"(C) an individual who is pregnant or parenting, as referred to in section 129(a)(1)(B) of the Workforce Innovation and Opportunity Act;

"(D) a youth who is an individual with a disability, as referred to in section 129(a)(1)(B) of the Workforce Innovation and Opportunity Act;

"(E) a low-income individual who requires additional assistance to enter or complete an educational program or to secure or hold employment, as referred to in section 129(a)(1)(B) of the Workforce Innovation and Opportunity Act; or

"(F) living in a community that has faced acute or long-term exposure to substantial discrimination, historical oppression, intergenerational poverty, civil unrest, a high rate of violence, or drug overdose deaths.

"(c) APPLICATION.—An eligible entity seeking a grant under subsection (a) shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(d) USE OF FUNDS FOR MENTAL HEALTH PROMOTION, PREVENTION, INTERVENTION AND TREATMENT PROGRAMS.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) to carry out the following:

"(1) Creation, implementation, and expansion of services and supports that are culturally and linguistically appropriate and youth-guided, involve and include family and community members (including business leaders and faith-based organizations), and provide for continuity of care between child- and adult-serving systems to ensure seamless transition.

"(2) Infrastructure and organization change at a State, Tribal, or territorial level to improve cross-system collaboration, service capacity, and expertise related to youth and young adults with, or at-risk of,

mental health conditions and substance use disorders as they transition into adult roles and responsibilities.

''(3) Public awareness and cross-system provider training for individuals employed at institutions of higher education and community colleges, behavioral health providers, individuals working in the criminal justice system, primary care providers, vocational service providers, and child welfare workers.

''(e) MATCHING FUNDS.—The Secretary may not award a grant under this section to an eligible entity unless the eligible entity agrees, with respect to the costs to be incurred by the eligible entity in carrying out the activities described in subsection (d), to make available non-Federal contributions (in cash or in kind) toward such costs in an amount that is not less than 10 percent of the total amount of Federal funds provided in the grant.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $25,000,000 for each of fiscal years 2024 through 2033.''.

SEC. 6047. STUDY ON THE EFFECTS OF SMARTPHONE AND SOCIAL MEDIA USE ON ADOLESCENTS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct or support research on—

(1) smartphone and social media use by adolescents; and

(2) the effects of such use on—

(A) emotional, behavioral, and physical health and development; and

(B) disparities in minority and underserved populations.

(b) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to the Congress, and make publicly available, a report on the findings of research described in this section.

Subtitle E—Community Based Care

SEC. 6051. MENTAL HEALTH AT THE BORDER.

(a) SHORT TITLE.—This section may be cited as the ''Immigrants' Mental Health Act of 2022''.

(b) DEFINITIONS.—In this section:

(1) FORWARD OPERATING BASE.—The term ''forward operating base'' means a permanent facility—

(A) established by U.S. Customs and Border Protection in forward or remote locations; and

(B) designated as such by U.S. Customs and Border Protection.

(2) The term ''U.S. Customs and Border Protection facility'' means any of the following facilities that typically detain migrants on behalf of U.S. Customs and Border Protection:

(A) U.S. Border Patrol stations.

(B) Ports of entry.

(C) Checkpoints.

(D) Forward operating bases.

(E) Secondary inspection areas.

(F) Short-term custody facilities.

(c) TRAINING FOR CERTAIN CBP PERSONNEL IN MENTAL HEALTH ISSUES.—

(1) TRAINING TO IDENTIFY RISK FACTORS AND WARNING SIGNS IN IMMIGRANTS AND REFUGEES.—

(A) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection, in consultation with the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and nongovernmental experts in

the delivery of health care in humanitarian crises and in the delivery of health care to children, shall develop and implement a training curriculum for U.S. Customs and Border Protection agents and officers to enable such agents and officers to identify the risk factors and warning signs in immigrants and refugees of mental health issues relating to trauma.

(B) REQUIREMENTS.—The training curriculum required under subparagraph (A) shall—

(i) be offered to all U.S. Customs and Border Protection agents and officers working at U.S. Customs and Border Protection facilities;

(ii) provide for crisis intervention using a trauma-informed approach; and

(iii) provide for mental health screenings for immigrants and refugees arriving at the border in their preferred language or with appropriate language assistance.

(2) TRAINING TO ADDRESS MENTAL HEALTH AND WELLNESS OF CBP AGENTS AND OFFICERS.—

(A) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection, in consultation with the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and nongovernmental experts in the delivery of mental health care, shall develop and implement a training curriculum for U.S. Customs and Border Protection agents and officers assigned to U.S. Customs and Border Protection facilities to address the mental health and wellness of individuals working at such facilities.

(B) REQUIREMENT.—The training curriculum described in subparagraph (A) shall be designed to help the agents and officers described in such subparagraph—

(i) to better manage their own stress and the stress of their coworkers; and

(ii) to be more aware of the psychological pressures experienced during their jobs.

(3) ANNUAL REVIEW OF TRAINING.—Beginning in fiscal year 2023, the Assistant Secretary for Mental Health and Substance Use shall—

(A) conduct an annual review of the training required under paragraphs (1) and (2); and

(B) submit the results of each such review, including any recommendations for improvement of such training, to—

(i) the Commissioner of U.S. Customs and Border Protection;

(ii) the Committee on Appropriations of the Senate;

(iii) the Committee on Health, Education, Labor, and Pensions of the Senate;

(iv) the Committee on Homeland Security and Governmental Affairs of the Senate;

(v) the Committee on the Judiciary of the Senate;

(vi) the Committee on Appropriations of the House of Representatives;

(vii) the Committee on Energy and Commerce of the House of Representatives;

(viii) the Committee on Homeland Security of the House of Representatives; and

(ix) the Committee on the Judiciary of the House of Representatives.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated—

(A) $50,000 for fiscal year 2023 to develop the training curriculum required under paragraphs (1) and (2); and

(B) for each of the fiscal years 2024 through 2028—

(i) $20,000 to provide the training required under paragraphs (1) and (2); and

(ii) such sums as may be necessary to conduct the annual review of training pursuant to paragraph (3).

(d) STAFFING BORDER FACILITIES AND DETENTION CENTERS.—

(1) IN GENERAL.—The Commissioner of U.S. Customs and Border Protection shall assign at least 1 qualified mental or behavioral health expert to each U.S. Customs and Border Protection facility to adequately evaluate the mental health needs of immigrants, refugees, border patrol agents, and staff.

(2) QUALIFICATIONS.—Each mental or behavioral health expert assigned pursuant to paragraph (1)—

(A) shall be bilingual;

(B) shall be well-versed in culturally and linguistically appropriate and trauma-informed interventions; and

(C) shall have particular expertise in child or adolescent mental health or family mental health.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $3,000,000 for each of the fiscal years 2023 through 2027 to carry out this subsection.

(e) CONFIDENTIALITY OF DEPARTMENT OF HEALTH AND HUMAN SERVICES MENTAL HEALTH INFORMATION FOR ASYLUM DETERMINATIONS, IMMIGRATION HEARINGS, OR DEPORTATION PROCEEDINGS.—The officers, employees, and agents of the Department of Health and Human Services, including the Office of Refugee Resettlement, may not share with the Department of Homeland Security, and the officers, employees, and agents of the Department of Homeland Security may not request or receive from the Department of Health and Human Services, for the purposes of an asylum determination, immigration hearing, or deportation proceeding, any information or record that—

(1) concerns the mental health of an alien; and

(2) was obtained or produced by a mental or behavioral health professional while the alien was in a shelter or otherwise in the custody of the Federal Government.

SEC. 6052. ASIAN AMERICAN, AFRICAN AMERICAN, NATIVE HAWAIIAN, PACIFIC ISLANDER, INDIGENOUS, MIDDLE EASTERN AND NORTH AFRICAN, AND HISPANIC AND LATINO BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGY.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 6022, is further amended by adding at the end the following new section:

"SEC. 554. BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGY.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall, in coordination with advocacy and behavioral and mental health organizations serving populations of Asian American, African American, Native Hawaiian, Pacific Islander, Indigenous, Middle Eastern and North African (in this section referred to as 'MENA'), and Hispanic and Latino/a/x individuals or communities, develop and implement an outreach and education strategy to promote

behavioral and mental health, emphasize that behavioral and mental health conditions are treatable and that reasonable accommodations under section 504 of the Rehabilitation Act of 1973 and titles II and III of the Americans with Disabilities Act of 1990 are necessary and may help, as well as reduce stigma associated with mental health conditions and substance abuse among the Asian American, African American, Native Hawaiian, Pacific Islander, Indigenous, MENA, and Hispanic and Latino/a/x populations. Such strategy shall—

''(1) be designed to—

''(A) meet the diverse cultural and language needs of the various Asian American, African American, Indigenous, MENA, Native Hawaiian, Pacific Islander, and Hispanic and Latino/a/x populations; and

''(B) ensure that approaches recommended in the strategy are developmentally (with respect to the beneficiary's relative age and experience) and age appropriate, as well as cognitively accessible to persons with cognitive disabilities;

''(2) increase awareness of symptoms of mental illnesses common among such populations, taking into account differences within subgroups (such as

gender, gender identity, age, sexual orientation, disability, and ethnicity) of such populations;

''(3) provide information on evidence-based, culturally and linguistically appropriate and adapted interventions and treatments;

''(4) ensure full participation of, and engage, both consumers and community members representing the communities of focus in the development and implementation of materials; and

''(5) seek to broaden the perspective among both individuals in such communities and stakeholders serving such communities to use a comprehensive public health approach to promoting behavioral and mental health that addresses a holistic view of health by focusing on the intersection between behavioral and physical health.

''(b) REPORTS.—Beginning not later than 1 year after the date of the enactment of this section and annually thereafter, the Secretary, acting through the Assistant Secretary, shall submit to the Congress, and make publicly available, a report on the extent to which the strategy developed and implemented under subsection (a) increased behavioral and mental health outcomes associated with mental health conditions and substance abuse among Asian American, African American, Native Hawaiian, Pa-

cific Islander, Indigenous, MENA, and Hispanic and Latino/a/x populations.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $10,000,000 for each of fiscal years 2024 through 2028.''.

Subtitle F—Reports

SEC. 6061. ADDRESSING RACIAL AND ETHNIC MENTAL HEALTH INEQUITIES RESEARCH GAPS.

(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act—

(1) the Director of the National Institute on Minority Health and Health Disparities shall enter into an arrangement with the National Academy of Sciences to carry out the activities under subsection (b); or

(2) if the National Academy of Sciences declines to enter into such an arrangement, the Director of the National Institute on Minority Health and Health Disparities, in cooperation with the Agency for Healthcare Research and Quality, shall carry out the activities under subsection (b).

(b) ACTIVITIES.—The applicable entity under subsection (a) shall—

(1) conduct a study with respect to mental health inequities in racial and ethnic minority

groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)), as amended by title I of this Act); and

(2) submit to the Congress a report on the results of such study, including—

(A) a compilation of information on the dynamics of mental health outcomes in such racial and ethnic minority groups;

(B) the degree and impacts of the co-occurrence of mental conditions with other disabilities in such racial and ethnic groups, including physical disabilities, mental disabilities, substance use disorders, severe and persistent mental illness, and mental disorders or mental health conditions which co-occur with one another;

(C) a compilation of information on the impact of community violence, community trauma, adverse childhood experiences, weather extremes worsened by climate change (such as heat waves, flooding, hurricanes, and wildfires), substance use, and other psychological traumas, on mental disorders in such racial and ethnic minority groups, stratified by household income level;

(D) a compilation of information on the impact of the intersectionality of transgender individuals, gender nonbinary individuals, sexual orientation, and age in racial and ethnic minority groups; and

(E) a description of how protective factors contrast and compare among different communities of color, identifying cultural strengths.

SEC. 6062. RESEARCH ON ADVERSE HEALTH EFFECTS ASSOCIATED WITH INTERACTIONS WITH LAW ENFORCEMENT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the Office of Minority Health of the Centers for Disease Control and Prevention (established pursuant to section 1707A of the Public Health Service Act (42 U.S.C. 300u–6a)), shall conduct research on the adverse health effects associated with interactions with law enforcement.

(b) EFFECTS AMONG RACIAL AND ETHNIC MINORITIES.—The research under subsection (a) shall include research on—

(1) the health consequences, both individual and community-wide, of trauma related to violence

committed by law enforcement among racial and ethnic minorities; and

(2) the disproportionate burden of morbidity and mortality associated with such trauma.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall—

(1) complete the research under this section; and

(2) submit to the Congress a report on the findings, conclusions, and recommendations resulting from such research.

SEC. 6063. GEOACCESS STUDY.

The Assistant Secretary for Mental Health and Substance Use shall—

(1) conduct a study to—

(A) determine which geographic areas of the United States have shortages of racially and ethnically diverse mental health providers, as well as mental health providers trained to work with racially and ethnically diverse clients and clients with multiple mental health, cognitive, and developmental disabilities; and

(B) assess the preparedness of mental health providers to deliver culturally and lin-

guistically appropriate, affordable, and accessible services; and

(2) submit a report to Congress on the results of such study.

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).

(b) CONTENT OF REPORT.—The report under subsection (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;

(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;

(B) Medicaid expansion States who provide behavioral health coverage for newly eligible enrollees;

(C) how enrollment in coverage affects treatment availability; and

(D) the impacts of COVID–19 to receiving and accessing treatment for behavioral health, substance use disorders, and diverse racial and ethnic groups, and recommendations for addressing such barriers;

(3) an assessment of current barriers, inclusive of social determinants of health and cultural barriers, that prevent adults from receiving behavioral health and substance use disorder treatment, and recommendations for addressing such barriers, particularly for low-income women and adults from racial and ethnic groups;

(4) an assessment of disparities in access to addiction counselors and mental or behavioral health care providers acting in accordance with State law, stratified by race, ethnicity, gender identity, geographic location, and insurance type, and recommendations to promote greater access equity; and

(5) recommendations to promote greater equity in access to care for behavioral services and sub-

stance use disorders, particularly for low-income women and adults from diverse racial and ethnic groups.

SEC. 6065. TECHNICAL CORRECTION.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended—

(1) by redesignating the second section 550 (42 U.S.C. 290ee–10) (relating to Sobriety Treatment And Recovery Teams) as section 552A; and

(2) by moving such section, as so redesignated, so as to appear after section 552 (42 U.S.C. 290ee–7).

Subtitle G—Miscellaneous Provisions

SEC. 6071. CHILDREN'S MENTAL HEALTH INFRASTRUCTURE ACT.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after subpart V, as amended by section 6041, the following new subpart:

"Subpart VI—Increasing Investment in Pediatric Behavioral Health Services

"SEC. 340AA–1. GRANTS TO CHILDREN'S HOSPITALS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services

Administration, shall make grants to eligible entities for the purpose of improving their ability to provide pediatric behavioral health services, including by—

''(1) constructing or modernizing sites of care for pediatric behavioral health services;

''(2) expanding capacity to provide pediatric behavioral health services, including enhancements to digital infrastructure, telehealth capabilities, or other improvements to patient care infrastructure; and

''(3) supporting the reallocation of existing resources to accommodate pediatric behavioral health patients, including by—

''(A) converting or adding a sufficient number of beds to establish or increase the hospital's inventory of licensed and operational, short-term psychiatric and substance use inpatient beds; and

''(B) ensuring compliance with safety standards.

''(b) ELIGIBILITY.—To be eligible to seek a grant under this section, an entity shall be a hospital that predominantly treats individuals under the age of 21, including any hospital that receives funds under section 340E.

''(c) FUNDING.—To carry out this section, there is hereby appropriated, out of amounts in the Treasury not

otherwise obligated, $2,000,000,000 for each of fiscal years 2022 through 2026.''.

SEC. 6072. MENTAL HEALTH FOR LATINOS.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by sections 6022, 6023, 6052, and 6016, is further amended by adding at the end the following new section:

''SEC. 557. BEHAVIORAL AND MENTAL HEALTH OUTREACH AND EDUCATION STRATEGY.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall, in coordination with advocacy and behavioral and mental health organizations serving populations of Hispanic and Latino individuals or communities, develop and implement an outreach and education strategy to promote behavioral and mental health and reduce stigma associated with mental health conditions and substance abuse among the Hispanic and Latino populations. Such strategy shall—

''(1) be designed to—

''(A) meet the diverse cultural and language needs of the various Hispanic and Latino populations; and

''(B) be developmentally and age-appropriate;

''(2) increase awareness of symptoms of mental illnesses common among such populations, taking into account differences within subgroups, such as gender, gender identity, age, sexual orientation, or ethnicity, of such populations;

''(3) provide information on evidence-based, culturally and linguistically appropriate and adapted interventions and treatments;

''(4) ensure full participation of, and engage, both consumers and community members in the development and implementation of materials;

''(5) seek to broaden the perspective among both individuals in these communities and stakeholders serving these communities to use a comprehensive public health approach to promoting behavioral health that addresses a holistic view of health by focusing on the intersection between behavioral and physical health; and

''(6) address the impact of the SARS–CoV–2 pandemic on the mental and behavioral health of the Hispanic and Latino populations.

''(b) REPORTS.—Beginning not later than 1 year after the date of the enactment of this section and annually thereafter, the Secretary, acting through the Assistant Secretary, shall submit to Congress, and make publicly

available, a report on the extent to which the strategy developed and implemented under subsection (a) improved behavioral and mental health outcomes associated with mental health conditions and substance abuse among Hispanic and Latino populations.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,000,000 for each of fiscal years 2023 through 2025.''.

SEC. 6073. STRENGTHENING MENTAL HEALTH SUPPORTS FOR BIPOC COMMUNITIES.

(a) IN GENERAL.—Section 1942(a) of the Public Health Service Act (42 U.S.C. 300x–52(a)) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) by redesignating paragraph (2) as paragraph (5); and

(3) by inserting after paragraph (1) the following:

''(2) services provided by the State to adults with a serious mental illness and children with a serious emotional disturbance who are members of racial and ethnic minority groups, including—

''(A) the extent to which such services are provided to such adults and children; and

"(B) the outcomes experienced by such adults and children as a result of the provision of such services, including with respect to—

"(i) diversions from hospitalization and criminal justice system involvement;

"(ii) treatment for first episode psychosis or undefined psychosis;

"(iii) reductions in suicide and increased utilization of appropriate treatments and interventions for suicidal ideation;

"(iv) response through crisis services, including mobile crisis services;

"(v) treatment of individuals who are experiencing homelessness or housing insecurity and individuals residing in rural communities; and

"(vi) increased patient family and caregiver engagement and education on serious mental illness to reduce social stigma and promote healthy social support for patients;

"(3) any outreach by the State to, and the hiring of, providers of mental health services from multiple disciplines (such as a psychologist, psychiatrist,

peer support provider, or social worker) who are members of racial and ethnic minority groups;

''(4) any outreach by the State to providers from multiple disciplines of mental health services—

''(A) to provide training on culturally effective, culturally affirming, and linguistically competent services; and

''(B) to increase awareness of community-defined practices by practitioners of racial and ethnic minority groups; and''.

(b) APPLICABILITY.—The amendments made by subsection (a) shall apply with respect to funding agreements entered into under section 1911 or 1921 of the Public Health Service Act (42 U.S.C. 300x; 42 U.S.C. 300x–21) on or after the date of the enactment of this Act.

SEC. 6074. STRONG SUPPORT FOR CHILDREN.

(a) DATA ANALYSIS AND STRATEGY IMPLEMENTATION TO PREVENT AND MITIGATE CHILDHOOD TRAUMA.—Title XXXI of the Public Health Service Act (42 U.S.C. 300kk) is amended by adding at the end the following:

"SEC. 3102. DATA ANALYSIS AND STRATEGY IMPLEMENTATION TO PREVENT AND MITIGATE CHILDHOOD TRAUMA.

''(a) IN GENERAL.—The Secretary shall establish a program—

''(1) to support the development and implementation of programs that use data analysis methods to identify and facilitate strategies for early intervention and prevention, in order to prevent and mitigate childhood trauma and support communities and families, including—

''(A) improving connections through care coordination;

''(B) aligning community initiatives in targeted areas of need; and

''(C) expanding community capacity through cross-sector collaboration; and

''(2) to evaluate the effectiveness of these programs in improving outcomes for children.

''(b) GRANTS.—The Secretary shall award grants to up to 5 eligible entities to carry out the activities described in subsection (a).

''(c) USE OF FUNDS.—A grant for activities under this section shall be used to support the development and implementation of programs that use data analysis methods to identify and facilitate strategies for early interven-

tion and prevention, in order to prevent and mitigate childhood trauma and support communities and families, including as follows:

''(1) Utilize data analysis methods to—

''(A) identify specific geographic areas, such as census tracts, with a high prevalence of adverse childhood experiences and significant risk factors for poor outcomes for children (such as increased risk of experiencing adverse childhood experiences), including areas with high rates of—

''(i) poor public health outcomes including illness, disease, suicide, and mortality;

''(ii) exclusionary discipline practices, including suspensions, expulsions, and referrals to law enforcement, as well as low graduation rates;

''(iii) substance use disorders;

''(iv) poverty;

''(v) foster system involvement or referrals;

''(vi) housing instability and homelessness;

''(vii) food insecurity;

''(viii) inequity, including disparities in income, wealth, employment, educational attainment, health care access, and public health outcomes, along lines of race, sex, sexuality and gender identity, ethnicity, or nationality;

''(ix) incarceration rates; or

''(x) other indicators of adversity as defined by the Secretary; and

''(B) identify strategies to improve outcomes for children aged 0 through 17 that build on strengths in communities that could be further supported, including—

''(i) existing support networks for families; and

''(ii) enhanced connections to community-based organizations.

''(2) Implement strategies identified pursuant to paragraph (1)(B) to facilitate outreach and involvement of children and their caregivers in Federal, State, or local programs that provide reparative, gender-responsive, culturally specific, and trauma-informed prevention services, and for which children and their caregivers are eligible, including—

''(A) home visiting programs;

"(B) training and education on parenting skills;

"(C) substance use disorder prevention and treatment that is voluntary and noncoercive;

"(D) mental health supports and care that is voluntary and noncoercive;

"(E) family and intimate partner violence prevention services;

"(F) child advocacy center programming;

"(G) economic and nutrition support services;

"(H) housing support services, including emergency and temporary shelter for those experiencing homelessness and housing insecurity, as well as stable, long-term housing;

"(I) voluntary, noncoercive, gender-responsive, and culturally specific mental health supports in school and early childhood education center-based settings;

"(J) wraparound programs for transitioning youth and youth currently in the foster system;

"(K) programming to support the health and well-being of lesbian, gay, bisexual,

transgender, and intersex children and their families; and

''(L) family resource center services.

''(d) SPECIAL RULES.—

''(1) PRIMARY PAYER RESTRICTION.—The Secretary may not award a grant under this section to an eligible entity for a service if the service to be provided is available pursuant to the State plan approved under title XIX of the Social Security Act for the State in which the program funded by the grant is being conducted unless the State and all eligible subdivisions involved—

''(A) will enter into agreements with public or nonprofit private entities under which the entities will provide the service; and

''(B) demonstrate that the State and all eligible subdivisions will ensure that the entities providing the service—

''(i) will seek payment for each such service rendered in accordance with the usual payment schedule under the State plan; and

''(ii) the entities have entered into a participation agreement and are qualified to receive payments under such plan.

''(2) IMPLEMENTATION.—An eligible entity that receives a grant under this section may use—

''(A) not more than 25 percent of the amounts made available through the grant for the first 24 months of the grant period to utilize data analysis methods to—

''(i) identify specific geographic areas where care coordination, prevention and early intervention, and facilitation services will be provided; and

''(ii) identify support and intervention services to improve outcomes for children located in a geographic area identified under subsection (c)(1)(A); and

''(B) not more than 10 percent of the grant in each subsequent year to continue data analysis activities.

''(3) ADMINISTRATION.—An eligible entity that receives a grant under this section may not use more than 5 percent of amounts received through the grant for administration, reporting, and program oversight functions, including the development of systems to improve data collection and data sharing for the purposes of improving services and the provision of care.

''(4) PRIORITY.—

''(A) IN GENERAL.—In awarding grants under this section, the Secretary shall give priority, to the extent practical, to eligible entities that use community-based system dynamic modeling as the primary data analysis method.

''(B) SYSTEM DYNAMIC MODELING DEFINED.—The term 'system dynamic modeling' means a method of data analysis and predictive modeling that includes—

''(i) utilization of community-based participatory research methods for involving community in the process of understanding and changing systems and evaluating outcomes of grants;

''(ii) consideration of a multitude of environmental risk factors and ascertainment of the significance of contributing community risk factors for purposes of identifying strategies to reduce adverse child outcomes, including—

''(I) maltreatment cases;

''(II) involvement with the juvenile criminal legal system or foster system;

''(III) exclusionary school discipline; or

''(IV) exposure to violence; and

''(iii) identification of cross-sector responses involving reparative, trauma-informed, culturally specific, gender-responsive, and community-based organizations to reduce adverse child outcomes.

''(5) SUBGRANT.—

''(A) IN GENERAL.—An eligible entity that receives a grant under this section shall use at least 25 percent of the total amount of the grant to make subgrants to organizations that aid in implementing the strategy identified under subsection (c)(1)(B) for preventing and mitigating childhood trauma and supporting communities and families.

''(B) ELIGIBILITY.—To be eligible to receive a subgrant under this paragraph, an organization shall prepare and submit to the eligible entity an application in such form, and containing such information, as the eligible entity may require, including evidence that the—

''(i) needs of the population to be served are urgent and are not met by the

services currently available in the geographic area; and

''(ii) organization has the capacity to provide the services listed in subsection (c)(2).

''(C) SUPPLEMENT NOT SUPPLANT.—Subgrant funds received pursuant to this paragraph by an organization shall be used to supplement and not supplant State or local funds provided to the partnership organization for services listed in subsection (c)(2).

''(e) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity shall submit to the Secretary an application in such form, and containing such information, as the Secretary may require, to include the following:

''(1) A demonstration that—

''(A) the applicant utilizes trauma-informed, culturally specific, and gender-responsive practices, including a demonstration of the extent to which the applicant has trained staff in these practices;

''(B) the applicant has the capacity to administer the grant, including conducting all required data analysis activities; and

"(C) services will be provided to children and families in an accessible, culturally relevant, and linguistically specific manner consistent with local needs.

"(2) A preliminary analysis of how the applicant will use the grant to—

"(A) identify the geographic area or areas to be served using data analysis methods;

"(B) utilize data analysis methods to identify strategies to improve outcomes for children in the geographic area;

"(C) facilitate strategies identified through care coordination efforts; and

"(D) track data for evaluation of outcomes.

"(3) A detailed project plan for the use of the grant that includes anticipated technical assistance needs.

"(4) Additional funding sources, including State and local funds, supporting the prevention and mitigation of adverse childhood experiences.

"(f) GRANT AMOUNT.—The amount of a grant under this section shall not exceed $9,500,000.

"(g) PERIOD OF A GRANT.—The period of a grant under this section shall not exceed 7 years.

''(h) SERVICE PROVISION WITHOUT REGARD TO ABILITY TO PAY.—As a condition on receipt of a grant under this section, an eligible entity shall agree that any assistance provided to an individual through the grant will be provided without regard to—

''(1) the ability of the individual to pay for such services;

''(2) the current or past health condition of the individual to be served;

''(3) the immigration status of the individual to be served;

''(4) the sexual orientation and gender identity of the individual to be served; and

''(5) any prior involvement of the individual in the criminal legal system.

''(i) PROHIBITIONS.—In addition to any other prohibitions determined by the Secretary, an eligible entity may not use a grant under this section to—

''(1) use data analysis methods to inform individual case decisions, including child removal or placement decisions, or to target services at certain individuals or families;

''(2) require any individual or family to participate in any service or program as a condition of re-

ceipt of a benefit to which the individual or family is otherwise eligible;

''(3) increase the presence or funding of law enforcement surveillance, involvement, or activity in implementing the strategies identified under subsection (c)(1)(B); or

''(4) enable the practice of conversion therapy.

''(j) EVALUATION.—

''(1) DATA MODEL EVALUATION.—Not later than 36 months after the date of enactment of this section, the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, in coordination with the grantees receiving a grant under this section, shall complete an evaluation of the effectiveness of the data model accuracy of the grant program under this section to address each of the following:

''(A) Determining the effectiveness of the grantees' use of data analysis methods to identify geographic areas pursuant to subsection (c)(1).

''(B) Examining the grantees' development and utilization of data analysis methods.

"(C) Examining the grantees' ability to effectively utilize data analysis methods in future prevention work.

"(D) Establishing a method for rigorously evaluating the activities of grantees and comparing the reduction of child and family exposure to adverse experiences in other communities with similar demographics.

"(E) Examining the grantees' utilization of community-based system dynamics modeling methods and other community engagement methods.

"(2) PROGRAM EVALUATION.—Not later than 6 years after the date of enactment of this section, the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, in coordination with eligible entities receiving grants under this section, shall complete an evaluation of the effectiveness of the grant program under this section.

"(3) DATA COLLECTION.—

"(A) IN GENERAL.—The Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services and each eligible entity receiving a grant under this

section shall collect any relevant data necessary to complete the evaluations required by paragraphs (1) and (2) to include—

"(i) the activities funded by the grant under this section, including development and implementation data analysis methods;

"(ii) the number of children and of families receiving coordination and facilitation of care and services; and

"(iii) the effect of activities supported by the grant under this section on the local area serviced by the program, including such effects on—

"(I) children and adolescents' health and well-being;

"(II) the number of children who enter into or depart from foster services; and

"(III) homelessness and housing insecurity.

"(B) STUDY.—

"(i) IN GENERAL.—Not later than 7 years after the date of enactment of this section, the Assistant Secretary for Plan-

ning and Evaluation of the Department of Health and Human Services shall—

"(I) complete a study on the results 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 community members, clients, organizational representatives, and researchers in all aspects of the research process; and

"(II) submit a report on the results of the study to the Congress.

"(ii) PARTNERS.—In conducting the study under clause (i), the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services shall ensure that partners and persons that have participated in the grant program under this section on every level, especially those such partners or persons receiving services and support through the program, have an opportunity to contribute

their expertise to evaluating the strategy and outcomes.

''(k) REPORT.—Not later than three months after the completion of the evaluation required by subsection (j)(2), the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services shall submit to Congress and make available to the public on the internet website of the Department of Health and Human Services a report based upon the evaluation under subsection (j)(2), to include—

''(1) the impact of the program under this section on homelessness and housing insecurity, substance use disorder and drug deaths, incarceration, foster system involvement, and other child and family outcomes as identified by the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services;

''(2) an analysis of which elements of the program should be replicated and scaled by governmental or non-governmental entities; and

''(3) such recommendations for legislation and administrative action as the Secretary determines appropriate.

''(l) DEFINITION.—In this section:

"(1) 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:

"(A) Abuse, such as any of the following:

"(i) Emotional and psychological abuse.

"(ii) Physical abuse.

"(iii) Sexual abuse.

"(B) Household challenges such as any of the following:

"(i) A household member is treated violently.

"(ii) A household member has a substance use disorder.

"(iii) A household member has a mental health condition.

"(iv) Parental separation or divorce.

"(v) A household member is incarcerated, is placed in immigrant detention, or has been deported.

"(vi) A household member has a life-threatening illness such as COVID–19.

"(C) Neglect.

"(D) Living in—

"(i) impoverished communities that lack access to human services;

"(ii) areas of high unemployment neighborhoods; or

"(iii) communities experiencing de facto segregation.

"(E) Experiencing food insecurity and poor nutrition.

"(F) Witnessing violence.

"(G) Involvement with the foster system.

"(H) Experiencing discrimination.

"(I) Dealing with historical and ongoing traumas due to systemic and interpersonal racism.

"(J) Dealing with historical and ongoing traumas regarding systemic and interpersonal sexism, homophobia, biphobia, and transphobia.

"(K) Dealing with the threat of deportation or detention as a result of immigration status.

"(L) The impacts of multigenerational poverty resulting from limited educational and economic opportunities.

"(M) Living through natural disasters such as earthquakes, forest fires, floods, or hurricanes.

"(2) The term 'eligible entity' means a State or local health department.

"(3) The term 'practice of conversion therapy'—

"(A) means any practice or treatment by any person that seeks to change another individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender, if such person receives monetary compensation in exchange for any such practice or treatment; and

"(B) does not include any practice or treatment that does not seek to change sexual orientation or gender identity and—

"(i) provides assistance to an individual undergoing a gender transition; or

"(ii) provides acceptance, support, and understanding of a client or facilitation of a client's coping, social support, and identity exploration and development.

''(m) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section for the period of fiscal years 2023 through 2030—

''(1) to carry out subsection (a)(1) through the award of grants under subsection (b)—

''(A) $47,500,000 for grants; and

''(B) such sums as may be necessary for the administrative costs of carrying out such subsection; and

''(2) $7,500,000 to carry out the evaluation under subsection (a)(2).''.

(b) CARE COORDINATION GRANTS.—Part E of title XII of the Public Health Service Act (42 U.S.C. 300d–51 et seq.) is amended by adding at the end the following new section:

''SEC. 1255. CARE COORDINATION GRANTS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to establish or expand trauma-informed care coordination services to support—

''(1) children aged 0 through 5 at risk of adverse childhood experiences; and

''(2) their caregivers, including prenatal people of any age.

''(b) NUMBER OF GRANTS.—Subject to the availability of appropriations, the Secretary shall award not

fewer than 9 and not more than 40 grants under this section.

''(c) AMOUNT OF GRANTS.—Subject to the availability of appropriations, the amount of a grant under this section for a fiscal year shall be—

''(1) not less than $250,000; and

''(2) not more than $1,000,000.

''(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall be a local government or Indian Tribe, acting through the public health department thereof if such government or Tribe has a public health department.

''(e) PRIORITY.—

''(1) IN GENERAL.—In awarding grants under this section, the Secretary shall give priority to eligible entities proposing to serve communities with a high need for trauma-informed care coordination services, as demonstrated by indicators such as—

''(A) pregnant people who face barriers to prenatal care;

''(B) mortality or morbidity of people giving birth or infants;

''(C) caretakers and parents who are living with a mental health condition or substance use disorder;

''(D) a high prevalence of community violence, including domestic violence, as demonstrated by instances of homicide and public health statistics, including treatment of injury or trauma;

''(E) high proportions of low-income children;

''(F) a high prevalence of child fatalities or near fatalities related to child abuse and neglect;

''(G) significant disparities in health outcomes for people giving birth and infants;

''(H) a high rate of exclusionary discipline and referrals to law enforcement; and

''(I) a high rate of homelessness and housing instability.

''(2) DATA FROM TRIBAL AREAS.—The Secretary, acting through the Director of the Indian Health Service, shall consult with Indian Tribes to establish criteria to measure indicators of need, for purposes of paragraph (1), with respect to Tribal areas.

''(f) USE OF FUNDS.—

''(1) REQUIRED USES.—

"(A) IN GENERAL.—A grant received under this section shall be used to establish or expand gender-responsive, culturally specific, trauma-informed care coordination services, including by instituting and conducting risk and needs assessments including—

"(i) using strengths-based approaches focused on protective factors for children and their caregivers, including prenatal people of any age; and

"(ii) inputting screening results into a centralized intake system to promote a single point of access system across providers and services.

"(B) TRAINING.—A grant received under this section shall be used to ensure that individuals employed through the grant funds, in whole or in part, have received sufficient and up-to-date training on trauma-informed care and strategies that are reparative, culturally sensitive, gender-responsive, and healing-centered.

"(2) PERMISSIBLE USES.—A grant received under this section may be used for any of the following:

"(A) Employing care coordinators, case managers, community health workers, certified infant mental health specialists, and outreach and engagement specialists to work with children and their caregivers, including prenatal individuals, to prevent and respond to adverse childhood experiences by connecting clients with culturally specific, trauma-informed care treatment services, including economic, social, food, and housing supports.

"(B) Providing training described in paragraph (1)(B) to community health providers and community partners.

"(C) Expanding, enhancing, modifying, and connecting the existing network of community programs and services to achieve a more comprehensive and coordinated system of care approach, including—

"(i) developing local infrastructure to bolster and shape community support systems and map and build access to services in a coordinated and comprehensive way; and

"(ii) creating infrastructure to conduct outreach to children and families, in-

cluding those experiencing homelessness and housing instability, so they acquire access to the services and supports they need and the benefits to which they are entitled.

''(D) Compiling information on resources (including any referral services) available through community-based organizations and local, State, and Federal agencies, such as—

''(i) programs addressing social determinants of health, including—

''(I) emergency, temporary, and long-term housing;

''(II) programs that offer free or affordable and nutritious food;

''(III) vocational and workforce development; and

''(IV) transportation supports;

''(ii) home visiting programs for new parents and their infants;

''(iii) workforce development programs to support caregivers in skill building;

''(iv) trauma-responsive, parenting skills-building programs;

''(v) the continuum of substance use prevention, intervention, and treatment

programs and mental health support programs, including programs with trauma-informed, gender-responsive, and culturally specific counseling; and

''(vi) childcare support and early childhood education, including Head Start and Early Head Start programs.

''(E) Subject to subsection (g)(1), establishing or updating a database that compiles data used to track the effectiveness of the care coordination services funded through the grant.

''(F) Developing and implementing referral partnership agreements with community-based organizations, parent organizations, substance use disorder treatment providers and facilities, housing and shelter providers, health care providers, mental health care providers, and Federal and State offices and programs that implement practices to support children ages 0 through 5 who are at risk of adverse childhood experiences and their caregivers, including prenatal people. Such practices shall include—

''(i) a bilateral 'warm handoff' system whereby a grantee understands the needs of the children and their families, and fam-

ilies are involved in addressing these needs; and

"(ii) an active service connection whereby the children and families are each actively connected with a resource in a well-coordinated way that ensures availability and direct contact.

"(G) Supporting cross-system planning and collaboration among employees who may work in emergency medical services, health care services, public health, early childhood education, and substance use disorder treatment and recovery support.

"(H) Providing or subsidizing services to address barriers that children, prenatal individuals, and caregivers face to utilizing community resources and services, such as by providing or subsidizing transportation or childcare costs as applicable and within reasonable amounts.

"(I) Creating or expanding infrastructure and investing in technology, including the provision of communications technology and internet service to children and their caregivers, to enable increased telemedicine capabilities to reach participants.

''(3) INDIAN TRIBES.—In the case of an eligible entity that is an Indian Tribe, the Secretary may waive such provisions of this subsection as the Secretary determines appropriate.

''(4) PROHIBITIONS.—In addition to any other prohibitions determined by the Secretary, an eligible entity may not use a grant under this section to—

''(A) use data analysis methods to inform individual case decisions, including child removal or placement decisions, or to target services at certain individuals or families;

''(B) require any individual or family to participate in any service or program as a condition of receipt of a benefit to which the individual or family is otherwise eligible; or

''(C) increase the presence or funding of law enforcement surveillance, involvement, or activity in connection with trauma-informed care coordination services supported pursuant to this section.

''(g) REQUIREMENTS.—As a condition on receipt of a grant under this section, an eligible entity shall agree to each of the following funding conditions:

''(1) RESTRICTION OF FUNDING ALLOCATION.—The eligible entity will not use more than 30 percent

of the funds made available to the entity through the grant (for the total grant period) to establish or update a database pursuant to subsection (f)(2)(E).

''(2) ACCESSIBLE SETTING.—

''(A) IN GENERAL.—The eligible entity will ensure that all care coordination services provided through the grant are provided in a setting that is accessible, including through mobile settings, to—

''(i) low-income or no-income individuals, including individuals experiencing homelessness or housing instability; and

''(ii) individuals in rural areas.

''(B) COMMUNITY OUTREACH.—In complying with subparagraph (A), the eligible entity will ensure that at least 50 percent of the care coordination services provided through the grant occur in community settings that are convenient to the children and caregivers who are being served, such as homes, schools, and shelters, whether for initial outreach or as part of long-term care.

''(3) SUPPLEMENT NOT SUPPLANT.—The grant will be used to supplement not supplant other Fed-

eral, State, or local funds available for care coordination services.

''(4) CONFIDENTIALITY.—The eligible entity will maintain the confidentiality of individuals receiving services through the grant in a manner consistent with applicable law.

''(5) PARTNERING; RISK STRATIFICATION.—In providing care coordination services through the grant, the eligible entity will—

''(A) partner with community-based organizations with experience serving child populations prenatally through age 5;

''(B) coordinate with the local agency responsible for administering the State plan approved under title XIX of the Social Security Act; and

''(C) employ risk stratification to develop different effective models of care for different populations based on their needs.

''(h) APPLICATION.—

''(1) IN GENERAL.—To seek a grant under this section, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information, as the Secretary may require.

''(2) CONTENTS.—An application under paragraph (1) shall, at a minimum, contain each of the following:

''(A) Goals to be achieved through the grant, including the activities that will be undertaken to achieve those goals.

''(B) The number of individuals likely to be served through the grant, including demographic data on the populations to be served.

''(C) Existing programs and services that can be used to significantly increase the proportion of children and families who receive needed supports and services.

''(D) A plan for expanding, coordinating, or modifying the existing network of programs and services to meet the needs of children and families for preventing and mitigating the traumatic impact of adverse childhood experiences.

''(E) A demonstration of the ability of the eligible entity to reach the individuals to be served, including by partnering with local stakeholders.

''(F) An indication of how the personnel involved are reflective of the communities to be served.

"(G) A list of stakeholders with whom the entity plans to partner or consult.

"(i) REPORTING BY GRANTEES.—Not later than 4 years after the date of enactment of this section, an eligible entity receiving a grant under this section shall submit to the Secretary a report on the activities funded through the grant. Such report shall include, at a minimum, a description of—

"(1) the number of individuals served through activities funded through the grant, including demographics as applicable;

"(2) the number of referrals made through the grant and the rate of such referrals successfully linked or closed;

"(3) a qualitative analysis or number of collaborative partnerships with other organizations in carrying out the activities funded through the grant;

"(4) the number of services provided to individuals through the grant;

"(5) aggregated and de-identified outcomes experienced by individuals served through the grant such as—

"(A) the rate of successful service connections;

"(B) any increases in development of protective factors for children;

"(C) any increase in development of protective factors for the caregivers;

"(D) any mitigation of the negative outcomes associated with adverse childhood experiences or decreased likelihood of children experiencing an adverse childhood experience as evidenced by—

"(i) decreased presence of law enforcement or other punitive State surveillance in the community;

"(ii) a parent completing substance use treatment;

"(iii) a parent receiving voluntary treatment for mental health-related conditions;

"(iv) a family entering into or maintaining a stable housing situation;

"(v) a family achieving or maintaining economic security;

"(vi) a parent achieving or maintaining job stability; or

"(vii) a child meeting developmental markers for school readiness; and

''(E) reports of satisfaction with the coordination of care by people served; and

''(6) any other information required by the Secretary.

''(j) CONVENING PARTICIPANTS FOR SHARING LESSONS LEARNED.—After the period of all grants awarded under this section has concluded, the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services shall provide an in-person or online opportunity for persons participating in the programs funded through this section to share with each other—

''(1) lessons learned;

''(2) challenges experienced; and

''(3) ideas for next steps and solutions.

''(k) COMPILING FINDINGS AND CONCLUSIONS.—After providing the opportunity required by subsection (j), the Secretary shall—

''(1) compile the findings and conclusions of grantees under this section on the provision of care coordination services described in subsection (a);

''(2) submit a report on such findings and conclusions to the appropriate congressional committees; and

''(3) make such report publicly available.

''(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:

''(A) Abuse, such as any of the following:

''(i) Emotional and psychological abuse.

''(ii) Physical abuse.

''(iii) Sexual abuse.

''(B) Household challenges such as any of the following:

''(i) A household member is treated violently.

''(ii) A household member has a substance use disorder.

''(iii) A household member has a mental health condition.

''(iv) Parental separation or divorce.

''(v) A household member is incarcerated, is placed in immigrant detention, or has been deported.

''(vi) A household member has a life-threatening illness such as COVID–19.

"(C) Neglect.

"(D) Living in—

"(i) impoverished communities that lack access to human services;

"(ii) areas of high unemployment neighborhoods; or

"(iii) communities experiencing de facto segregation.

"(E) Experiencing food insecurity and poor nutrition.

"(F) Witnessing violence.

"(G) Involvement with the foster system.

"(H) Experiencing discrimination.

"(I) Dealing with historical and ongoing traumas due to systemic and interpersonal racism.

"(J) Dealing with historical and ongoing traumas regarding systemic and interpersonal sexism, homophobia, biphobia, and transphobia.

"(K) Dealing with the threat of deportation or detention as a result of immigration status.

"(L) The impacts of multigenerational poverty resulting from limited educational and economic opportunities.

''(M) Living through natural disasters such as earthquakes, forest fires, floods, or hurricanes.

''(2) CARE COORDINATION.—The term 'care coordination' means an active, ongoing process that—

''(A) assists children ages 0 through 5 at risk of, or who have experienced, an adverse childhood experience, and their caregivers, including prenatal people of any age, to identify, access, and use community resources and services;

''(B) is client-centered and comprehensive of the services a child or caregiver may need;

''(C) ensures a closed loop referral by obtaining feedback from the families served; and

''(D) works across systems and services to promote collaboration to effectively meet the needs of community members.

''(3) INDIAN TRIBE.—The term 'Indian Tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act.

''(4) PROTECTIVE FACTORS.—The term 'protective factors' refers to any supportive element in a child or caretaker's life that helps the child or care-

taker to withstand trauma such as a stable school environment or supportive peer relationships.

''(m) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—To carry out this section, there is authorized to be appropriated $15,000,000 for each of the 5 fiscal years following the fiscal year in which this section is enacted.

''(2) GRANTS TO INDIAN TRIBES.—Of the amount made available to carry out this section for a fiscal year, the Secretary shall use not less than 10 percent of such amount for grants to eligible entities that are Indian Tribes.

''(3) ADMINISTRATIVE EXPENSES.—Of the amount made available to carry out this section for a fiscal year, the Secretary may use not more than 15 percent of such amount for administrative expenses, including the expenses of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services for compiling and reporting information.

''(4) TECHNICAL ASSISTANCE.—Of the amount made available to carry out this section for a fiscal year, the Secretary may reserve up to 5 percent of such amount to provide technical assistance to eligi-

ble entities in preparing and submitting applications under this section.''.

SEC. 6075. IMPROVING ACCESS TO MENTAL HEALTH.

(a) ACCESS TO CLINICAL SOCIAL WORKERS.—Section 1833(a)(1)(F)(ii) of the Social Security Act (42 U.S.C. 1395l(a)(1)(F)(ii)) is amended by striking ''75 percent of the amount determined for payment of a psychologist under clause (L)'' and inserting ''85 percent of the fee schedule amount provided under section 1848''.

(b) ACCESS TO CLINICAL SOCIAL WORKER SERVICES PROVIDED TO RESIDENTS OF SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by section 6011(a)(5), is amended by inserting ''clinical social worker services,'' after ''peer support specialist services (as defined in section 1861(nnn)(7)),''.

(2) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) ACCESS TO THE COMPLETE SET OF CLINICAL SOCIAL WORKER SERVICES.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is further amended by striking ''for the diagnosis and treatment of mental illnesses (other than services'' and inserting ''(including services for the diagnosis and treatment of mental illnesses or services for health and behavior assessment and intervention (identified as of January 1, 2022, by HCPCS codes 96150 through 96161 (and any succeeding codes)), but not including services''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2023.

SEC. 6076. MENTAL HEALTH IN SCHOOLS EXCELLENCE PROGRAM.

(a) PROGRAM TO ESTABLISH PUBLIC-PRIVATE CONTRIBUTIONS TO INCREASE THE AVAILABLE WORKFORCE OF SCHOOL-BASED MENTAL HEALTH SERVICE PROVIDERS.—

(1) PROGRAM AUTHORIZED.—The Secretary shall carry out a program under which eligible graduate institutions may enter into an agreement with the Secretary to cover a portion of the cost of attendance of a participating student, which contribu-

tions shall be matched by equivalent contributions towards such cost of attendance by the Secretary.

(2) DESIGNATION OF PROGRAM.—The program under this subsection shall be known as the ''Mental Health in Schools Excellence Program''.

(3) AGREEMENTS.—The Secretary shall enter into an agreement with each eligible graduate institution seeking to participate in the program under this section. Each agreement shall specify the following:

(A) The manner (whether by direct grant, scholarship, or otherwise) in which the eligible graduate institution will contribute to the cost of attendance of a participating student.

(B) The maximum amount of the contribution to be made by the eligible graduate institution with respect to any particular participating student in any given academic year.

(C) The maximum number of individuals for whom the eligible graduate institution will make contributions in any given academic year.

(D) That the eligible graduate institution, in selecting participating students to receive assistance under the program, shall prioritize the

participating students described in paragraph (4)(B).

(E) Such other matters as the Secretary and the eligible graduate institution determine appropriate.

(4) OUTREACH.—The Secretary shall—

(A) make publicly available and periodically update on the internet website of the Department of Education a list of the eligible graduate institutions participating in the program under this subsection that shall specify, for each such graduate institution, appropriate information on the agreement between the Secretary and such college or university under paragraph (3); and

(B) conduct outreach about the program under this section to participating students who, as undergraduates—

(i) received a Federal Pell Grant under section 401 of the Higher Education Act of 1965 (20 U.S.C. 1070a); or

(ii) attended an institution listed in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)).

(5) MATCHING CONTRIBUTIONS.—The Secretary may provide a contribution of up to 50 percent of the cost of attendance of a participating student if the eligible graduate institution at which such student is enrolled enters into an agreement under paragraph (3) with the Secretary to match such contribution.

(b) DEFINITIONS.—In this section:

(1) COST OF ATTENDANCE.—The term ''cost of attendance'' has the meaning given the term in section 472 of the Higher Education Act of 1965 (20 U.S.C. 1087ll).

(2) ELIGIBLE GRADUATE INSTITUTION.—The term ''eligible graduate institution'' means an institution of higher education in that offers a program of study that leads to a graduate degree—

(A) in school psychology that is accredited or approved by the National Association of School Psychologists' Program Accreditation Board or the Commission on Accreditation of the American Psychological Association and that prepares students in such program for the State licensing or certification examination in school psychology at the specialist level;

(B) in an accredited school counseling program that prepares students in such program for the State licensing or certification examination in school counseling;

(C) in school social work that is accredited by the Council on Social Work Education and that prepares students in such program for the State licensing or certification examination in school social work;

(D) in another school-based mental health field that prepares students in such program for the State licensing or certification examination in such field, if applicable; or

(E) in any combination of study described in subparagraphs (A) through (D).

(3) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given such term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001), but excludes any institution of higher education described in section 102(a)(1)(C) of such Act.

(4) PARTICIPATING STUDENT.—The term ''participating student'' means an individual who is enrolled in a graduate degree program in a school-

based mental health field at a participating eligible graduate institution.

(5) SCHOOL-BASED MENTAL HEALTH FIELD.—The term ''school-based mental health field'' means each of the following fields:

(A) School counseling.

(B) School social work.

(C) School psychology.

(D) Any other field of study that leads to employment as a school-based mental health services provider, as determined by the Secretary.

(6) SCHOOL-BASED MENTAL HEALTH SERVICES PROVIDER.—The term ''school-based mental health services provider'' has the meaning given the term in section 4102 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7112).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Education.

SEC. 6077. SCHOOL SOCIAL WORKERS IMPROVING STUDENT SUCCESS.

(a) SCHOOL SOCIAL WORKER GRANTS.—

(1) PURPOSES.—The purpose of this section is to assist States and local educational agencies in hiring additional school social workers in order to in-

crease access to mental health and other student support services to students in elementary and secondary schools in the United States to the minimum ratios recommended by the National Association of Social Workers, the School Social Work Association of America, and the American Council for School Social Work of one school social worker for every 250 students, and one school social worker for every 50 students when a social worker is providing services to students with intensive needs.

(2) ESEA AMENDMENT.—Subpart 4 of part F of title IV of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7271 et seq.) is amended by adding at the end the following new section:

"SEC. 4645. GRANTS FOR SCHOOL SOCIAL WORKERS.

''(a) GRANTS AUTHORIZED.—

''(1) IN GENERAL.—From the amounts appropriated under subsection (g), the Secretary shall award grants to high-need local educational agencies to enable such agencies to retain school social workers employed by such agencies or to hire additional school social workers.

''(2) DURATION.—A grant awarded under this section shall be awarded for a period not to exceed 4 years.

''(3) SUPPLEMENT, NOT SUPPLANT.—Funds made available under this section shall be used to supplement, and not to supplant, other Federal, State, or local funds used for hiring and retaining school social workers.

''(b) APPLICATION.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, a high-need local educational agency shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(2) CONTENTS.—An application submitted under paragraph (1) shall include an assurance that each school social worker who receives assistance under the grant will provide the services described in subsection (d), and a description of the specific services to be provided by such social worker.

''(c) USE OF FUNDS.—A high-need local educational agency receiving a grant under this section—

''(1) shall use the grant—

"(A) to achieve a ratio of not less than 1 school social worker for every 250 students served by the agency, by—

"(i) retaining school social workers employed by such agency; or

"(ii)(I) employing additional school social workers; or

"(II) hiring contractors to serve as school social workers only in a case in which—

"(aa) the local educational agency demonstrates to the Secretary that the agency—

"(AA) has not been able to employ a sufficient number of school social workers under subclause (I) to achieve such ratio despite strong and continuing efforts to recruit and employ school social workers; and

"(BB) hiring contractors is the only viable option to ensure students have adequate access to school social work services; and

''(bb) each such contractor meets the requirements of subparagraphs (A) and (B) of subsection (h)(2); and

''(B) to ensure that each school social worker who receives assistance under such grant provides the services described in subsection (d); and

''(2) may use the grant to reimburse school social workers who receive assistance under such grant for—

''(A) in the case of a school served by the agency in which the majority of students are higher risk students, to hire or retain additional school social workers in accordance with clauses (i) and (ii) of paragraph (1)(A) to achieve a ratio of not less than 1 school social worker for every 50 students;

''(B) travel expenses incurred during home visits and other school-related trips;

''(C) any additional expenses incurred by such social workers in rendering any service described in subsection (d); and

''(D) the cost of clinical social work supervision for such social workers.

''(d) RESPONSIBILITIES OF A SCHOOL SOCIAL WORKER.—A school social worker who receives assistance under a grant under this section shall provide the following services:

''(1) Identifying high-need students in each school that the social worker serves, and targeting services provided at the school to such students.

''(2) Providing students in each school that the school social worker serves, social work services to promote school engagement and improve academic outcomes, including—

''(A) counseling and crisis intervention;

''(B) trauma-informed services;

''(C) evidence-based educational, behavioral, and mental health services (such as implementing multi-tiered programs and practices, monitoring progress, and evaluating service effectiveness);

''(D) addressing the social and emotional learning needs of students;

''(E) promoting a school climate and culture conducive to student learning and teaching excellence (such as promoting effective school policies and administrative procedures, enhancing the professional capacity of school per-

sonnel, and facilitating engagement between student, family, school, and community);

''(F) providing access to school-based and community based resources (such as promoting a continuum of services, mobilizing resources and promoting assets, providing leadership, interdisciplinary collaboration, systems coordination, and professional consultation, and connecting students and families to resource systems);

''(G) working with students, families, schools, and communities to address barriers to educational attainment (such as homelessness and housing insecurity, lack of transportation, food insecurity, equity, social justice issues, access to quality education, and school, family, and community risk factors);

''(H) providing assistance to schools and teachers to design social-emotional, educational, behavioral, and mental health interventions;

''(I) case management activities to coordinate the delivery of and access to the appropriate social work services to the highest-need students;

"(J) home visits to meet the family of students in need of social work services in the home environment;

"(K) supervising or coordinating district level school social work services; and

"(L) other services the Secretary determines, in partnership with students, educators, and community member voices, are necessary to be carried out by such a social worker.

"(e) GRANT RENEWAL.—

"(1) IN GENERAL.—A grant awarded under this section may be renewed for additional periods with the same duration as the original grant period.

"(2) CONTINUING ELIGIBILITY APPLICATION.—To be eligible for a renewal under this section a high-need local educational agency shall submit to the Secretary, for each renewal, a report on the progress of such agency in retaining and hiring school social workers to achieve the ratio of not less than 1 school social worker for every 250 students served by the agency, and shall include—

"(A) a description of the staffing expansion of school social workers funded through the original grant received under this section; and

"(B) a description of the work conducted by such social workers for higher risk students.

"(f) TECHNICAL ASSISTANCE.—

"(1) IN GENERAL.—The Secretary shall provide technical assistance to high-need local educational agencies, including such agencies that do not have adequate staff, in applying for grants under this section.

"(2) EXTENSION OF APPLICATION PERIOD.—The Secretary shall extend any application period for a grant under this section for any high-need local educational agency that—

"(A) submits to the Secretary a written notification of the intent to apply for a grant under this section before requesting technical assistance under paragraph (1); and

"(B) after submitting the notification under subparagraph (A), requests such technical assistance.

"(g) AUTHORIZATION FOR APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $100,000,000 for each of fiscal years 2023 through 2027.

"(h) DEFINITIONS.—In this section:

"(1) HIGH-NEED LOCAL EDUCATIONAL AGENCY.—The term 'high-need local educational agency'

has the meaning given the term in section 200 of the Higher Education Act of 1965 (20 U.S.C. 1021).

''(2) SCHOOL SOCIAL WORKER.—The term 'school social worker' means an individual who—

''(A) has a graduate degree in social work from a social work program that is accredited by the Council on Social Work Education; and

''(B) meets all other State and local credentialing requirements for practicing as a social worker in an elementary school or secondary school.''.

(b) NATIONAL TECHNICAL ASSISTANCE CENTER FOR SCHOOL SOCIAL WORK.—

(1) IN GENERAL.—The Secretary of Education shall establish an evaluation, documentation, dissemination, and technical assistance resource center to provide appropriate information, training, and technical assistance to States, political subdivisions of States, federally recognized Indian Tribes, Tribal organizations, institutions of higher education, State and local educational agencies, and individual students and educators with respect to hiring and retaining school social workers at elementary schools and secondary schools served by local educational agencies.

(2) RESPONSIBILITIES OF THE CENTER.—The center established under paragraph (1) shall conduct activities for the purpose of—

(A) developing and continuing statewide or Tribal strategies for improving the effectiveness of the school social work workforce;

(B) studying the costs and effectiveness of school social work programs at institutions of higher education to identify areas of improvement and provide information on relevant issues of importance to State, Tribal, and national policymakers;

(C) working with Federal agencies and other State, Tribal, and national stakeholders to collect, evaluate, and disseminate data regarding school social work ratios, outcomes and best practices of school-based mental health services, and impact of expanding the number of school social workers within elementary schools and secondary schools; and

(D) establishing partnerships among national, State, Tribal, and local governments, and local educational agencies, institutions of higher education, non-profit organizations, and

State and national trade associations for the purposes of—

(i) data collection and dissemination;

(ii) establishing a school social work workforce development program;

(iii) documenting the success of school social work methods on a national level; and

(iv) conducting other activities determined appropriate by the Secretary.

(3) DEFINITIONS.—In this subsection:

(A) ESEA TERMS.—Except as otherwise provided, any term used in this subsection that is defined in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801) shall have the meaning given that term in such section.

(B) SCHOOL SOCIAL WORKER.—The term ''school social worker'' has the meaning given the term in section 4645(h) of the Elementary and Secondary Education Act of 1965, as added by subsection (a).

SEC. 6078. OPIOID GRANTS TO SUPPORT CAREGIVERS, KINSHIP CARE FAMILIES, AND KINSHIP CAREGIVERS.

(a) OPIOID GRANTS.—Section 1003(b)(2) of the 21st Century Cures Act (42 U.S.C. 290ee–3 note) is amended—

(1) by redesignating subparagraph (E) as subparagraph (F); and

(2) by inserting after subparagraph (D) the following:

''(E) Supporting opioid abuse prevention and treatment services within a State provided by State and local agencies for children and caregivers, kinship care families, and kinship caregivers through—

''(i) workforce recruitment and training;

''(ii) health care services (including such services described in subparagraph (D)); and

''(iii) foster and adoptive parent recruitment and training.''.

(b) DEFINITIONS.—Section 1003 of the 21st Century Cures Act (42 U.S.C. 290ee–3 note) is amended—

(1) by redesignating subsections (h), (i), and (j) as subsections (i), (j), and (k), respectively; and

(2) by inserting after subsection (g) the following:

''(h) DEFINITIONS.—In this section:

''(1) The term 'kinship care family' means a family with a kinship caregiver.

''(2) The term 'kinship caregiver' means a relative of a child by blood, marriage, or adoption, who—

''(A) lives with the child;

''(B) is the primary caregiver of the child because the biological or adoptive parent of the child is unable or unwilling to serve as the primary caregiver of the child; and

''(C) has a legal relationship to the child or is raising the child informally.''.

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 1003(i) of the 21st Century Cures Act (42 U.S.C. 290ee–3 note), as redesignated, is amended by inserting '', and $255,000,000 for each of fiscal years 2022 through 2026'' after ''2021''.

(d) SET ASIDE.—Section 1003(j) of the 21st Century Cures Act (42 U.S.C. 290ee–3 note), as redesignated, is amended—

(1) by striking '', and up to'' and inserting '', up to''; and

(2) by inserting before the period at the end ", and 1 percent of such amount for such fiscal year shall be made available to carry out subsection (b)(2)(E)".

TITLE VII—ADDRESSING HIGH IMPACT MINORITY DISEASES

Subtitle A—Cancer

SEC. 7001. LUNG CANCER MORTALITY REDUCTION.

(a) FINDINGS.—Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 25 percent of all cancer deaths.

(2) Since the National Cancer Act of 1971 (Public Law 92–218; 85 Stat. 778), coordinated and comprehensive research has raised the 5-year survival rates for breast cancer to 90 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(3) The 5-year survival rate for lung cancer is still only 18 percent, and a similar coordinated and comprehensive research effort is required to achieve increases in lung cancer survivability rates.

(4) Sixty percent of lung cancer cases are now diagnosed in nonsmokers or former smokers.

(5) Two-thirds of nonsmokers diagnosed with lung cancer are women.

(6) Certain minority populations, such as African-American males, have disproportionately high rates of lung cancer incidence and mortality, despite their smoking rate being similar to other racial groups.

(7) Members of the Baby Boomer Generation are entering their 60s, the most common age at which people develop lung cancer.

(8) Tobacco addiction and exposure to other lung cancer carcinogens such as Agent Orange and other herbicides and battlefield emissions are serious problems among military personnel and war veterans.

(9) Significant and rapid improvements in lung cancer mortality can be expected through greater use and access to lung cancer screening tests for at-risk individuals.

(10) Recent research has shown that screening with low-dose computed tomography scan reduced lung cancer death mortality by 20 percent for those with a high risk of lung cancer through early detection. The Centers for Medicare & Medicaid Services

supports annual lung cancer screening for high-risk patients with low-dose computed tomography.

(11) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(12) The August 2001 Report of the Lung Cancer Progress Review Group of the National Cancer Institute stated that funding for lung cancer research was ''far below the levels characterized for other common malignancies and far out of proportion to its massive health impact''.

(13) The Report of the Lung Cancer Progress Review Group identified as its ''highest priority'' the creation of integrated, multidisciplinary, multi-institutional research consortia organized around the problem of lung cancer rather than around specific research disciplines.

(14) The United States must enhance its response to the issues raised in the Report of the Lung Cancer Progress Review Group, and this can be accomplished through the establishment of a coordinated effort designed to reduce the lung cancer mortality rate by 50 percent by 2023 and targeted funding to support this coordinated effort.

(b) SENSE OF CONGRESS CONCERNING INVESTMENT IN LUNG CANCER RESEARCH.—It is the sense of the Congress that—

(1) lung cancer mortality reduction should be made a national public health priority; and

(2) a comprehensive mortality reduction program coordinated by the Secretary of Health and Human Services is justified and necessary to adequately address and reduce lung cancer mortality.

(c) LUNG CANCER MORTALITY REDUCTION PROGRAM.—

(1) IN GENERAL.—Subpart 1 of part C of title IV of the Public Health Service Act (42 U.S.C. 285 et seq.) is amended by adding at the end the following:

"SEC. 417H. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—Not later than 6 months after the date of the enactment of the Health Equity and Accountability Act of 2022, the Secretary, in consultation with the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services,

the Director of the National Institute on Minority Health and Health Disparities, the Administrator of the Environmental Protection Agency, and other members of the Lung Cancer Advisory Board established under section 7001 of the Health Equity and Accountability Act of 2022, shall implement a comprehensive program, to be known as the Lung Cancer Mortality Reduction Program, to achieve a reduction of at least 25 percent in the mortality rate of lung cancer by 2027.

''(b) REQUIREMENTS.—The Program shall include at least the following:

''(1) With respect to the National Institutes of Health—

''(A) a strategic review and prioritization by the National Cancer Institute of research grants to achieve the goal specified in subsection (a);

''(B) the provision of funds to enable the Airway Biology and Disease Branch of the National Heart, Lung, and Blood Institute to expand its research programs to include predispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, and the diagnosis and treatment of such diseases;

"(C) the provision of funds to enable the National Institute of Biomedical Imaging and Bioengineering to expedite the development of computer-assisted diagnostic, surgical, treatment, and drug-testing innovations to reduce lung cancer mortality, such as through expansion of the Institute's Quantum Grant Program and Image-Guided Interventions program; and

"(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to the lung cancer incidence.

"(2) With respect to the Food and Drug Administration—

"(A) activities under section 529B of the Federal Food, Drug, and Cosmetic Act; and

"(B) activities under section 561 of the Federal Food, Drug, and Cosmetic Act to expand access to investigational drugs and devices for the diagnosis, monitoring, or treatment of lung cancer.

"(3) With respect to the Centers for Disease Control and Prevention, the establishment of an early disease research and management program under section 1511.

''(4) With respect to the Agency for Healthcare Research and Quality, the conduct of a biannual review of lung cancer screening, diagnostic, and treatment protocols, and the issuance of updated guidelines.

''(5) The promotion (including education) of lung cancer screening within minority and rural populations and the study of the effectiveness of efforts to increase such screening.

''(6) The cooperation and coordination of all minority and health disparity programs within the Department of Health and Human Services to ensure that all aspects of the Lung Cancer Mortality Reduction Program under this section adequately address the burden of lung cancer on minority and rural populations.

''(7) The cooperation and coordination of all tobacco control and cessation programs within agencies of the Department of Health and Human Services to achieve the goals of the Lung Cancer Mortality Reduction Program under this section with particular emphasis on the coordination of drug and other cessation treatments with early detection protocols.''.

(2) FEDERAL FOOD, DRUG, AND COSMETIC ACT.—Subchapter B of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et seq.) is amended by adding at the end the following:

"SEC. 529B. DRUGS RELATING TO LUNG CANCER.

''(a) IN GENERAL.—The provisions of this subchapter shall apply to a drug described in subsection (b) to the same extent and in the same manner as such provisions apply to a drug for a rare disease or condition (as defined in section 526).

''(b) QUALIFIED DRUGS.—A drug described in this subsection is—

''(1) a chemoprevention drug for precancerous conditions of the lung;

''(2) a drug for targeted therapeutic treatments, including any vaccine, for lung cancer; or

''(3) a drug to curtail or prevent nicotine addiction.

''(c) BOARD.—The Board established under section 7001 of the Health Equity and Accountability Act of 2022 shall monitor the program implemented under this section.''.

(3) ACCESS TO UNAPPROVED THERAPIES.—Section 561(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb(e)) is amended by in-

serting before the period the following: ''and shall include expanding access to drugs under section 529B, with substantial consideration being given to whether the totality of information available to the Secretary regarding the safety and effectiveness of an investigational drug, as compared to the risk of morbidity and death from the disease, indicates that a patient may obtain more benefit than risk if treated with the drug''.

(4) CDC.—Title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) is amended by adding at the end the following:

''SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT PROGRAM.

''The Secretary shall establish and implement an early disease research and management program targeted at the high incidence and mortality rates of lung cancer among minority and low-income populations.''.

(d) DEPARTMENT OF DEFENSE AND DEPARTMENT OF VETERANS AFFAIRS.—The Secretary of Defense and the Secretary of Veterans Affairs, each in coordination with the Secretary of Health and Human Services, shall engage—

(1) in the implementation within the Department of Defense and the Department of Veterans

Affairs, as the case may be, of an early detection and disease management research program for members of the Armed Forces and veterans whose smoking history and exposure to carcinogens during service on active duty in the Armed Forces has increased their risk for lung cancer; and

(2) in the implementation of coordinated care programs for members of the Armed Forces and veterans diagnosed with lung cancer.

(e) LUNG CANCER ADVISORY BOARD.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall convene a Lung Cancer Advisory Board (referred to in this section as the ''Board'')—

(A) to monitor the programs established under this section (and the amendments made by this section); and

(B) to provide annual reports to the Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

(2) COMPOSITION.—The Board shall be comprised of—

(A) the Secretary of Health and Human Services;

(B) the Secretary of Defense;

(C) the Secretary of Veterans Affairs; and

(D) 2 representatives each from the fields of clinical medicine focused on lung cancer, lung cancer research, imaging, drug development, and lung cancer advocacy, to be appointed by the Secretary of Health and Human Services.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—To carry out this section (and the amendments made by this section), there are authorized to be appropriated $75,000,000 for fiscal year 2023 and such sums as may be necessary for each of fiscal years 2024 through 2026.

(2) LUNG CANCER MORTALITY REDUCTION PROGRAM.—The amounts appropriated under paragraph (1) shall be allocated as follows:

(A) $25,000,000 for fiscal year 2023, and such sums as may be necessary for each of fiscal years 2024 through 2026, for the activities described in section 417H(b)(1)(B) of the Public Health Service Act, as added by subsection (d);

(B) $25,000,000 for fiscal year 2023, and such sums as may be necessary for each of fis-

cal years 2024 through 2026, for the activities described in section 417H(b)(1)(C) of the Public Health Service Act;

(C) $10,000,000 for fiscal year 2023, and such sums as may be necessary for each of fiscal years 2024 through 2026, for the activities described in section 417H(b)(1)(D) of the Public Health Service Act; and

(D) $15,000,000 for fiscal year 2023, and such sums as may be necessary for each of fiscal years 2024 through 2026, for the activities described in section 417H(b)(3) of the Public Health Service Act.

SEC. 7002. EXPANSION OF PROSTATE CANCER RESEARCH, OUTREACH, SCREENING, TESTING, ACCESS, AND TREATMENT EFFECTIVENESS.

(a) FINDINGS.—Congress makes the following findings:

(1) Prostate cancer is the second leading cause of cancer death among men.

(2) In 2020, an estimated 191,930 individuals in the United States will be diagnosed with prostate cancer and approximately 33,330 will die from the disease.

(3) Roughly 2,000,000 to 3,000,000 people in the United States are living with a diagnosis of prostate cancer and its consequences.

(4) Although prostate cancer generally affects older individuals, younger men are also at risk for the disease, and when prostate cancer appears in early middle age, it frequently takes on a more aggressive form.

(5) There are significant racial and ethnic disparities that demand attention, for example, African Americans have prostate cancer mortality rates that are more than double those in the White population.

(6) Underserved rural populations have higher rates of mortality compared to their urban counterparts, and innovative and cost-efficient methods to improve rural access to high-quality care should take advantage of advances in telehealth to diagnose and treat prostate cancer when appropriate.

(7) Certain populations of veterans may have nearly twice the incidence of prostate cancer as the general population of the United States.

(8) Urologists may constitute the specialists who diagnose and treat the vast majority of prostate cancer patients.

(9) Although much basic and translational research has been completed and much is currently known, there are still many unanswered questions, such as the extent to which known disparities are attributable to disease etiology, access to care, or education and awareness in the community.

(10) Causes of prostate cancer are not known. There is not good information regarding how to differentiate accurately, early on, between aggressive and indolent forms of the disease. As a result, there is significant overtreatment in prostate cancer. There are no treatments that can durably arrest growth or cure prostate cancer once it has metastasized.

(11) A significant proportion of cases may be clinically indolent and overdiagnosed, resulting in significant overtreatment. More accurate tests will allow men and their families to face less physical, psychological, financial, and emotional trauma, and billions of dollars could be saved in private and public health care systems.

(12) Prostate cancer research and health care programs across Federal agencies should be coordinated to improve accountability and actively encourage the translation of research into practice and to

identify and implement best practices in order to foster an integrated and consistent focus on effective prevention, diagnosis, and treatment of the disease.

(b) PROSTATE CANCER COORDINATION AND EDUCATION.—

(1) INTERAGENCY PROSTATE CANCER COORDINATION AND EDUCATION TASK FORCE.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs, in cooperation with the Secretary of Defense and the Secretary of Health and Human Services, shall establish an Interagency Prostate Cancer Coordination and Education Task Force (in this section referred to as the ''Prostate Cancer Task Force'').

(2) DUTIES.—The Prostate Cancer Task Force shall—

(A) develop a summary of advances in prostate cancer research supported or conducted by Federal agencies relevant to the diagnosis, prevention, and treatment of prostate cancer, including psychosocial impairments related to prostate cancer treatment, and compile a list of best practices that warrant broader adoption in health care programs;

(B) consider establishing, and advocating for, a guidance to enable physicians to allow screening of men who are age 74 or older, on a case-by-case basis, taking into account quality of life and family history of prostate cancer;

(C) share and coordinate information on research and health care program activities by the Federal Government, including activities related to—

(i) determining how to improve research and health care programs, including psychosocial impairments related to prostate cancer treatment;

(ii) identifying any gaps in the overall research inventory and in health care programs;

(iii) identifying opportunities to promote translation of research into practice; and

(iv) maximizing the effects of Federal Government efforts by identifying opportunities for collaboration and leveraging of resources in research and health care programs that serve individuals who are sus-

ceptible to or diagnosed with prostate cancer;

(D) develop a comprehensive interagency strategy and advise relevant Federal agencies in the solicitation of proposals for collaborative, multidisciplinary research and health care programs, including proposals to evaluate factors that may be related to the etiology of prostate cancer, that would—

(i) result in innovative approaches to study emerging scientific opportunities or eliminate knowledge gaps in research to improve the prostate cancer research portfolio of the Federal Government; and

(ii) outline key research questions, methodologies, and knowledge gaps;

(E) develop a coordinated message related to screening and treatment for prostate cancer to be reflected in educational and beneficiary materials for Federal health programs as such materials are updated; and

(F) not later than two years after the date of the establishment of the Prostate Cancer Task Force, submit to the expert advisory panels appointed under paragraph (4) to be re-

viewed and returned within 30 days, and then within 90 days submitted to Congress, recommendations—

(i) regarding any appropriate changes to research and health care programs, including recommendations to improve the research portfolio of the Department of Veterans Affairs, the Department of Defense, the National Institutes of Health, and other Federal agencies to ensure that scientifically based strategic planning is implemented in support of research and health care program priorities;

(ii) designed to ensure that the research and health care programs and activities of the Department of Veterans Affairs, the Department of Defense, the Department of Health and Human Services, and other Federal agencies are free of unnecessary duplication;

(iii) regarding public participation in decisions relating to prostate cancer research and health care programs to increase the involvement of patient advocates, community organizations, and med-

ical associations representing a broad geographical area;

(iv) on how to best disseminate information on prostate cancer research and progress achieved by health care programs;

(v) on how to expand partnerships between public entities, including Federal agencies, and private entities to encourage collaborative, cross-cutting research and health care delivery;

(vi) assessing any cost savings and efficiencies realized through the efforts identified in, and supported through, this subsection and recommending expansion of those efforts that have proved most promising while also ensuring against any conflicts in directives in law;

(vii) identifying key priority action items from among the recommendations specified in clauses (i) through (vi); and

(viii) with respect to the level of funding needed by each agency to implement such recommendations.

(3) MEMBERS OF THE PROSTATE CANCER TASK FORCE.—The Prostate Cancer Task Force shall be

comprised of representatives from such Federal agencies as the head of each such applicable agency determines necessary, so as to coordinate a uniform message relating to prostate cancer screening and treatment where appropriate, including representatives of each of the following:

(A) The Department of Veterans Affairs, including representatives of each relevant program area of the Department of Veterans Affairs.

(B) The Prostate Cancer Research Program of the Congressionally Directed Medical Research Program of the Department of Defense.

(C) The Department of Health and Human Services, including, at a minimum, representatives of each of the following:

(i) The National Institutes of Health.

(ii) National research institutes and centers, including the National Cancer Institute, the National Institute of Allergy and Infectious Diseases, and the Office of Minority Health.

(iii) The Centers for Medicare & Medicaid Services.

(iv) The Food and Drug Administration.

(v) The Centers for Disease Control and Prevention.

(vi) The Agency for Healthcare Research and Quality.

(vii) The Health Resources and Services Administration.

(4) APPOINTING EXPERT ADVISORY PANELS.—The Prostate Cancer Task Force shall appoint expert advisory panels, as the task force determines appropriate, to provide input and concurrence from—

(A) individuals and organizations from the medical, prostate cancer patient and advocate, research, and delivery communities with expertise in prostate cancer diagnosis, treatment, and research, including practicing urologists, primary care providers, and others; and

(B) individuals with expertise in education and outreach to underserved populations affected by prostate cancer.

(5) MEETINGS.—The Prostate Cancer Task Force shall convene not less frequently than twice

each year, or more frequently as the Secretary of Veterans Affairs determines to be appropriate.

(6) FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Prostate Cancer Task Force.

(7) SUNSET DATE.—The Prostate Cancer Task Force shall terminate on September 30, 2025.

(c) PROSTATE CANCER RESEARCH.—

(1) RESEARCH COORDINATION PROGRAM.—

(A) IN GENERAL.—The Secretary of Veterans Affairs, in coordination with the Secretary of Defense and the Secretary of Health and Human Services, shall establish and carry out a program to coordinate and intensify prostate cancer research.

(B) ELEMENTS.—The program established under subparagraph (A) shall—

(i) develop advances in diagnostic and prognostic methods and tests, including biomarkers and an improved prostate cancer screening blood test, including improvements or alternatives to the prostate specific antigen test and additional tests to distinguish indolent from aggressive disease;

(ii) develop a better understanding of the etiology of the disease (including an analysis of lifestyle factors proven to be involved in higher rates of prostate cancer, such as obesity and diet, and in different ethnic, racial, and socioeconomic groups, such as the African-American, Latino or Hispanic, and American Indian populations and men with a family history of prostate cancer) to improve prevention efforts;

(iii) expand basic research into prostate cancer, including studies of fundamental molecular and cellular mechanisms;

(iv) identify and provide clinical testing of novel agents for the prevention and treatment of prostate cancer;

(v) establish clinical registries for prostate cancer;

(vi) use the National Institute of Biomedical Imaging and Bioengineering and the National Cancer Institute for assessment of appropriate imaging modalities; and

(vii) address such other matters relating to prostate cancer research as may be identified by the Federal agencies participating in such program.

(C) UNDERSERVED MINORITY GRANT PROGRAM.—In carrying out the program established under subparagraph (A), the Secretary shall—

(i) award grants to eligible entities to carry out components of the research outlined in subparagraph (B);

(ii) integrate and build upon existing knowledge gained from comparative effectiveness research; and

(iii) recognize and address—

(I) the racial and ethnic disparities in the incidence and mortality rates of prostate cancer and men with a family history of prostate cancer;

(II) any barriers in access to care and participation in clinical trials that are specific to racial, ethnic, and other underserved minorities and men with a family history of prostate cancer;

(III) outreach and educational efforts to raise awareness among the populations described in subclause (II); and

(IV) appropriate access and utilization of imaging modalities.

(2) PROSTATE CANCER ADVISORY BOARD.—

(A) IN GENERAL.—There is established in the Office of the Chief Scientist of the Food and Drug Administration a Prostate Cancer Scientific Advisory Board.

(B) DUTIES.—The board established under subparagraph (A) shall be responsible for accelerating real-time sharing of the latest research data and accelerating movement of new medicines for the treatment of prostate cancer to patients.

(d) TELEHEALTH AND RURAL ACCESS PILOT PROJECTS.—

(1) ESTABLISHMENT OF PILOT PROJECTS.—

(A) IN GENERAL.—The Secretary of Veterans Affairs, in cooperation with the Secretary of Defense and the Secretary of Health and Human Services (referred to in this subsection collectively as the ''Secretaries'') shall establish

four-year telehealth pilot projects for the purpose of analyzing the clinical outcomes and cost-effectiveness associated with telehealth services in a variety of geographic areas that contain high proportions of medically underserved populations, including African Americans, Latinos or Hispanics, American Indians or Alaska Natives, and those in rural areas.

(B) EFFICIENT AND EFFECTIVE CARE.—Pilot projects established under subparagraph (A) shall promote efficient use of specialist care through better coordination of primary care and physician extender teams in underserved areas and more effectively employ tumor boards to better counsel patients.

(2) ELIGIBLE ENTITIES.—

(A) IN GENERAL.—The Secretaries shall select eligible entities to participate in the pilot projects established under this subsection.

(B) PRIORITY.—In selecting eligible entities to participate in the pilot projects under this subsection, the Secretaries shall give priority to entities located in medically underserved areas, particularly those that include African Americans, Latinos and Hispanics, and

facilities of the Indian Health Service, including facilities operated by the Indian Health Service, tribally operated facilities, and facilities administered by an Urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) pursuant to title V of that Act (25 U.S.C. 1651 et seq.), and those in rural areas.

(3) EVALUATION.—The Secretaries shall, through the pilot projects established under this subsection, evaluate—

(A) the effective and economic delivery of care in diagnosing and treating prostate cancer with the use of telehealth services in medically underserved and Tribal areas including collaborative uses of health professionals and integration of the range of telehealth and other technologies;

(B) the effectiveness of improving the capacity of nonmedical providers and nonspecialized medical providers to provide health services for prostate cancer in medically underserved and Tribal areas, including the exploration of innovative medical home models with collaboration between urologists, other relevant medical

specialists, including oncologists, radiologists, and primary care teams, and coordination of care through the efficient use of primary care teams and physician extenders; and

(C) the effectiveness of using telehealth services to provide prostate cancer treatment in medically underserved areas, including the use of tumor boards to facilitate better patient counseling.

(4) REPORT.—Not later than one year after the completion of the pilot projects under this subsection, the Secretaries shall submit to Congress a report describing the outcomes of such pilot projects, including any cost savings and efficiencies realized, and providing recommendations, if any, for expanding the use of telehealth services.

(e) EDUCATION AND AWARENESS.—

(1) CAMPAIGN.—

(A) IN GENERAL.—The Secretary of Veterans Affairs shall develop a national education campaign for prostate cancer.

(B) ELEMENTS.—The campaign developed under subparagraph (A) shall involve the use of written educational materials and public service announcements consistent with the findings of

the Prostate Cancer Task Force under subsection (b) that are intended to encourage men to seek prostate cancer screening when appropriate.

(2) RACIAL DISPARITIES AND THE POPULATION OF MEN WITH A FAMILY HISTORY OF PROSTATE CANCER.—In developing the campaign under paragraph (1), the Secretary shall ensure that educational materials and public service announcements used in the campaign are more readily available in communities experiencing racial disparities in the incidence and mortality rates of prostate cancer and to men of any race classification with a family history of prostate cancer.

(3) GRANTS.—In carrying out the campaign under this subsection, the Secretary shall award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section for the period of fiscal years 2023 through 2027 an amount equal to the amount of savings for the Federal Government projected to be achieved over such period by implementation of this section.

SEC. 7003. PROSTATE RESEARCH, IMAGING, AND MEN'S EDUCATION.

(a) FINDINGS.—Congress makes the following findings:

(1) Prostate cancer has reached epidemic proportions, particularly among African-American men, and strikes and kills men in numbers comparable to the number of women who lose their lives from breast cancer.

(2) Life-saving breakthroughs in screening, diagnosis, and treatment of breast cancer resulted from the development of advanced imaging technologies led by the Federal Government.

(3) Men should have accurate and affordable prostate cancer screening exams and minimally invasive treatment tools, similar to what women have for breast cancer.

(4) While it is important for men to take advantage of current prostate cancer screening techniques, a recent National Cancer Institute study demonstrated that the most common available methods of detecting prostate cancer (PSA blood test and physical exams) are not foolproof, causing numerous false alarms and false reassurances.

(5) The absence of advanced imaging technologies for prostate cancer causes the lack of accu-

rate information critical for clinical decisions, resulting in missed cancers and lost lives, as well as unnecessary and costly medical procedures, with related complications.

(6) With prostate imaging tools, men and their families would face less physical, psychological, financial, and emotional trauma and billions of dollars could be saved in private and public health care systems.

(b) RESEARCH AND DEVELOPMENT OF PROSTATE CANCER IMAGING TECHNOLOGIES.—

(1) EXPANSION OF RESEARCH.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the National Institutes of Health and the Administrator of the Health Resources and Services Administration, and in consultation with the Secretary of Defense, shall carry out a program to expand and intensify research to develop innovative advanced imaging technologies for prostate cancer detection, diagnosis, and treatment comparable to state-of-the-art mammography technologies.

(2) EARLY STAGE RESEARCH.—In implementing the program under paragraph (1), the Secretary, acting through the Administrator of the

Health Resources and Services Administration, shall carry out a grant program to encourage the early stages of research in prostate imaging to develop and implement new ideas, proof of concepts, and pilot studies for high-risk technologic innovation in prostate cancer imaging that would have a high potential impact for improving patient care, including individualized care, quality of life, and cost-effectiveness.

(3) LARGE SCALE LATER STAGE RESEARCH.—In implementing the program under paragraph (1), the Secretary, acting through the Director of the National Institutes of Health, shall utilize the National Institute of Biomedical Imaging and Bioengineering and the National Cancer Institute for advanced stages of research in prostate imaging, including technology development and clinical trials for projects determined by the Secretary to have demonstrated promising preliminary results and proof of concept.

(4) INTERDISCIPLINARY PRIVATE-PUBLIC PARTNERSHIPS.—In developing the program under paragraph (1), the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish interdisciplinary private-

public partnerships to develop and implement research strategies for expedited innovation in imaging and image-guided treatment and to conduct such research.

(5) RACIAL DISPARITIES.—In developing the program under paragraph (1), the Secretary shall recognize and address—

(A) the racial disparities in the incidences of prostate cancer and mortality rates with respect to such disease; and

(B) any barriers in access to care and participation in clinical trials that are specific to racial minorities.

(6) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—Subject to subparagraph (B), there is authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2023 through 2027.

(B) SPECIFIC ALLOCATIONS.—Of the amount authorized to be appropriated under subparagraph (A) for each of the fiscal years described in such subparagraph—

(i) no less than 10 percent may be used to carry out the grant program under paragraph (2); and

(ii) no more than 1 percent may be used to carry out paragraph (4).

(c) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—

(1) NATIONAL CAMPAIGN.—The Secretary shall carry out a national campaign to increase the awareness and knowledge of individuals in the United States with respect to the need for prostate cancer screening and for improved detection technologies.

(2) REQUIREMENTS.—The national campaign conducted under this subsection shall include—

(A) roles for the Health Resources Services Administration, the Office of Minority Health of the Department of Health and Human Services, the Centers for Disease Control and Prevention, and the Office of Minority Health and Health Equity of the Centers for Disease Control and Prevention; and

(B) the development and distribution of written educational materials, and the development and placing of public service announcements, that are intended to encourage men to

seek prostate cancer screening and to create awareness of the need for improved imaging technologies for prostate cancer screening and diagnosis, including in vitro blood testing and imaging technologies.

(3) RACIAL DISPARITIES.—In developing the national campaign under paragraph (1), the Secretary shall recognize and address—

(A) the racial disparities in the incidences of prostate cancer and mortality rates with respect to such disease; and

(B) any barriers in access to care and participation in clinical trials that are specific to racial minorities.

(4) GRANTS.—The Secretary shall establish a program to award grants to nonprofit private entities to enable such entities to test alternative outreach and education strategies to increase the awareness and knowledge of individuals in the United States with respect to the need for prostate cancer screening and improved imaging technologies.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $10,000,000 for each of fiscal years 2023 through 2027.

(d) IMPROVING PROSTATE CANCER SCREENING BLOOD TESTS.—

(1) IN GENERAL.—The Secretary, in coordination with the Secretary of Defense, shall support research to develop an improved prostate cancer screening blood test using in-vitro detection.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $20,000,000 for each of fiscal years 2023 through 2027.

(e) REPORTING AND COMPLIANCE.—

(1) REPORT AND STRATEGY.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report that details the strategy of the Secretary for implementing the requirements of this section and the status of such efforts.

(2) FULL COMPLIANCE.—Not later than 36 months after the date of the enactment of this Act, and annually thereafter, the Secretary shall submit to Congress a report that—

(A) describes the research and development and public awareness and education campaigns funded under this section;

(B) provides evidence that projects involving high-risk, high impact technologic innovation, proof of concept, and pilot studies are prioritized;

(C) provides evidence that the Secretary recognizes and addresses any barriers in access to care and participation in clinical trials that are specific to racial minorities in the implementation of this section;

(D) contains assurances that all the other provisions of this section are fully implemented; and

(E) certifies compliance with the provisions of this section, or in the case of a Federal agency that has not complied with any of such provisions, an explanation as to such failure to comply.

SEC. 7004. PROSTATE CANCER DETECTION RESEARCH AND EDUCATION.

(a) PLAN TO DEVELOP AND VALIDATE A TEST OR TESTS FOR PROSTATE CANCER.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the National Institutes of Health, shall establish an advi-

sory council on prostate cancer (referred to in this section as the ''advisory council'') to draft a plan for the development and validation of an accurate test or tests, such as biomarkers or imaging, to detect and diagnose prostate cancer.

(2) ADVISORY COUNCIL.—

(A) MEMBERSHIP.—

(i) FEDERAL MEMBERS.—The advisory council shall be comprised of the following experts:

(I) A designee of the Centers for Disease Control and Prevention.

(II) A designee of the Centers for Medicare & Medicaid Services.

(III) A designee of the Office of the Director of the National Cancer Institute.

(IV) A designee of the Director of the Department of Defense Congressionally Directed Medical Research Programs.

(V) A designee of the Director of the National Institute of Biomedical Imaging and Bioengineering.

(VI) A designee of the Director of the National Institute of General Medical Sciences.

(VII) A designee of the Director of the National Institute on Minority Health and Health Disparities.

(VIII) A designee of the Director of the National Institutes of Health.

(IX) A designee of the Commissioner of Food Drugs.

(X) A designee of the Director of the Agency for Healthcare Research and Quality.

(XI) A designee of the Director of the Telemedicine and Advanced Technology Research Center of the Department of Defense.

(ii) NON-FEDERAL MEMBERS.—In addition to the members described in clause (i), the advisory council shall include 8 expert members from outside the Federal Government to be appointed by the Secretary, which shall include—

(I) 2 prostate cancer patient advocates;

(II) 2 health care providers with a range of expertise and experience in prostate cancer; and

(III) 4 leading researchers with prostate cancer-related expertise in a range of clinical disciplines.

(B) MEETINGS.—The advisory council shall meet quarterly and such meetings shall be open to the public.

(C) ADVICE.—The advisory council shall advise the Secretary, or the Secretary's designee.

(D) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, the advisory council shall provide to the Secretary, or the Secretary's designee, and Congress—

(i) an initial evaluation of all federally funded efforts in prostate cancer research relating to the development and validation of an accurate test or tests to detect and diagnose prostate cancer;

(ii) a plan for the development and validation of a reliable test or tests for the detection and accurate diagnosis of prostate cancer; and

(iii) a set of standards for prostate cancer screening, developed in coordination with the United States Preventive Services Task Force, to ensure that any tools for screening, detection, and diagnosis developed in accordance with the plan under clause (ii) will meet the requirements of the Task Force for recommendation as a proven preventive or diagnostic service.

(E) TERMINATION.—The advisory council shall terminate on December 31, 2026.

(3) FUNDING.—Notwithstanding any other provision of law, the Secretary may make available $1,000,000, from any unobligated amounts appropriated to the National Institutes of Health, for each of fiscal years 2023 through 2027 to carry out this subsection.

(b) COORDINATION AND INTENSIFICATION OF PROSTATE CANCER RESEARCH.—

(1) IN GENERAL.—The Director of the National Institutes of Health, in consultation with the Secretary of Defense, shall coordinate and intensify research in accordance with the plan provided under subsection (a)(2)(D)(ii), with particular attention provided to leveraging existing research to develop

and validate a test or tests, such as biomarkers or imaging, to detect and accurately diagnose prostate cancer in order to improve quality of life for millions of individuals in the United States, and decrease health care system costs.

(2) FUNDING.—Notwithstanding any other provision of law, the Secretary may make available $30,000,000, from any unobligated amounts appropriated to the National Institutes of Health, for each of fiscal years 2024 through 2028 to carry out this subsection.

SEC. 7005. NATIONAL PROSTATE CANCER COUNCIL.

(a) NATIONAL PROSTATE CANCER COUNCIL.—

(1) ESTABLISHMENT.—There is established in the Office of the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') the National Prostate Cancer Council on Screening, Early Detection, Assessment, and Monitoring of Prostate Cancer (referred to in this section as the ''Council'').

(2) PURPOSE OF THE COUNCIL.—The Council shall—

(A) develop and implement a national strategic plan for the accelerated creation, advancement, and testing of diagnostic tools to improve

screening, early detection, assessment, and monitoring of prostate cancer, including—

(i) early detection of aggressive prostate cancer to save lives;

(ii) monitoring of tumor response to treatment, including recurrence and progression; and

(iii) accurate assessment and surveillance of indolent disease to reduce unnecessary biopsies and treatment;

(B) provide information and coordination of prostate cancer research and services across all Federal agencies;

(C) review diagnostic tools and their overall effectiveness at screening, detecting, assessing, and monitoring of prostate cancer;

(D) evaluate all programs in prostate cancer that are in existence on the date of enactment of this Act, including Federal budget requests and approvals and public-private partnerships;

(E) submit an annual report to the Secretary and Congress on the creation and implementation of the national strategic plan under subparagraph (A); and

(F) ensure the inclusion of men at high-risk for prostate cancer, including men from minority ethnic and racial populations and men who are least likely to receive care, in clinical, research, and service efforts, with the purpose of decreasing health disparities.

(3) MEMBERSHIP.—

(A) FEDERAL MEMBERS.—The Council shall be led by the Secretary or the Secretary's designee and comprised of the following experts:

(i) Two representatives of the National Institutes of Health, including 1 representative of the National Institute of Biomedical Imaging and Bioengineering and 1 representative of the National Cancer Institute.

(ii) A representative of the Centers for Disease Control and Prevention.

(iii) A representative of the Centers for Medicare & Medicaid Services.

(iv) A designee of the Director of the Department of Defense Congressionally Directed Medical Research Programs.

(v) A designee of the Director of the Office of Minority Health.

(vi) A representative of the Food and Drug Administration.

(vii) A representative of the Agency for Healthcare Research and Quality.

(B) NON-FEDERAL MEMBERS.—In addition to the members described in subparagraph (A), the Council shall include 14 expert members from outside the Federal Government, which shall include—

(i) 6 prostate cancer patient advocates, including—

(I) 2 patient-survivors;

(II) 2 caregivers of prostate cancer patients; and

(III) 2 representatives from national prostate cancer disease organizations that fund research or have demonstrated experience in providing assistance to patients, families, and medical professionals, including information on health care options, education, and referral; and

(ii) 8 health care stakeholders with specific expertise in prostate cancer research in the critical areas of clinical ex-

pertise, including medical oncology, radiology, radiation oncology, urology, and pathology.

(4) MEETINGS.—The Council shall meet quarterly and meetings shall be open to the public.

(5) ADVICE.—The Council shall advise the Secretary, or the Secretary's designee.

(6) ANNUAL REPORT.—The Council shall submit annual reports, beginning not later than 1 year after the date of enactment of this Act, to the Secretary or the Secretary's designee and to Congress. The annual report shall include—

(A) in the first year—

(i) an evaluation of all federally funded efforts in prostate cancer research and gaps relating to the development and validation of diagnostic tools for prostate cancer; and

(ii) recommendations for priority actions to expand, eliminate, coordinate, or condense programs based on the performance, mission, and purpose of the programs; and

(B) annually thereafter for 5 years—

(i) an outline for the development and implementation of a national research plan for creation and validation of accurate diagnostic tools to improve prostate cancer care in accordance with paragraph (1);

(ii) roles for the National Cancer Institute, National Institute on Minority Health and Health Disparities, and the Office of Minority Health of the Department of Health and Human Services;

(iii) an analysis of the disparities in the incidence and mortality rates of prostate cancer in men at high risk of the disease, including individuals with family history, increasing age, or African-American heritage; and

(iv) a review of the progress towards the realization of the proposed strategic plan.

(7) TERMINATION.—The Council shall terminate on December 31, 2027.

SEC. 7006. IMPROVED MEDICAID COVERAGE FOR CERTAIN BREAST AND CERVICAL CANCER PATIENTS IN THE TERRITORIES.

(a) ELIMINATION OF FUNDING LIMITATIONS.—Section 1108(g)(4) of the Social Security Act (42 U.S.C. 1308(g)(4)) is amended—

(1) by striking ''paragraphs (1), (2), (3), and (4) of''; and

(2) by adding at the end the following: ''With respect to fiscal years beginning with fiscal year 2023, payment for medical assistance for individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII) shall not be taken into account in applying subsection (f) (as increased in accordance with this subsection) to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for such fiscal year.''.

(b) APPLICATION OF ENHANCED FMAP FOR HIGHEST STATE.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by adding at the end the following: ''Notwithstanding the first sentence of this subsection, with respect to medical assistance described in clause (4) of such sentence that is furnished in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa in a fiscal year, the Federal medical as-

sistance percentage is equal to the highest such percentage applied under such clause for such fiscal year for any of the 50 States or the District of Columbia that provides such medical assistance for any portion of such fiscal year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for medical assistance for items and services furnished on or after October 1, 2023.

SEC. 7007. CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES.

(a) DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, appropriate use of items and services covered under the Medicare program

under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and referral patterns with respect to target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as Pap smears, prostate cancer screenings, colon and colorectal cancer screenings, breast cancer screenings, and computed tomography scans, for lung cancer among target individuals;

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for target individuals who are persons with limited English proficiency; and

(E) encourage the incorporation of community health workers to increase the efficiency and appropriateness of cancer screening programs.

(2) COMMUNITY HEALTH WORKER DEFINED.—In this section, the term ''community health worker'' includes a community health advocate, a lay health worker, a community health representative, a peer health promoter, a community health outreach worker, and a promotore de salud, who promotes health

or nutrition within the community in which the individual resides.

(3) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual of a racial and ethnic minority group, as defined in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)), who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act.

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall evaluate best practices in the private sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including the following:

(A) Two projects, each of which shall target different ethnic subpopulations, for each of

the 5 following major racial and ethnic minority groups:

(i) American Indians and Alaska Natives, Eskimos, and Aleuts.

(ii) Asian Americans.

(iii) Blacks and African Americans.

(iv) Latinos and Hispanics.

(v) Native Hawaiians and other Pacific Islanders.

(B) One project within the Pacific Islands or United States insular areas.

(C) At least one project in a rural area.

(D) At least one project in an inner-city area.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—The Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects if the initial report under subsection (c) contains an evaluation that demonstration projects—

(A) reduce expenditures under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); or

(B) do not increase expenditures under such Medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of Medicare beneficiaries and health care providers.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date the Secretary implements the initial demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects.

(2) CONTENT OF REPORT.—Each report under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration projects.

(C) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 7008. REDUCING CANCER DISPARITIES WITHIN MEDICARE.

(a) DEVELOPMENT OF MEASURES OF DISPARITIES IN QUALITY OF CANCER CARE.—

(1) DEVELOPMENT OF MEASURES.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall enter into an agreement with an entity that specializes in developing quality measures for cancer care under which the entity shall develop a uniform set of measures to evaluate disparities in the quality of cancer care and annually update such set of measures.

(2) MEASURES TO BE INCLUDED.—Such set of measures shall include, with respect to the treatment of cancer, measures of patient outcomes, the process for delivering medical care related to such treatment, patient counseling and engagement in deci-

sion-making, patient experience of care, resource use, and practice capabilities, such as care coordination.

(b) ESTABLISHMENT OF REPORTING PROCESS.—

(1) IN GENERAL.—The Secretary shall establish a reporting process that requires and provides for a method for health care providers specified under paragraph (2) to submit to the Secretary and make public data on the performance of such providers during each reporting period through use of the measures developed pursuant to subsection (a). Such data shall be submitted in a form and manner and at a time specified by the Secretary.

(2) SPECIFICATION OF PROVIDERS TO REPORT ON MEASURES.—The Secretary shall specify the classes of Medicare providers of services and suppliers, including hospitals, cancer centers, physicians, primary care providers, and specialty providers, that will be required under such process to publicly report on the measures specified under subsection (a).

(3) ASSESSMENT OF CHANGES.—Under such reporting process, the Secretary shall establish a format that assesses changes in both the absolute and relative disparities in cancer care over time. These

measures shall be presented in an easily comprehensible format, such as those presented in the final publications relating to Healthy People 2010 or the National Healthcare Disparities Report.

(4) INITIAL IMPLEMENTATION.—The Secretary shall implement the reporting process under this subsection for reporting periods beginning not later than 6 months after the date that measures are first established under subsection (a).

Subtitle B—Viral Hepatitis and Liver Cancer Control and Prevention

SEC. 7051. VIRAL HEPATITIS AND LIVER CANCER CONTROL AND PREVENTION.

(a) SHORT TITLE.—This section may be cited as the ''Viral Hepatitis and Liver Cancer Control and Prevention Act of 2022''.

(b) FINDINGS.—Congress finds the following:

(1) In the United States, nearly 5,000,000 persons are living with the hepatitis B virus (referred to in this section as ''HBV'') or the hepatitis C virus (referred to in this section as ''HCV'').

(2) The Centers for Disease Control and Prevention (referred to in this section as the ''CDC''), has recognized HCV as the Nation's most common

chronic bloodborne virus infection and HBV as the deadliest vaccine-preventable disease.

(3) HBV is transmitted through contact with infectious blood, semen, or other bodily fluids and is 100 times more infectious than HIV. HCV is transmitted by contact with infectious blood, particularly through percutaneous exposures (such as puncture through the skin).

(4) In the United States, chronic HBV and HCV are the most common causes of liver cancer, the second deadliest and fastest growing cancer in this country. These viruses are the most common cause of chronic liver disease, liver cirrhosis, and the most common indications for liver transplantation. In 2019, nearly 16,000 deaths per year in the United States were attributed to chronic HBV and HCV. Chronic HCV is also a leading cause of death in Americans living with HIV/AIDS, many of those living with HIV/AIDS are coinfected with chronic HBV, chronic HCV, or both.

(5) The CDC estimates that in 2019, 57,500 people in the United States were newly infected with HCV and 20,700 people in the United States were newly infected with HBV. These estimates could be much higher due to many reasons, including lack of

screening education and awareness, and perceived marginalization of the populations at risk.

(6) The CDC reported a 374 percent increase in hepatitis C cases from 2010 to 2017, stemming from the opioid, heroin, and overdose epidemics affecting communities nationwide. From 2014 to 2015, the number of reported cases of acute hepatitis B infection in the United States rose for the first time since 2006, increasing by 20.7 percent, which is also largely attributable to the opioid epidemic.

(7) HBV and HCV disproportionately affect certain populations in the United States. Although representing only about 6 percent of the population, Asian Americans and Pacific Islanders account for half of all chronic HBV cases in the United States. Baby boomers (those born between 1945 and 1965) account for approximately 75 percent of domestic chronic HCV cases. In addition, African Americans, Latinos, and American Indian and Native Alaskans are among the groups which have disproportionately high rates of HBV or HCV infections in the United States.

(8) Liver cancer is a leading cause of cancer death among the Asian American and Pacific Is-

lander community. Asian and Pacific Islander men and women are more than twice as likely to develop liver cancer compared to the non-Hispanic White population. The higher incidence rate of liver cancer is partially explained by higher incidence rates of hepatitis B and diabetes, which are comorbidities shown to increase an individual's risk of developing liver cancer.

(9) Chronic HBV and chronic HCV usually do not cause symptoms early in the course of the disease, but after many years of a clinically ''silent'' phase, CDC estimates show more than 33 percent of infected individuals will develop cirrhosis, end-stage liver disease, or liver cancer. Since most individuals with chronic HBV, HCV, or both are unaware of their infection, they do not know to take precautions to prevent the spread of their infection and can unknowingly exacerbate their own disease progression. For those chronically infected with HBV or HCV, regular monitoring can lead to the early detection of liver cancer at a stage where a treatment is still possible.

(10) For both chronic HBV and chronic HCV, behavioral changes and appropriate medical care can slow disease progression if diagnosis is made early.

Early diagnosis, which is determined through simple blood tests, can reduce the risk of transmission and disease progression through education and vaccination of household members and other susceptible persons at risk.

(11) Treatment for chronic HCV can eradicate the disease in approximately 90 percent of those currently treated. While there is no cure for chronic HBV, available treatments can effectively suppress viral replication in the overwhelming majority of those treated, thereby reducing the risk of transmission and progression to liver scarring or liver cancer.

(12) The annual health care costs attributable to HBV and HCV in the United States are significant. For HBV, it is estimated to be approximately $2,500,000,000 ($2,000 per infected person). In 2000, the lifetime cost of HBV, before the availability of most current therapies, was approximately $80,000 per chronically infected person, totaling more than $100,000,000,000. For HCV, medical costs for patients are expected to increase from $30,000,000,000 in 2009 to over $85,000,000,000 in 2024. Avoiding these costs by screening and diagnosing individuals earlier, and connecting them to

appropriate treatment and care, will save lives and critical health care dollars. Currently, without a comprehensive screening, testing, and diagnosis program, most patients are diagnosed too late when they need a liver transplant costing at least $314,000 for uncomplicated cases or when they have liver cancer or end-stage liver disease which costs $30,980 to $110,576 per hospital admission. As health care costs continue to grow, it is critical that the Federal Government invests in effective mechanisms to avoid documented cost drivers.

(13) In 2021, the Department of Health and Human Services released its ''Viral Hepatitis National Strategic Plan: A Roadmap for Elimination for the United States, 2021–2025'' (referred to in this section as the ''HHS Strategic Plan''). In March 2017, the National Academies of Sciences, Engineering, and Medicine released a report entitled, ''A National Strategy for the Elimination of Hepatitis B and C: Phase Two Report'' (referred to in this section as the ''NAS report''), recommending specific actions to eliminate viral hepatitis as public health problems in the United States by 2030.

(14) According to the NAS report, chronic HBV and HCV infections cause substantial mor-

bidity and mortality despite being preventable and treatable. Deficiencies in the implementation of established guidelines for the prevention, diagnosis, and medical management of chronic HBV and HCV infections perpetuate personal and economic burdens. Existing grants are not sufficient for the scale of the health burden presented by HBV and HCV.

(15) Screening and testing for HBV and HCV is aligned with the goals of Healthy People 2030 to increase immunization rates, reduce rates of infectious diseases, and improve health for people with chronic infections. Awareness of disease and access to prevention and treatment remain essential components for reducing infectious disease transmission.

(16) Federal support is necessary to increase knowledge and awareness of HBV and HCV and to assist State and local prevention and control efforts in reducing the morbidity and mortality of these epidemics.

(17) The Secretary of Health and Human Services has the discretion to carry out this section (including the amendments made by this section) directly and through whichever of the agencies of the Public Health Service the Secretary determines to be appropriate, which may (in the Secretary's discre-

tion) include the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the National Institutes of Health (including the National Institute on Minority Health and Health Disparities), and other agencies of such Service.

(c) BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is further amended—

(1) by striking section 317N (42 U.S.C. 247b–15); and

(2) by adding after part V the following:

"PART W—BIENNIAL ASSESSMENT OF HHS HEPATITIS B AND HEPATITIS C PREVENTION, EDUCATION, RESEARCH, AND MEDICAL MANAGEMENT PLAN

"SEC. 399OO. BIENNIAL UPDATE OF THE PLAN.

''(a) IN GENERAL.—The Secretary shall conduct a biennial assessment of the Secretary's plan for the prevention, control, and medical management of, and education and research relating to, hepatitis B and hepatitis C, for the purposes of—

''(1) incorporating into such plan new knowledge or observations relating to hepatitis B and hepatitis C (such as knowledge and observations that may be derived from clinical, laboratory, and epidemiological research and disease detection, prevention, and surveillance outcomes);

''(2) addressing gaps in the coverage or effectiveness of the plan; and

''(3) evaluating and, if appropriate, updating recommendations, guidelines, or educational materials of the Centers for Disease Control and Prevention or the National Institutes of Health for health care providers or the public on viral hepatitis in order to be consistent with the plan.

''(b) PUBLICATION OF NOTICE OF ASSESSMENTS.—Not later than October 1 of the first even-numbered year beginning after the date of the enactment of this part, and October 1 of each even-numbered year thereafter, the Secretary shall publish in the Federal Register a notice of the results of the assessments conducted under subsection (a). Such notice shall include—

''(1) a description of any revisions to the plan referred to in subsection (a) as a result of the assessment;

''(2) an explanation of the basis for any such revisions, including the ways in which such revisions can reasonably be expected to further promote the original goals and objectives of the plan; and

''(3) in the case of a determination by the Secretary that the plan does not need revision, an explanation of the basis for such determination.

''SEC. 399OO–1. ELEMENTS OF PROGRAM.

''(a) EDUCATION AND AWARENESS PROGRAMS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Assistant Secretary for Mental Health and Substance Use, and in accordance with the plan referred to in section 399OO(a), shall implement programs to increase awareness and enhance knowledge and understanding of hepatitis B and hepatitis C. Such programs shall include—

''(1) the conduct of culturally and linguistically appropriate health education in primary and secondary schools, college campuses, public awareness campaigns, and community outreach activities (especially to the ethnic communities with high rates of chronic hepatitis B and chronic hepatitis C and other high-risk groups) to promote public awareness and knowledge about—

"(A) the value of hepatitis A and hepatitis B immunization;

"(B) risk factors, transmission, and prevention of hepatitis B and hepatitis C;

"(C) the value of screening for the early detection of hepatitis B and hepatitis C; and

"(D) options available for the treatment of chronic hepatitis B and chronic hepatitis C;

"(2) the promotion of immunization programs that increase awareness and access to hepatitis A and hepatitis B vaccines for susceptible adults and children;

"(3) the training of health care professionals regarding the importance of vaccinating individuals infected with hepatitis C and individuals who are at risk for hepatitis C infection against hepatitis A and hepatitis B;

"(4) the training of health care professionals regarding the importance of vaccinating individuals chronically infected with hepatitis B and individuals who are at risk for chronic hepatitis B infection against the hepatitis A virus;

"(5) the training of health care professionals and health educators to make them aware of the high rates of chronic hepatitis B and chronic hepa-

titis C in certain adult ethnic populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening;

''(6) the development and distribution of health education curricula (including information relating to the special needs of individuals infected with or at risk of hepatitis B and hepatitis C, such as the importance of prevention and early intervention, regular monitoring, the recognition of psychosocial needs, appropriate treatment, and liver cancer screening) for individuals providing hepatitis B and hepatitis C counseling; and

''(7) support for the implementation of the curricula described in paragraph (6) by State and local public health agencies.

''(b) IMMUNIZATION, PREVENTION, AND CONTROL PROGRAMS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support the integration of activities described in paragraph (3) into existing clinical and public health programs at State, local, territorial, and Tribal levels (including community health clinics, programs for the prevention and

treatment of HIV/AIDS, sexually transmitted infections, and substance abuse, and programs for individuals in correctional settings).

''(2) COORDINATION OF DEVELOPMENT OF FEDERAL SCREENING GUIDELINES.—

''(A) REFERENCES.—For purposes of this subsection, the term 'CDC Director' means the Director of the Centers for Disease Control and Prevention, and the term 'AHRQ Director' means the Director of the Agency for Healthcare Research and Quality.

''(B) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Due to the rapidly evolving standard of care associated with diagnosing and treating viral hepatitis infection, the AHRQ Director shall convene the Preventive Services Task Force under section 915(a) to review its recommendation for screening for HBV and HCV infection every 3 years.

''(3) ACTIVITIES.—

''(A) VOLUNTARY TESTING PROGRAMS.—

''(i) IN GENERAL.—The Secretary shall establish a mechanism by which to support and promote the development of State, local, territorial, and Tribal vol-

untary hepatitis B and hepatitis C testing programs to screen the high-prevalence populations to aid in the early identification of chronically infected individuals.

''(ii) CONFIDENTIALITY OF THE TEST RESULTS.—The Secretary shall prohibit the use of the results of a hepatitis B or hepatitis C test conducted by a testing program developed or supported under this subparagraph for any of the following:

''(I) Issues relating to health insurance.

''(II) To screen or determine suitability for employment.

''(III) To discharge a person from employment.

''(B) COUNSELING REGARDING VIRAL HEPATITIS.—The Secretary shall support State, local, territorial, and Tribal programs in a wide variety of settings, including those providing primary and specialty health care services in nonprofit private and public sectors, to—

''(i) provide individuals with ongoing risk factors for hepatitis B and hepatitis C

infection with client-centered education and counseling which concentrates on—

"(I) promoting testing of individuals that have been exposed to their blood, family members, and their sexual partners; and

"(II) changing behaviors that place individuals at risk for infection;

"(ii) provide individuals chronically infected with hepatitis B or hepatitis C with education, health information, and counseling to reduce their risk of—

"(I) dying from end-stage liver disease and liver cancer; and

"(II) transmitting viral hepatitis to others; and

"(iii) provide people chronically infected with hepatitis B or hepatitis C who are pregnant or of childbearing age with culturally and linguistically appropriate health information, such as how to prevent hepatitis B perinatal infection, and to alleviate fears associated with pregnancy or raising a family.

"(C) IMMUNIZATION.—The Secretary shall support State, local, territorial, and Tribal efforts to expand the current vaccination programs to protect every child in the Nation and all susceptible adults, particularly those infected with hepatitis C and high-prevalence ethnic populations and other high-risk groups, from the risks of acute and chronic hepatitis B infection by—

"(i) ensuring continued funding for hepatitis B vaccination for all children 18 years of age or younger through the Vaccines for Children program;

"(ii) ensuring that the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are followed regarding hepatitis B vaccination for infants, children, and adults;

"(iii) requiring proof of hepatitis B vaccination for entry into public or private daycare, preschool, elementary school, secondary school, and institutions of higher education;

"(iv) expanding the availability of hepatitis B vaccination for all adults to protect them from becoming acutely or chronically infected, including ethnic and other populations with high prevalence rates of chronic hepatitis B infection;

"(v) expanding the availability of hepatitis B vaccination for all adults, particularly those of reproductive age (women and men less than 45 years of age), to protect them from the risk of hepatitis B infection;

"(vi) ensuring the vaccination of individuals infected, or at risk for infection, with hepatitis C against hepatitis A, hepatitis B, and other infectious diseases, as appropriate, for which such individuals may be at increased risk; and

"(vii) ensuring the vaccination of individuals infected, or at risk for infection, with hepatitis B against hepatitis A virus and other infectious diseases, as appropriate, for which such individuals may be at increased risk.

''(D) MEDICAL REFERRAL.—The Secretary shall support State, local, territorial, and Tribal programs that support—

''(i) referral of persons chronically infected with hepatitis B or hepatitis C—

''(I) for medical evaluation to determine the appropriateness for antiviral treatment to reduce the risk of progression to cirrhosis and liver cancer; and

''(II) for ongoing medical management including regular monitoring of liver function and screening for liver cancer; and

''(ii) referral of persons infected with acute or chronic hepatitis B infection or acute or chronic hepatitis C infection for drug and alcohol abuse treatment where appropriate.

''(4) INCREASED SUPPORT FOR ADULT VIRAL HEPATITIS PREVENTION COORDINATORS.—The Secretary, acting through the CDC Director, shall provide increased support to adult viral hepatitis prevention coordinators in State, local, territorial, and Tribal health departments in order to enhance the

additional management, networking, and technical expertise needed to ensure successful integration of hepatitis B and hepatitis C prevention and control activities into existing public health programs.

''(c) EPIDEMIOLOGICAL SURVEILLANCE.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall support the establishment and maintenance of a national chronic and acute hepatitis B and hepatitis C surveillance program, in order to identify—

''(A) trends in the incidence of acute and chronic hepatitis B and acute and chronic hepatitis C;

''(B) trends in the prevalence of acute and chronic hepatitis B and acute and chronic hepatitis C infection among groups that may be disproportionately affected; and

''(C) trends in liver cancer and end-stage liver disease incidence and deaths, caused by chronic hepatitis B and chronic hepatitis C in the high-risk ethnic populations.

''(2) SEROPREVALENCE AND LIVER CANCER STUDIES.—The Secretary, acting through the Director of the Centers for Disease Control and Preven-

tion, shall prepare a report outlining the population-based seroprevalence studies currently underway, future planned studies, the criteria involved in determining which seroprevalence studies to conduct, defer, or suspend, and the scope of those studies, the economic and clinical impact of hepatitis B and hepatitis C, and the impact of chronic hepatitis B and chronic hepatitis C infections on the quality of life. Not later than one year after the date of the enactment of this part, the Secretary shall submit the report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives.

''(3) CONFIDENTIALITY.—The Secretary shall not disclose any individually identifiable information identified under paragraph (1) or derived through studies under paragraph (2).

''(d) RESEARCH.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Director of the National Cancer Institute, and the Director of the National Institutes of Health, shall—

''(1) conduct epidemiologic and community-based research to develop, implement, and evaluate best practices for hepatitis B and hepatitis C pre-

vention especially in the ethnic populations with high rates of chronic hepatitis B and chronic hepatitis C and other high-risk groups;

''(2) conduct research on hepatitis B and hepatitis C natural history, pathophysiology, improved treatments and prevention (such as the hepatitis C vaccine), and noninvasive tests that help to predict the risk of progression to liver cirrhosis and liver cancer;

''(3) conduct research that will lead to better noninvasive or blood tests to screen for liver cancer, and more effective treatments of liver cancer caused by chronic hepatitis B and chronic hepatitis C; and

''(4) conduct research comparing the effectiveness of screening, diagnostic, management, and treatment approaches for chronic hepatitis B, chronic hepatitis C, and liver cancer in the affected communities.

''(e) UNDERSERVED AND DISPROPORTIONATELY AFFECTED POPULATIONS.—In carrying out this section, the Secretary shall provide expanded support for individuals with limited access to health education, testing, and health care services and groups that may be disproportionately affected by hepatitis B and hepatitis C.

''(f) EVALUATION OF PROGRAM.—The Secretary shall develop benchmarks for evaluating the effectiveness of the programs and activities conducted under this section and make determinations as to whether such benchmarks have been achieved.

''SEC. 399OO–2. GRANTS.

''(a) IN GENERAL.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, States, political subdivisions of States, territories, Indian Tribes, or nonprofit entities that have special expertise relating to hepatitis B, hepatitis C, or both, to carry out activities under this part.

''(b) APPLICATION.—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''SEC. 399OO–3. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this part $90,000,000 for fiscal year 2023, $110,000,000 for fiscal year 2024, $130,000,000 for fiscal year 2025, and $150,000,000 for fiscal year 2026.''.

SEC. 7052. LIVER CANCER AND DISEASE PREVENTION, AWARENESS, AND PATIENT TRACKING GRANTS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new section:

"SEC. 330Q. LIVER CANCER AND DISEASE PREVENTION, AWARENESS, AND PATIENT TRACKING GRANTS.

''(a) PREVENTION INITIATIVE GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants and enter into cooperative agreements with entities for the purpose of expanding and supporting—

''(A) prevention activities (including providing screenings, vaccinations, or other preventative interventions) for conditions known to increase an individual's risk of developing a major liver disease, such as liver cancer, hepatitis B, hepatitis C, nonalcoholic fatty liver disease, nonalcoholic steatohepatitis, and cirrhosis of the liver;

''(B) activities relating to detection and provision of guidance for individuals at high

risk for contracting liver cancer and other liver diseases; and

''(C) viral hepatitis surveillance to provide for timely and accurate information regarding progress to eliminate viral hepatitis.

''(2) REPORT.—An entity that receives a grant or cooperative agreement under paragraph (1) shall submit to the Secretary, at a time specified by the Secretary, a report describing each activity carried out pursuant to such paragraph and evaluating the effectiveness of such activity in promoting prevention and treatment of liver cancer and other liver diseases.

''(3) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $90,000,000 for each of fiscal years 2023 through 2027.

''(b) AWARENESS INITIATIVE GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants to eligible entities for the purpose of raising awareness for liver cancer and other liver diseases, which may include the production, dissemination, and distribution of informational materials targeted towards commu-

nities and populations with a higher risk for developing liver cancer and other liver diseases.

''(2) ELIGIBLE ENTITIES.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including a description of how the entity, in disseminating information on liver cancer and other liver diseases pursuant to paragraph (1), will—

''(A) with respect to any community or population, consult with members of such community or population and provide such information in a manner that is culturally and linguistically appropriate for such community or population;

''(B) highlight the range of preventative measures and treatments available for liver cancer and other liver diseases;

''(C) integrate information on available hepatitis B and hepatitis C testing programs into any liver cancer presentations carried out by the entity; and

''(D) address communities and populations with a higher risk for contracting liver cancer and other liver diseases.

''(3) PREFERENCE.—In awarding grants under paragraph (1), the Secretary shall give preference to entities that—

''(A) work with a Federally qualified health center;

''(B) are community-based organizations; or

''(C) serve communities and populations with a higher risk for contracting liver cancer and other liver diseases.

''(4) REPORT.—An entity that receives a grant under paragraph (1) shall submit to the Secretary, at a time specified by the Secretary, a report describing each activity carried out pursuant to such paragraph and evaluating the effectiveness of such activity in raising awareness for liver cancer and other liver diseases.

''(5) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2023 through 2027.''.

Subtitle C—Acquired Bone Marrow Failure Diseases

SEC. 7101. ACQUIRED BONE MARROW FAILURE DISEASES.

(a) SHORT TITLE.—This section may be cited as the ''Bone Marrow Failure Disease Research and Treatment Act''.

(b) FINDINGS.—The Congress finds the following:

(1) Between 20,000 and 30,000 people in the United States are diagnosed each year with myelodysplastic syndromes, aplastic anemia, paroxysmal nocturnal hemoglobinuria, and other acquired bone marrow failure diseases.

(2) Acquired bone marrow failure diseases have a debilitating and often fatal impact on those diagnosed with these diseases.

(3) While some treatments for acquired bone marrow failure diseases can prolong and improve the quality of patients' lives, there is no single cure for these diseases.

(4) The prevalence of acquired bone marrow failure diseases in the United States will continue to grow as the general public ages.

(5) Evidence exists suggesting that acquired bone marrow failure diseases occur more often in

minority populations, particularly in Asian-American and Latino or Hispanic populations.

(6) The National Heart, Lung, and Blood Institute and the National Cancer Institute have conducted important research into the causes of and treatments for acquired bone marrow failure diseases.

(7) The National Marrow Donor Program Registry has made significant contributions to the fight against bone marrow failure diseases by connecting millions of potential marrow donors with individuals and families suffering from these conditions.

(8) Despite these advances, a more comprehensive Federal strategic effort among numerous Federal agencies is needed to discover a cure for acquired bone marrow failure disorders.

(9) Greater Federal surveillance of acquired bone marrow failure diseases is needed to gain a better understanding of the causes of acquired bone marrow failure diseases.

(10) The Federal Government should increase its research support for and engage with public and private organizations in developing a comprehensive approach to combat and cure acquired bone marrow failure diseases.

(c) NATIONAL ACQUIRED BONE MARROW FAILURE DISEASE REGISTRY.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 317V, as added by section 1009, the following:

"SEC. 317W. NATIONAL ACQUIRED BONE MARROW FAILURE DISEASE REGISTRY.

''(a) ESTABLISHMENT OF REGISTRY.—

''(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(A) develop a system to collect data on acquired bone marrow failure diseases; and

''(B) establish and maintain a national and publicly available registry, to be known as the National Acquired Bone Marrow Failure Disease Registry, in accordance with paragraph (3).

''(2) RECOMMENDATIONS OF ADVISORY COMMITTEE.—In carrying out this subsection, the Secretary shall take into consideration the recommendations of the Advisory Committee on Acquired Bone Marrow Failure Diseases established under subsection (b).

"(3) PURPOSES OF REGISTRY.—The National Acquired Bone Marrow Failure Disease Registry shall—

"(A) identify the incidence and prevalence of acquired bone marrow failure diseases in the United States;

"(B) be used to collect and store data on acquired bone marrow failure diseases, including data concerning—

"(i) the age, race or ethnicity, general geographic location, sex, and family history of individuals who are diagnosed with acquired bone marrow failure diseases, and any other characteristics of such individuals determined appropriate by the Secretary;

"(ii) the genetic and environmental factors that may be associated with developing acquired bone marrow failure diseases;

"(iii) treatment approaches for dealing with acquired bone marrow failure diseases;

"(iv) outcomes for individuals treated for acquired bone marrow failure diseases,

including outcomes for recipients of stem cell therapeutic products as contained in the database established pursuant to section 379A; and

''(v) any other factors pertaining to acquired bone marrow failure diseases determined appropriate by the Secretary; and

''(C) be made available—

''(i) to the general public; and

''(ii) to researchers to facilitate further research into the causes of, and treatments for, acquired bone marrow failure diseases in accordance with standard practices of the Centers for Disease Control and Prevention.

''(b) ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee, to be known as the Advisory Committee on Acquired Bone Marrow Failure Diseases.

''(2) MEMBERS.—The members of the Advisory Committee on Acquired Bone Marrow Failure Dis-

eases shall be appointed by the Secretary, acting through the Director of the Centers for Disease Control and Prevention, and shall include at least one representative from each of the following:

''(A) A national patient advocacy organization with experience advocating on behalf of patients suffering from acquired bone marrow failure diseases.

''(B) The National Institutes of Health, including at least one representative from each of—

''(i) the National Cancer Institute;

''(ii) the National Heart, Lung, and Blood Institute; and

''(iii) the Office of Rare Diseases.

''(C) The Centers for Disease Control and Prevention.

''(D) Clinicians with experience in—

''(i) diagnosing or treating acquired bone marrow failure diseases; or

''(ii) medical data registries.

''(E) Epidemiologists who have experience with data registries.

"(F) Publicly or privately funded researchers who have experience researching acquired bone marrow failure diseases.

"(G) The entity operating the C.W. Bill Young Cell Transplantation Program established pursuant to section 379 and the entity operating the C.W. Bill Young Cell Transplantation Program Outcomes Database.

"(3) RESPONSIBILITIES.—The Advisory Committee on Acquired Bone Marrow Failure Diseases shall provide recommendations to the Secretary on the establishment and maintenance of the National Acquired Bone Marrow Failure Disease Registry, including recommendations on the collection, maintenance, and dissemination of data.

"(4) PUBLIC AVAILABILITY.—The Secretary shall make the recommendations of the Advisory Committee on Acquired Bone Marrow Failure Disease publicly available.

"(c) GRANTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants to, and enter into contracts and cooperative agreements with, public or private nonprofit entities for the management of, as well as the collection,

analysis, and reporting of data to be included in, the National Acquired Bone Marrow Failure Disease Registry.

''(d) DEFINITION.—In this section, the term 'acquired bone marrow failure disease' means—

''(1) myelodysplastic syndromes;

''(2) aplastic anemia;

''(3) paroxysmal nocturnal hemoglobinuria;

''(4) pure red cell aplasia;

''(5) acute myeloid leukemia that has progressed from myelodysplastic syndromes; or

''(6) large granular lymphocytic leukemia.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $3,000,000 for each of fiscal years 2023 through 2027.''.

(d) PILOT STUDIES THROUGH THE AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY.—

(1) PILOT STUDIES.—The Secretary of Health and Human Services, acting through the Director of the Agency for Toxic Substances and Disease Registry, shall conduct pilot studies to determine which environmental factors, including exposure to toxins, may cause acquired bone marrow failure diseases.

(2) COLLABORATION WITH THE RADIATION INJURY TREATMENT NETWORK.—In carrying out the directives of this section, the Secretary of Health

and Human Services may collaborate with the Radiation Injury Treatment Network of the C.W. Bill Young Cell Transplantation Program established pursuant to section 379 of the Public Health Service Act (42 U.S.C. 274k) to—

(A) augment data for the pilot studies authorized by this section;

(B) access technical assistance that may be provided by the Radiation Injury Treatment Network; or

(C) perform joint research projects.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $1,000,000 for each of fiscal years 2023 through 2027.

(e) MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE MARROW FAILURE DISEASES.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707A the following:

"SEC. 1707B. MINORITY-FOCUSED PROGRAMS ON ACQUIRED BONE MARROW FAILURE DISEASE.

''(a) INFORMATION AND REFERRAL SERVICES.—

''(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Deputy Assistant Sec-

retary for Minority Health, shall establish and coordinate outreach and informational programs targeted to minority populations affected by acquired bone marrow failure diseases.

''(2) PROGRAM REQUIREMENTS.—Minority-focused outreach and informational programs authorized by this section at the National Minority Health Resource Center supported under section 1707(b)(8) (including by means of the Center's website, through appropriate locations such as the Center's knowledge center, and through appropriate programs such as the Center's resource persons network) and through minority health consultants located at each Department of Health and Human Services regional office—

''(A) shall make information about treatment options and clinical trials for acquired bone marrow failure diseases publicly available; and

''(B) shall provide referral services for treatment options and clinical trials.

''(b) HISPANIC AND ASIAN-AMERICAN AND PACIFIC ISLANDER OUTREACH.—

''(1) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Minority

Health, shall undertake a coordinated outreach effort to connect Hispanic, Asian-American, and Pacific Islander communities with comprehensive services focused on treatment of, and information about, acquired bone marrow failure diseases.

''(2) COLLABORATION.—In carrying out this subsection, the Secretary may collaborate with public health agencies, nonprofit organizations, community groups, and online entities to disseminate information about treatment options and clinical trials for acquired bone marrow failure diseases.

''(c) GRANTS AND COOPERATIVE AGREEMENTS.—

''(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary, acting through the Deputy Assistant Secretary for Minority Health, shall award grants to, or enter into cooperative agreements with, entities to perform research on acquired bone marrow failure diseases.

''(2) REQUIREMENT.—Grants and cooperative agreements authorized by this subsection shall be awarded or entered into on a competitive, peer-reviewed basis.

''(3) SCOPE OF RESEARCH.—Research funded under this subsection shall examine factors affecting

the incidence of acquired bone marrow failure diseases in minority populations.

''(d) DEFINITION.—In this section, the term 'acquired bone marrow failure disease' has the meaning given to such term in section 317W(d).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,000,000 for each of fiscal years 2023 through 2027''.

(f) DIAGNOSIS AND QUALITY OF CARE FOR ACQUIRED BONE MARROW FAILURE DISEASES.—

(1) GRANTS.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, shall award grants to entities to improve diagnostic practices and quality of care with respect to patients with acquired bone marrow failure diseases.

(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $2,000,000 for each of fiscal years 2023 through 2027.

(g) DEFINITION.—In this section, the term ''acquired bone marrow failure disease'' has the meaning given such term in section 317W(d) of the Public Health Service Act, as added by subsection (c).

Subtitle D—Cardiovascular Disease, Chronic Disease, Obesity, and Other Disease Issues

SEC. 7151. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations that have a higher than average risk for many chronic diseases and cancers.

(b) PARTICIPANTS.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;

(3) health care researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health, the National Institute on Minority Health and Health Disparities, and the National Institutes of Health; and

(5) other experts as the Secretary determines appropriate.

(c) DISEASES.—Screening guidelines for minority populations shall be developed as appropriate under subsection (a) for—

(1) hypertension;

(2) hypercholesterolemia;

(3) diabetes;

(4) cardiovascular disease;

(5) cancers, including breast, prostate, colon, cervical, and lung cancer;

(6) other pulmonary problems including sleep apnea;

(7) asthma;

(8) kidney diseases;

(9) eye diseases and disorders, including glaucoma;

(10) HIV/AIDS and sexually transmitted infections;

(11) uterine fibroids;

(12) autoimmune diseases, including lupus;

(13) mental health conditions;

(14) dental health conditions and oral diseases, including oral cancer;

(15) environmental and related health illnesses and conditions;

(16) sickle cell disease and sickle cell trait;

(17) violence and injury prevention and control;

(18) genetic and related conditions;

(19) heart disease and stroke;

(20) tuberculosis;

(21) chronic obstructive pulmonary disease;

(22) musculoskeletal diseases, arthritis, and obesity; and

(23) other diseases determined appropriate by the Secretary.

(d) DISSEMINATION.—Not later than 2 years after the date of enactment of this Act, the Secretary shall publish and disseminate to health care provider organizations the guidelines developed under subsection (a).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

SEC. 7152. CDC WISEWOMAN SCREENING PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n–4a) is amended—

(1) in subsection (a)—

(A) by striking the heading and inserting ''IN GENERAL.—''; and

(B) in the matter preceding paragraph (1), by striking ''may make grants'' and all that fol-

lows through ''purpose'' and inserting the following: ''may make grants to such States for the purpose''; and

(2) in subsection (d)(1), by striking ''there are authorized'' and all that follows through the period and inserting ''there are authorized to be appropriated $23,000,000 for fiscal year 2023, $25,300,000 for fiscal year 2024, $27,800,000 for fiscal year 2025, $30,800,000 for fiscal year 2026, and $34,000,000 for fiscal year 2027.''.

SEC. 7153. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 5201(a)(6), is amended by adding at the end the following:

''SEC. 399V–9. REPORT ON CARDIOVASCULAR CARE FOR WOMEN AND MINORITIES.

''Not later than September 30, 2023, and annually thereafter, the Secretary shall prepare and submit to Congress a report on the quality of and access to care for women and minorities with heart disease, stroke, and other cardiovascular diseases. The report shall contain recommendations for eliminating disparities in, and improving the treatment of, heart disease, stroke, and other cardiovascular diseases in women, racial and ethnic minori-

ties, those for whom English is not their primary language, and individuals with disabilities.''.

SEC. 7154. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES IN MEDICAID, CHIP, AND PRIVATE HEALTH INSURANCE.

(a) REQUIRING MEDICAID COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE AND TEMPORARY ENHANCED FMAP FOR COVERAGE OF TOBACCO CESSATION SERVICES.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) by amending subsection (a)(4)(D) to read as follows:

''(D) counseling and pharmacotherapy for cessation of tobacco use by individuals who are eligible under the State plan (as defined in subsection (bb)); and'';

(2) in subsection (b), by inserting ''(bb)(2),'' after ''(aa),''; and

(3) by striking subsection (bb) and inserting the following:

''(bb) COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—

''(1) IN GENERAL.—For purposes of this title, the term 'counseling and pharmacotherapy for ces-

sation of tobacco use by individuals who are eligible under the State plan' means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for the cessation of tobacco use by individuals who use tobacco products or who are being treated for tobacco use that is furnished—

"(A) by or under the supervision of a physician; or

"(B) by any other health care professional who—

"(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

"(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose;

which is recommended in the guideline entitled, 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline' published by the Public Health Service in May

2008 (or any subsequent modification of such guideline) or is recommended for the cessation of tobacco use by the United States Preventive Services Task Force or any additional intervention approved by the Food and Drug Administration as safe and effective in helping smokers quit.

''(2) TEMPORARY ENHANCED FMAP FOR COVERAGE OF TOBACCO CESSATION SERVICES.—Notwithstanding subsection (b), for calendar quarters occurring during the period beginning on the date of the enactment of this paragraph and ending 2 years after the last day of the emergency period described in section 1135(g)(1)(B), the Federal medical assistance percentage with respect to amounts expended by a State for medical assistance for counseling and pharmacotherapy for cessation of tobacco use by individuals who are eligible under the State plan (as defined in paragraph (1)) shall be equal to 100 percent.''.

(b) NO COST SHARING.—

(1) IN GENERAL.—Subsections (a)(2) and (b)(2) of section 1916 of the Social Security Act (42 U.S.C. 1396o), as amended by section 2007(d)(4), are each amended—

(A) in subparagraph (B), by striking ", and counseling" and all that follows through "section 1905(bb)(2)(A)";

(B) in subparagraph (I), by striking "or" after the comma;

(C) in subparagraph (J), by striking "; and" and inserting ", or"; and

(D) by adding at the end the following new subparagraph:

"(K) counseling and pharmacotherapy for cessation of tobacco use by individuals who are eligible under the State plan (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting tobacco cessation in accordance with the guideline specified in section 1905(bb); and".

(2) APPLICATION TO ALTERNATIVE COST SHARING.—Section 1916A(b)(3)(B) of the Social Security Act (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

(A) in clause (iii), by striking ", and counseling and pharmacotherapy for cessation of to-

bacco use by pregnant women (as defined in section 1905(bb))''; and

(B) by adding at the end the following new clause:

''(xiv) Counseling and pharmacotherapy for cessation of tobacco use by individuals who are eligible under the State plan (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting tobacco cessation in accordance with the guideline specified in section 1905(bb).''.

(c) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)) is amended to read as follows:

''(F) Nonprescription drugs, except, when recommended in accordance with the guideline referred to in section 1905(bb), agents approved by the Food and Drug Administration

under the over-the-counter monograph process for purposes of promoting tobacco cessation.''.

(d) STATE MONITORING AND PROMOTING OF COMPREHENSIVE TOBACCO CESSATION SERVICES UNDER MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4251(d)(3)(A), is amended—

(1) in paragraph (87), by striking ''and'' at the end;

(2) in paragraph (88), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (8) the following new paragraph:

''(89) provide for the State to monitor and promote the use of comprehensive tobacco cessation services under the State plan (including conducting an outreach campaign to increase awareness of the benefits of using such services) among—

''(A) individuals entitled to medical assistance under the State plan who use tobacco products; and

''(B) clinicians and others who provide services to individuals entitled to medical assistance under the State plan.''.

(e) FEDERAL REIMBURSEMENT FOR OUTREACH CAMPAIGN.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(1) in paragraph (6)(B), by striking ''plus'' at the end;

(2) in paragraph (7), by striking the period at the end and inserting ''; plus''; and

(3) by inserting after paragraph (7) the following new paragraph:

''(8) with respect to the development, implementation, and evaluation of an outreach campaign to—

''(A) increase awareness of comprehensive tobacco cessation services covered in the State plan among—

''(i) individuals who are likely to be eligible for medical assistance under the State plan; and

''(ii) clinicians and others who provide services to individuals who are likely to be eligible for medical assistance under the State plan; and

''(B) increase awareness of the benefits of using comprehensive tobacco cessation services covered in the State plan among—

"(i) individuals who are likely to be eligible for medical assistance under the State plan; and

"(ii) clinicians and others who provide services to individuals who are likely to be eligible for medical assistance under the State plan about the benefits of using comprehensive tobacco cessation services;

for calendar quarters occurring during the period beginning on the date of the enactment of this paragraph and ending on 2 years after the last day of the emergency period described in section 1135(g)(1)(B), an amount equal to 100 percent of the sums expended during each quarter which are attributable to such development, implementation, and evaluation, and for calendar quarters succeeding such period, an amount equal to Federal medical assistance percentage determined under section 1905(b) of the sums expended during each quarter which are so attributable.".

(f) NO PRIOR AUTHORIZATION FOR TOBACCO CESSATION DRUGS UNDER MEDICAID.—Section 1927(d) of the Social Security Act (42 U.S.C. 1396r–8(d)) is amended—

(1) in paragraph (1)(A), by striking ''A State'' and inserting ''Subject to paragraph (8), a State''; and

(2) by adding at the end the following new paragraph:

''(8) NO PRIOR AUTHORIZATION PROGRAMS FOR TOBACCO CESSATION DRUGS.—A State plan may not require, as a condition of coverage or payment for a covered outpatient drug, the approval of an agent to promote smoking cessation (including agents approved by the Food and Drug Administration) or tobacco cessation.''.

(g) EXCLUSION OF ENHANCED PAYMENTS FROM TERRITORIAL CAPS.—Notwithstanding any other provision of law, for purposes of section 1108 of the Social Security Act (42 U.S.C. 1308), with respect to any additional amount paid to a territory as a result of the application of section 1905(bb)(2) of the Social Security Act (42 U.S.C. 1396d(bb)(2))—

(1) the limitation on payments to territories under subsections (f) and (g) of such section 1108 shall not apply to such additional amounts; and

(2) such additional amounts shall be disregarded in applying such subsections.

(h) REQUIRING CHIP COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—

(1) IN GENERAL.—Section 2103(c)(2) of the Social Security Act (42 U.S.C. 1397cc(c)(2)) is amended by adding at the end the following new subparagraph:

"(D) Counseling and pharmacotherapy for cessation of tobacco use by individuals who are eligible under the State child health plan.".

(2) COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE DEFINED.—Section 2110(c) of the Social Security Act (42 U.S.C. 1397jj(c)) is amended by adding at the end the following new paragraph:

"(10) COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—The term 'counseling and pharmacotherapy for cessation of tobacco use' means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for the cessation of tobacco use by individuals who use tobacco products or who are being treated for tobacco use that are furnished—

"(A) by or under the supervision of a physician; or

"(B) by any other health care professional who—

"(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

"(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose;

which is recommended in the guideline entitled, 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline' published by the Public Health Service in May 2008 (or any subsequent modification of such guideline) or is recommended for the cessation of tobacco use by the United States Preventive Services Task Force or any additional intervention approved by the Food and Drug Administration as safe and effective in helping smokers quit.".

(i) NO COST SHARING.—Section 2103(e) of the Social Security Act (42 U.S.C. 1397cc(e)) is amended by adding at the end the following new paragraph:

''(5) NO COST SHARING ON BENEFITS FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for counseling and pharmacotherapy for cessation of tobacco use (as defined in section 2110(c)(10)) and prescription drugs that are covered under a State child health plan that are prescribed for purposes of promoting tobacco cessation in accordance with the guideline specified in section 2110(c)(10)(B).''.

(j) EXCEPTION FROM OPTIONAL RESTRICTION UNDER CHIP PRESCRIPTION DRUG COVERAGE.—Section 2103 of the Social Security Act (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

''(g) EXCEPTION FROM OPTIONAL RESTRICTION UNDER CHIP PRESCRIPTION DRUG COVERAGE.—The State child health plan may exclude or otherwise restrict nonprescription drugs, except, in the case of—

''(1) pregnant women when recommended in accordance with the guideline specified in section

2110(c)(10)(B), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting tobacco cessation; and

''(2) individuals who are eligible under the State child health plan when recommended in accordance with the Guideline referred to in section 2110(c)(10)(B), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting tobacco cessation.''.

(k) STATE MONITORING AND PROMOTING OF COMPREHENSIVE TOBACCO CESSATION SERVICES UNDER CHIP.—Section 2102 of the Social Security Act (42 U.S.C. 1397bb) is amended by adding at the end the following new subsection:

''(d) STATE MONITORING AND PROMOTING OF COMPREHENSIVE TOBACCO CESSATION SERVICES UNDER CHIP.—A State child health plan shall include a description of the procedures to be used by the State to monitor and promote the use of comprehensive tobacco cessation services under the State plan (including conducting an outreach campaign to increase awareness of the benefits of using such services) among—

''(1) individuals entitled to medical assistance under the State child health plan who use tobacco products; and

''(2) clinicians and others who provide services to individuals entitled to medical assistance under the State child health plan.''.

(l) FEDERAL REIMBURSEMENT FOR CHIP COVERAGE AND OUTREACH CAMPAIGN.—

(1) IN GENERAL.—Section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)) is amended by adding at the end the following new paragraph:

''(5) FEDERAL REIMBURSEMENT FOR CHIP COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES AND OUTREACH CAMPAIGN.—In addition to the payments made under paragraph (1) for calendar quarters occurring during the period beginning on the date of the enactment of this paragraph and ending on 2 years after the last day of the emergency period described in section 1135(g)(1)(B), the Secretary shall pay—

''(A) an amount equal to 100 percent of the sums expended during each quarter which are attributable to the cost of furnishing counseling and pharmacotherapy for cessation of tobacco use by individuals who are eligible under

the State child health plan (net of any payments made to the State under paragraph (1) with respect to such counseling and pharmacotherapy); plus

''(B) an amount equal to 100 percent of the sums expended during each quarter which are attributable to the development, implementation, and evaluation of an outreach campaign to—

''(i) increase awareness of comprehensive tobacco cessation services covered in the State child health plan among—

''(I) individuals who are likely to be eligible for medical assistance under the State child health plan; and

''(II) clinicians and others who provide services to individuals who are likely to be eligible for medical assistance under the State child health plan; and

''(ii) increase awareness of the benefits of using comprehensive tobacco cessation services covered in the State child health plan among—

"(I) individuals who are likely to be eligible for medical assistance under the State child health plan; and

"(II) clinicians and others who provide services to individuals who are likely to be eligible for medical assistance under the State child health plan about the benefits of using comprehensive tobacco cessation services.".

(2) ADJUSTMENT OF CHIP ALLOTMENTS.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—

(A) in paragraph (2)(B), by striking " and (12)" and inserting "(12), and (13)"; and

(B) by adding at the end the following new paragraph:

"(13) ADJUSTING ALLOTMENTS TO ACCOUNT FOR FEDERAL PAYMENTS FOR CHIP COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES AND OUTREACH CAMPAIGN.—If a State (including the District of Columbia and each commonwealth and territory) receives a payment for a fiscal year under section 2105(a)(5), the allotment determined

for the State for such fiscal year shall be increased by the amount of such payment.''.

(m) NO PRIOR AUTHORIZATION FOR TOBACCO CESSATION DRUGS UNDER CHIP.—Section 2103 of the Social Security Act (42 U.S.C. 1397cc), as amended by subsection (c), is further amended—

(1) in subsection (c)(2)(A), by inserting ''(in accordance with subsection (h)'' after ''Coverage of prescription drugs''; and

(2) by adding at the end the following new subsection:

''(h) NO PRIOR AUTHORIZATION PROGRAMS FOR TOBACCO CESSATION DRUGS.—A State child health plan may not require, as a condition of coverage or payment for a prescription drugs, the approval of an agent to promote smoking cessation (including agents approved by the Food and Drug Administration) or tobacco cessation.''.

(n) COMPREHENSIVE COVERAGE OF TOBACCO CESSATION COVERAGE IN PRIVATE HEALTH INSURANCE.—Section 2713 of the Public Health Service Act (42 U.S.C. 300gg–13) is amended by adding at the end the following:

''(d) NO PRIOR AUTHORIZATION.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not impose any prior authorization requirement for tobacco cessation

counseling and pharmacotherapy that has in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force.''.

(o) RULE OF CONSTRUCTION.—None of the amendments made by this section shall be construed to limit coverage of any counseling or pharmacotherapy for individuals under 18 years of age.

(p) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first fiscal year that begins on or after the date of enactment of this Act.

SEC. 7155. CLINICAL RESEARCH FUNDING FOR ORAL HEALTH.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expand and intensify the conduct and support of the research activities of the National Institutes of Health and the National Institute of Dental and Craniofacial Research to improve the oral health of the population through the prevention and management of oral diseases and conditions.

(b) INCLUDED RESEARCH ACTIVITIES.—Research activities under subsection (a) shall include—

(1) comparative effectiveness research and clinical disease management research addressing early childhood cancer and oral cancer; and

(2) awarding of grants and contracts to support the training and development of health services researchers, comparative effectiveness researchers, and clinical researchers whose research improves the oral health of the population.

SEC. 7156. GUIDE ON EVIDENCE-BASED STRATEGIES FOR PUBLIC HEALTH DEPARTMENT OBESITY PREVENTION PROGRAMS.

(a) DEVELOPMENT AND DISSEMINATION OF AN EVIDENCE-BASED STRATEGIES GUIDE.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, not later than 2 years after the date of enactment of this Act, shall—

(1) develop a guide on evidence-based strategies for State, territorial, and local health departments to use to build and maintain effective obesity prevention and reduction programs, and, in consultation with stakeholders that have expertise in Tribal health, a guide on such evidence-based strategies with respect to Indian Tribes and Tribal organizations for such Indian Tribes and Tribal organizations to use for such purpose, both of which guides shall—

(A) describe an integrated program structure for implementing interventions proven to be effective in preventing and reducing the incidence of obesity; and

(B) recommend—

(i) optimal resources, including staffing and infrastructure, for promoting nutrition and obesity prevention and reduction; and

(ii) strategies for effective obesity prevention programs for State and local health departments, Indian Tribes, and Tribal organizations, including strategies related to—

(I) the application of evidence-based and evidence-informed practices to prevent and reduce obesity rates;

(II) the development, implementation, and evaluation of obesity prevention and reduction strategies for specific communities and populations;

(III) demonstrated knowledge of obesity prevention practices that reduce associated preventable diseases,

health conditions, death, and health care costs;

(IV) best practices for the coordination of efforts to prevent and reduce obesity and related chronic diseases;

(V) addressing the underlying risk factors and social determinants of health that impact obesity rates; and

(VI) interdisciplinary coordination between relevant public health officials specializing in fields such as nutrition, physical activity, epidemiology, communications, and policy implementation, and collaboration between public health officials and community-based organizations; and

(2) disseminate the guides and current research, evidence-based practices, tools, and educational materials related to obesity prevention, consistent with the guides, to State and local health departments, Indian Tribes, and Tribal organizations.

(b) TECHNICAL ASSISTANCE.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall provide technical assistance to State

and local health departments, Indian Tribes, and Tribal organizations to support such health departments in implementing the guides developed under subsection (a)(1).

(c) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—In this section, the terms ''Indian Tribe'' and ''Tribal organization'' have the meanings given the terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

SEC. 7157. STEPHANIE TUBBS JONES UTERINE FIBROID RESEARCH AND EDUCATION ACT.

(a) RESEARCH WITH RESPECT TO UTERINE FIBROIDS.—

(1) RESEARCH.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall expand, intensify, and coordinate programs for the conduct and support of research with respect to uterine fibroids.

(2) ADMINISTRATION AND COORDINATION.—The Secretary shall carry out the conduct and support of research pursuant to paragraph (1), in coordination with the appropriate institutes, offices, and centers of the National Institutes of Health and any other relevant Federal agency, as determined by the Director of the National Institutes of Health.

(3) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated $30,000,000 for each of fiscal years 2023 through 2027.

(b) RESEARCH WITH RESPECT TO MEDICAID COVERAGE OF UTERINE FIBROIDS TREATMENT.—

(1) RESEARCH.—The Secretary (or the Secretary's designee) shall establish a research database, or expand an existing research database, to collect data on services furnished to individuals diagnosed with uterine fibroids under a State plan (or a waiver of such a plan) under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or under a State child health plan (or a waiver of such a plan) under the Children's Health Insurance Program under title XXI of such Act (42 U.S.C. 1397aa et seq.) for the treatment of such fibroids for purposes of assessing the frequency at which such individuals are furnished such services.

(2) REPORT.—

(A) IN GENERAL.—Not later than the date that is two years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the amount of Federal

and State expenditures with respect to services furnished for the treatment of uterine fibroids under State plans (or waivers of such plans) under the Medicaid program under such title XIX and State child health plans (or waivers of such plans) under the Children's Health Insurance Program under such title XXI.

(B) COORDINATION.—The Secretary shall coordinate the development and submission of the report required under subparagraph (A) with any other relevant Federal agency, as determined by the Secretary.

(c) EDUCATION AND DISSEMINATION OF INFORMATION WITH RESPECT TO UTERINE FIBROIDS.—

(1) UTERINE FIBROIDS PUBLIC EDUCATION PROGRAM.—The Secretary shall develop and disseminate to the public information regarding uterine fibroids, including information on—

(A) the awareness, incidence, and prevalence of uterine fibroids among individuals, including all minority individuals;

(B) the elevated risk for minority individuals to develop uterine fibroids; and

(C) the availability, as medically appropriate, of the range of treatment options for

symptomatic uterine fibroids, including non-hysterectomy treatments and procedures.

(2) DISSEMINATION OF INFORMATION.—The Secretary may disseminate information under paragraph (1) directly or through arrangements with intra-agency initiatives, nonprofit organizations, consumer groups, institutions of higher education (as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)), or Federal, State, or local public private partnerships.

(3) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2023 through 2027.

Subtitle E—HIV/AIDS

SEC. 7201. STATEMENT OF POLICY.

It is the policy of the United States to achieve an AIDS-free generation, and to—

(1) expand access to lifesaving antiretroviral therapy for people living with HIV and immediately link people to continuous and coordinated high-quality care when they learn they are living with HIV;

(2) expand targeted efforts to prevent HIV infection using a combination of effective, evidence-

based approaches, including routine HIV screening, and universal access to HIV prevention tools, including preexposure prophylaxis, in communities disproportionately impacted by HIV, particularly communities of color;

(3) ensure laws, policies, and regulations do not impede access to prevention, treatment, and care for people living with HIV or disproportionately impacted by HIV;

(4) accelerate research for more efficacious HIV prevention and treatments tools, a cure, and a vaccine; and

(5) respect the human rights and dignity of persons living with HIV.

SEC. 7202. FINDINGS.

The Congress finds the following:

(1) Over 1,100,000 people are estimated to be living with HIV in the United States according to the Centers for Disease Control and Prevention, 14 percent of whom are unaware they are living with HIV.

(2) The Centers for Disease Control and Prevention estimates that, in 2019, there were approximately 34,800 people newly diagnosed with HIV. New HIV infections declined 8 percent from 37,800

in 2015, after a period of general stability. From 2015 to 2019, new infections among young gay and bisexual men (ages 13 to 24) dropped 33 percent overall, with declines in young men of all races, but African Americans, Hispanics, and Latinos continue to be severely and disproportionately affected.

(3) HIV disproportionately affects certain populations in the United States. Though Blacks/African Americans represent approximately 13 percent of the population, they account for almost half (44 percent) of all people living with HIV in the United States. Black/African-American men who have sex with men account for 26 percent of all new HIV infections and have remained stable from 2010 to 2019.

(4) Disparities continue to exist among Latinos and Hispanics; in 2019, Latinos and Hispanics made up 18 percent of the United States population and 30 percent of new infections.

(5) Though the rate of new infections among American Indians and Alaska Natives (referred to in this section as ''AI/AN'') is proportional to their population size, from 2015 to 2019, the annual number of HIV diagnoses increased among American Indians and Alaska Natives.

(6) Asian Americans account for about 2 percent of new HIV infections, but in 2013, 22 percent were undiagnosed, the highest rate of undiagnosed HIV among any race or ethnicity. Between 2010 and 2016, the number of Asian Americans receiving an HIV diagnosis increased by 42 percent.

(7) The latest data from the Centers for Disease Control and Prevention indicates that new infections among women remained stable for women in 2019.

(8) The history of HIV shows that culturally relevant and gender-responsive supportive services, including psychosocial support, treatment literacy, case management, and transportation are necessary strategies to reach and engage women and girls in medical care.

(9) From 2015 through 2019 in the United States and 6 dependent areas, the number of diagnoses of HIV infection for transgender adults and adolescents increased. In 2019, among transgender adults and adolescents, the largest percentage (93 percent) of diagnoses of HIV infections was for transgender male-to-female (MTF) people. By age, in 2019, the largest percentage (24 percent) of diagnoses of HIV infection among transgender persons

was for transgender MTF adults and adolescents aged 20 to 24 years, followed by transgender MTF adults and adolescents aged 25 to 29 years (23 percent).

(10) Stigma and discrimination contribute to such disparities.

(11) The Centers for Disease Control and Prevention has determined that increasing the proportion of people who know their HIV status is an essential component of comprehensive HIV treatment and prevention efforts and that early diagnosis is critical in order for people with HIV to receive life-extending therapy. Additionally, the Centers for Disease Control and Prevention recommends routine HIV screening in health care settings for all patients aged 13 to 64, regardless of risk.

(12) In 1998, Congress created the National Minority AIDS Initiative to provide technical assistance, build capacity, and strengthen outreach efforts among local institutions and community-based organizations that serve racial and ethnic minorities living with or vulnerable to HIV.

(13) To combat the HIV epidemic in the United States, the National HIV/AIDS Strategy (referred to in this section as ''NHAS'') provides a framework

of increasing access to care, reducing new infections, and eliminating HIV-related health disparities. The vision of NHAS is ''The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.''.

(14) In January 2019, the Department of Health and Human Services began implementing the initiative ''Ending the HIV Epidemic: A Plan for America''. The initiative seeks to reduce the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030, for an estimated 250,000 total HIV infection averted.

(15) At present, many States and United States territories have criminal statutes based on ''exposure'' to HIV. Most of these laws were adopted before the availability of effective antiretroviral treatment for HIV/AIDS.

(16) Research shows that stable housing leads to better health outcomes for those living with HIV. Inadequate or unstable housing is not only a barrier to effective treatment, but also increases the likelihood of engaging in risky behaviors leading to HIV infection. Insecure housing puts people with HIV/AIDS at risk of premature death from exposure to other diseases, poor nutrition, and lack of medical care.

(17) Due to advances in treatment, many people living with HIV today are living healthy lives and have the ability and desire to fully participate in all aspects of community life, including employment. Research associates being employed with tremendous economic, social, and health benefits for many people living with HIV.

(18) Despite the tremendous progress made in the treatment and prevention of HIV/AIDS, discriminatory policies stemming from continued stigmatization of HIV/AIDS and the LGBTQ+ community continue to plague the scientific community. This includes blood donation guidance updated by Food and Drug Administration in 2020 that recommends a 3-month deferral policy for gay and bisexual men before they are eligible to donate blood.

Health agencies in the United States must implement blood donation policies that are grounded in science and that do not unfairly single out any group of individuals.

(19) The common benefits associated with employment include income, autonomy, productivity, status within society, daily structure, making a contribution to one's community, and increased skills and self-esteem. Research also indicates that many people with disabilities, including people living with HIV, report perceiving themselves as being less disabled or not disabled at all, when working. Furthermore, some studies link working with better physical and mental health outcomes for people living with HIV when compared to those who are not working. Preliminary data also suggest that transitioning to employment is associated with reduced HIV-related health risk behavior for many people.

(20) In July 2012, the Food and Drug Administration approved the first drug to be used as pre-exposure prophylaxis (PrEP). PrEP reduces the risk of HIV infection in HIV-negative individuals. Studies have shown that PrEP reduces HIV transmission from sex by about 99 percent when taken consistently. Despite increases in PrEP uptake, PrEP use

remains low among gay and bisexual men of color. The Centers for Disease Control and Prevention found that uptake was lower among African-American (26 percent) and Latino (30 percent) men compared with White men (42 percent). Similarly, PrEP awareness was lower among African-American (86 percent) and Latino (87 percent) men compared with White men (95 percent). While clinical research on transgender populations and PrEP is currently limited, the Centers for Disease Control and Prevention recommends PrEP use in transgender populations. In September 2019, the Food and Drug Administration approved the second drug to be used as PrEP.

(21) Syringe service programs have been associated with lowered HIV infections, lower hepatitis C infections, and increased linkage to substance use treatment.

(22) There is now conclusive scientific evidence that a person living with HIV who is on antiretroviral therapy and is durably virally suppressed (defined as having a consistent viral load of less than 200 copies/ml) does not sexually transmit HIV. The conclusive evidence about the highly effective preventative benefits of antiretroviral therapy

provides an unprecedented opportunity to improve the lives of people living with HIV, improve treatment uptake and adherence, and advocate for expanded access to treatment and care.

SEC. 7203. ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.

Section 2623 of the Public Health Service Act (42 U.S.C. 300ff–31b) is amended by adding at the end the following:

''(c) ADDITIONAL FUNDING FOR AIDS DRUG ASSISTANCE PROGRAM TREATMENTS.—In addition to amounts otherwise authorized to be appropriated for carrying out this subpart, there are authorized to be appropriated such sums as may be necessary to carry out sections 2612(b)(3)(B) and 2616 for each of fiscal years 2023 through 2026.''.

SEC. 7204. ENHANCING THE NATIONAL HIV SURVEILLANCE SYSTEM.

(a) GRANTS.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall make grants to States to support integration of public health surveillance systems into all electronic health records in order to allow rapid communications between the clinical setting and health departments, by means that include—

(1) providing technical assistance and policy guidance to State and local health departments, clinical providers, and other agencies serving individuals with HIV to improve the interoperability of data systems relevant to monitoring HIV care and supportive services;

(2) capturing longitudinal data pertaining to the initiation and ongoing prescription or dispensing of antiretroviral therapy for individuals diagnosed with HIV (such as through pharmacy-based reporting);

(3) obtaining information—

(A) on a voluntary basis, on sexual orientation and gender identity; and

(B) on sources of coverage (or the lack of coverage) for medical treatment (including coverage through the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the Medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), the program under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.); commonly referred to as the ''Ryan White HIV/AIDS Program''), other public funding, private

insurance, and health maintenance organizations); and

(4) obtaining and using current geographic markers of residence (such as current address, zip code, partial zip code, and census block).

(b) PRIVACY AND SECURITY SAFEGUARDS.—In carrying out this section, the Secretary of Health and Human Services shall ensure that appropriate privacy and security safeguards are met to prevent unauthorized disclosure of protected health information and compliance with the HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act (42 U.S.C. 300jj–19)) and other relevant laws and regulations.

(c) PROHIBITION AGAINST IMPROPER USE OF DATA.—No grant under this section may be used to allow or facilitate the collection or use of surveillance or clinical data or records—

(1) for punitive measures of any kind, civil or criminal, against the subject of such data or records; or

(2) for imposing any requirement or restriction with respect to an individual without the individual's written consent.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated

such sums as may be necessary for each of fiscal years 2023 through 2026.

SEC. 7205. EVIDENCE-BASED STRATEGIES FOR IMPROVING LINKAGE TO, AND RETENTION IN, APPROPRIATE CARE.

(a) STRATEGIES.—The Secretary of Health and Human Services, in collaboration with the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, the Director of the Office of AIDS Research, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall—

(1) identify evidence-based strategies most effective at addressing the multifaceted issues that impede disease status awareness with respect to HIV/AIDS and linkage to, and retention in, appropriate care, taking into consideration health care systems issues, clinic and provider issues, and individual psychosocial, environmental, and other contextual factors;

(2) support the wide-scale implementation of the evidence-based strategies identified pursuant to paragraph (1), including through incorporating such strategies into health care coverage supported by the

Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), the program under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the ''Ryan White HIV/AIDS Program''), and health plans purchased through an Exchange established under title I of the Patient Protection and Affordable Care Act (Public Law 111–148); and

(3) not later than 1 year after the date of the enactment of this Act, submit a report to the Congress on the status of activities under paragraphs (1) and (2).

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2026.

SEC. 7206. IMPROVING ENTRY INTO, AND RETENTION IN, CARE AND ANTIRETROVIRAL ADHERENCE FOR PERSONS WITH HIV.

(a) SENSE OF CONGRESS.—It is the sense of Congress that AIDS research has led to scientific advancements that have—

(1) saved the lives of millions of people living with HIV;

(2) prevented millions of individuals from receiving new diagnoses of HIV; and

(3) had broad benefits that extend far beyond helping people at risk for, or living with, HIV.

(b) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health, shall expand, intensify, and coordinate operational and translational research and other activities of the National Institutes of Health regarding methods—

(1) to increase adoption of evidence-based adherence strategies within HIV care and treatment programs;

(2) to increase HIV testing and case detection rates;

(3) to reduce HIV-related health disparities;

(4) to ensure that research to improve adherence to HIV care and treatment programs address the unique concerns of women;

(5) to integrate HIV prevention and care services with mental health and substance use prevention and treatment delivery systems;

(6) to increase knowledge on the implementation of preexposure prophylaxis (referred to in this section as ''PrEP''), including with respect to—

(A) who can benefit most from PrEP;

(B) how to provide PrEP safely and efficiently;

(C) how to integrate PrEP with other essential prevention methods such as condoms; and

(D) how to ensure high levels of adherence; and

(7) to increase knowledge of ''undetectable and untransmittable'', when a person living with HIV who is on antiretroviral therapy and is durably virally suppressed (defined as having a consistent viral load of less than 200 copies/ml) cannot sexually transmit HIV.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2026.

SEC. 7207. SERVICES TO REDUCE HIV/AIDS IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) IN GENERAL.—For the purpose of reducing new HIV diagnoses in racial and ethnic minority communities, the Secretary of Health and Human Services, acting through the Deputy Assistant Secretary for Minority

Health, may make grants to public health agencies and faith-based organizations to conduct—

(1) outreach activities related to HIV prevention and testing activities;

(2) HIV prevention activities;

(3) HIV testing activities; and

(4) public health education campaigns on accessing HIV prevention medication.

(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.

SEC. 7208. MINORITY AIDS INITIATIVE.

(a) EXPANDED FUNDING.—The Secretary of Health and Human Services, in collaboration with the Deputy Assistant Secretary for Minority Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Assistant Secretary for Mental Health and Substance Use, shall provide funds and carry out activities to expand the Minority AIDS Initiative.

(b) USE OF FUNDS.—The additional funds made available under this section may be used, through the Minority AIDS Initiative, to support the following activities:

(1) Providing technical assistance and infrastructure support to reduce HIV/AIDS in minority populations.

(2) Increasing minority populations' access to HIV prevention and care services.

(3) Building strong community programs and partnerships to address HIV prevention and the health care needs of specific racial and ethnic minority populations.

(c) PRIORITY INTERVENTIONS.—Within the racial and ethnic minority populations referred to in subsection (b), priority in conducting intervention services shall be given to—

(1) men who have sex with men;

(2) youth;

(3) persons who engage in intravenous drug abuse;

(4) women;

(5) homeless individuals;

(6) individuals incarcerated or in the penal system;

(7) transgender individuals; and

(8) nonbinary individuals

(d) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appro-

priated $610,000,000 for fiscal year 2023 and such sums as may be necessary for each of fiscal years 2024 through 2027.

SEC. 7209. HEALTH CARE PROFESSIONALS TREATING INDIVIDUALS WITH HIV.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand, intensify, and coordinate workforce initiatives of the Health Resources and Services Administration to increase the capacity of the health workforce focusing primarily on HIV to meet the demand for culturally competent care, and may award grants for any of the following:

(1) Development of curricula for training primary care providers in HIV/AIDS prevention and care, including routine HIV testing.

(2) Support to expand access to culturally and linguistically accessible benefits counselors, trained peer navigators, and mental and behavioral health professionals with expertise in HIV.

(3) Training health care professionals to provide care to individuals living with HIV.

(4) Development by grant recipients under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.; commonly referred to as the ''Ryan

White HIV/AIDS Program'') and other persons, of policies for providing culturally relevant and sensitive treatment to individuals living with HIV, with particular emphasis on treatment to racial and ethnic minorities, men who have sex with men, and women, young people, and children living with HIV.

(5) Development and implementation of programs to increase the use of telehealth to respond to HIV-specific health care needs in rural and minority communities, with particular emphasis given to medically underserved communities and insular areas.

(6) Evaluating interdisciplinary medical provider care team models that promote high-quality care, with particular emphasis on care to racial and ethnic minorities.

(7) Training health care professionals to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in adult racial and ethnic minority populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening.

(8) Development of curricula for training primary care providers that HIV and tuberculosis are significant mutual comorbidities, and that a patient

who tests positive for one disease should be offered and encouraged to receive testing for the other.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2026.

SEC. 7210. HIV/AIDS PROVIDER LOAN REPAYMENT PROGRAM.

(a) IN GENERAL.—The Secretary may enter into an agreement with any physician, nurse practitioner, or physician assistant under which—

(1) the physician, nurse practitioner, or physician assistant agrees to serve as a medical provider for a period of not less than 2 years—

(A) at a Ryan White-funded or title X-funded facility with a critical shortage of doctors (as determined by the Secretary); or

(B) in an area with a high incidence of HIV/AIDS; and

(2) the Secretary agrees to make payments in accordance with subsection (b) on the professional education loans of the physician, nurse practitioner, or physician assistant.

(b) MANNER OF PAYMENTS.—The payments described in subsection (a) shall be made by the Secretary as follows:

(1) Upon completion by the physician, nurse practitioner, or physician assistant for whom the payments are to be made of the first year of the service specified in the agreement entered into with the Secretary under subsection (a), the Secretary shall pay 30 percent of the principal of and the interest on the individual's professional education loans.

(2) Upon completion by the physician, nurse practitioner, or physician assistant of the second year of such service, the Secretary shall pay another 30 percent of the principal of and the interest on such loans.

(3) Upon completion by that individual of a third year of such service, the Secretary shall pay another 25 percent of the principal of and the interest on such loans.

(c) APPLICABILITY OF CERTAIN PROVISIONS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) shall, except as inconsistent with this section, apply to the program carried out under this section in the same manner and to the same extent

as such provisions apply to the National Health Service Corps loan repayment program.

(d) REPORTS.—Not later than 18 months after the date of the enactment of this Act, and annually thereafter, the Secretary shall prepare and submit to Congress a report describing the program carried out under this section, including statements regarding the following:

(1) The number of physicians, nurse practitioners, and physician assistants enrolled in the program.

(2) The number and amount of loan repayments provided through the program.

(3) The placement location of loan repayment recipients at facilities described in subsection (a)(1).

(4) The default rate on such loans and actions required.

(5) The amount of outstanding default funds with respect to such loans.

(6) To the extent that it can be determined, the reason for the default on such a loan.

(7) The demographics of individuals participating in the program.

(8) An evaluation of the overall costs and benefits of the program.

(e) DEFINITIONS.—In this section:

(1) HIV/AIDS.—The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(2) NURSE PRACTITIONER.—The term ''nurse practitioner'' means a registered nurse who has completed an accredited graduate degree program in advanced nurse practice and has successfully passed a national certification exam.

(3) PHYSICIAN.—The term ''physician'' means a graduate of a school of medicine who has completed postgraduate training in general or pediatric medicine.

(4) PHYSICIAN ASSISTANT.—The term ''physician assistant'' means a medical provider who completed an accredited physician assistant training program and successfully passed the Physician Assistant National Certifying Examination.

(5) PROFESSIONAL EDUCATION LOAN.—The term ''professional education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other reasonable educational expenses, and reasonable living costs) at a school of medicine, school of nursing, or physician assistant training program; and

(B) includes only the portion of the loan that is outstanding on the date the physician, nurse practitioner, or physician assistant involved begins the service specified in the agreement under subsection (a).

(6) RYAN WHITE-FUNDED.—The term ''Ryan White-funded'' means, with respect to a facility, receiving funds under title XXVI of the Public Health Service Act (42 U.S.C. 300ff–11 et seq.).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(8) SCHOOL OF MEDICINE.—The term ''school of medicine'' has the meaning given to that term in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(9) TITLE X-FUNDED.—The term ''title X-funded'' means, with respect to a facility, receiving funds under title X of the Public Health Service Act (42 U.S.C. 300 et seq.).

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2026.

SEC. 7211. DENTAL EDUCATION LOAN REPAYMENT PROGRAM.

(a) IN GENERAL.—The Secretary may enter into an agreement with any dentist under which—

(1) the dentist agrees to serve as a dentist for a period of not less than 2 years at a facility with a critical shortage of dentists (as determined by the Secretary) in an area with a high incidence of HIV/AIDS; and

(2) the Secretary agrees to make payments in accordance with subsection (b) on the dental education loans of the dentist.

(b) MANNER OF PAYMENTS.—The payments described in subsection (a) shall be made by the Secretary as follows:

(1) Upon completion by the dentist for whom the payments are to be made of the first year of the service specified in the agreement entered into with the Secretary under subsection (a), the Secretary shall pay 30 percent of the principal of and the interest on the dental education loans of the dentist.

(2) Upon completion by the dentist of the second year of such service, the Secretary shall pay another 30 percent of the principal of and the interest on such loans.

(3) Upon completion by that individual of a third year of such service, the Secretary shall pay another 25 percent of the principal of and the interest on such loans.

(c) APPLICABILITY OF CERTAIN PROVISIONS.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) shall, except as inconsistent with this section, apply to the program carried out under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program.

(d) REPORTS.—Not later than 18 months after the date of the enactment of this Act, and annually thereafter, the Secretary shall prepare and submit to the Congress a report describing the program carried out under this section, including statements regarding the following:

(1) The number of dentists enrolled in the program.

(2) The number and amount of loan repayments provided through the program.

(3) The placement location of loan repayment recipients at facilities described in subsection (a)(1).

(4) The default rate on such loans and actions required.

(5) The amount of outstanding default funds with respect to such loans.

(6) To the extent that it can be determined, the reason for the default on such a loan.

(7) The demographics of individuals participating in the program.

(8) An evaluation of the overall costs and benefits of the program.

(e) DEFINITIONS.—In this section:

(1) DENTAL EDUCATION LOAN.—The term ''dental education loan''—

(A) means a loan that is incurred for the cost of attendance (including tuition, other reasonable educational expenses, and reasonable living costs) at a school of dentistry; and

(B) includes only the portion of the loan that is outstanding on the date the dentist involved begins the service specified in the agreement under subsection (a).

(2) DENTIST.—The term ''dentist'' means a graduate of a school of dentistry who has completed postgraduate training in general or pediatric dentistry.

(3) HIV/AIDS.—The term ''HIV/AIDS'' means human immunodeficiency virus and acquired immune deficiency syndrome.

(4) SCHOOL OF DENTISTRY.—The term ''school of dentistry'' has the meaning given to that term in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2023 through 2026.

SEC. 7212. REDUCING NEW HIV INFECTIONS AMONG INJECTING DRUG USERS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that providing sterile syringes and sterilized equipment to injecting drug users substantially reduces risk of HIV infection, increases the probability that they will initiate drug treatment, and does not increase drug use.

(b) IN GENERAL.—The Secretary of Health and Human Services may provide grants and technical assistance for the purpose of reducing the rate of HIV infections among injecting drug users through a comprehensive package of services for such users, including the provision

of sterile syringes, education and outreach, access to infectious disease testing, overdose prevention, and treatment for drug dependence.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2023 through 2026.

SEC. 7213. REPORT ON IMPACT OF HIV/AIDS IN VULNERABLE POPULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress and the President an annual report on the impact of HIV/AIDS for racial and ethnic minority communities, women, and youth aged 24 and younger.

(b) CONTENTS.—The report under subsection (a) shall include information on the—

(1) progress that has been made in reducing the impact of HIV/AIDS in such communities;

(2) opportunities that exist to make additional progress in reducing the impact of HIV/AIDS in such communities;

(3) challenges that may impede such additional progress; and

(4) Federal funding necessary to achieve substantial reductions in HIV/AIDS in racial and ethnic minority communities.

SEC. 7214. NATIONAL HIV/AIDS OBSERVANCE DAYS.

(a) NATIONAL OBSERVANCE DAYS.—It is the sense of Congress that national observance days highlighting the impact of HIV on communities of color include the following:

(1) National Black HIV/AIDS Awareness Day.

(2) National Latino AIDS Awareness Day.

(3) National Asian and Pacific Islander HIV/AIDS Awareness Day.

(4) National Native American HIV/AIDS Awareness Day.

(5) National Youth HIV/AIDS Awareness Day.

(b) CALL TO ACTION.—It is the sense of Congress that the President should call on members of communities of color—

(1) to become involved at the local community level in HIV testing, policy, and advocacy;

(2) to become aware, engaged, and empowered on the HIV epidemic within their communities; and

(3) to urge members of their communities to reduce risk factors, practice safe sex and other preven-

tive measures, be tested for HIV, and seek care when appropriate.

SEC. 7215. REVIEW OF ALL FEDERAL AND STATE LAWS, POLICIES, AND REGULATIONS REGARDING THE CRIMINAL PROSECUTION OF INDIVIDUALS FOR HIV-RELATED OFFENSES.

(a) FINDINGS.—Congress makes the following findings:

(1) At present, 32 States and 2 United States territories have criminal statutes based on perceived exposure to HIV, rather than behaviors motivated by an intent to harm, presenting a significant risk of transmission and resulting in actual transmission of HIV to another. 11 States have HIV-specific laws that make spitting or biting a felony, even though it is not possible to transmit HIV via saliva. 24 States require persons who are aware that they have HIV to disclose their status to sexual partners, regardless of whether they are noninfectious. 14 of these 24 States also require disclosure to needle-sharing partners. 25 States criminalize 1 or more behaviors that pose a low or negligible risk for HIV transmission.

(2) HIV-specific criminal laws are classified as felonies in 28 States. In 3 States, a person's exposure to another to HIV does not subject the person

to criminal prosecution for that act alone but may result in a sentence enhancement. 18 States impose sentences of up to 10 years per violation, 7 States impose sentences between 11 and 20 years, and 5 States impose sentences of greater than 20 years.

(3) When members of the Armed Forces acquire HIV, they are issued orders that require them to disclose and use a condom under all circumstances, including when the known risk of transmission is 0. Failure to disclose can result in prosecution under the Uniform Code of Military Justice (UCMJ).

(4) The number of prosecutions, arrests, and instances where HIV-based charges are used to induce plea agreements is unknown. Because State-level prosecution and arrest data are not readily available in any national legal database, the societal impact of these laws may be underestimated, and most cases that go to trial are not reduced to written, published opinions.

(5) State and Federal criminal law does not currently reflect the 4 decades of medical advances and discoveries made with regard to transmission and treatment of HIV/AIDS.

(6) According to the CDC, correct and consistent male or female condom use, or adherence to a preexposure prophylaxis (PrEP) regimen that results in viral suppression, are very effective in preventing HIV transmission. However, most State HIV-specific laws and prosecutions do not treat the use of a condom during sexual intercourse or adherence to PrEP as a mitigating factor or evidence that the defendant did not intend to transmit HIV.

(7) Criminal laws and prosecutions do not take into account the benefits of effective antiretroviral medications, which suppress the virus to extremely low levels and further reduce the already low risk of transmitting HIV to near 0.

(8) In addition to HIV-specific criminal laws, general criminal laws are often misused to prosecute people based on their HIV status. Although HIV, and even AIDS, currently is viewed as a treatable, chronic, medical condition, people living with HIV have been charged under aggravated assault, attempted murder, and even bioterrorism statutes because prosecutors, courts, and legislators continue to view and characterize the blood, semen, and saliva of people living with HIV as a ''deadly weapon''.

(9) Multiple peer-reviewed studies demonstrate that HIV-specific laws do not reduce risk-taking behavior or increase disclosure by people living with or at risk of HIV, and there is increasing evidence that these laws reduce the willingness to get tested. Furthermore, placing legal responsibility for preventing the transmission of HIV and other pathogens that can be sexually transmitted exclusively on people diagnosed with a sexually transmitted infection undermines the public health message that all people are responsible for practicing behaviors that protect themselves from HIV and other sexually transmitted infections. Unfortunately, some State laws that create an expectation of disclosure work against public health communication and discourage risk-reduction measures that could prevent transmission as a result of those who are acutely infected and unaware of their status.

(10) The identity of an individual subject to an HIV-based prosecution is broadcast through media reports, potentially destroying employment opportunities and relationships and violating the person's right to privacy.

(11) Individuals who are convicted after an HIV-based prosecution often must register as sex of-

fenders, even in cases involving consensual sexual activity. Their employability is destroyed, and their family relationships are fractured.

(12) The United Nations, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), urges governments to ''limit criminalization to cases of intentional transmission''. This requirement would limit prosecutions to situations ''where a person knows his or her HIV-positive status, acts with the intention to transmit HIV, and does in fact transmit it''. UNAIDS also recommends that criminal law should not be applied to cases where there is no significant risk of transmission.

(13) In 2010, the Federal Government released the first ever National HIV/AIDS Strategy (NHAS), which addressed HIV-specific criminal laws, stating: ''While we understand the intent behind these laws, they may not have the desired effect and they may make people less willing to disclose their status by making people feel at even greater risk of discrimination. In some cases, it may be appropriate for legislators to reconsider whether existing laws continue to further the public interest and public health. In many instances, the continued existence and enforcement of these types of laws run counter to scientific

evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.''. The NHAS also states that State legislatures should consider reviewing HIV-specific criminal statutes to ensure that they are consistent with current knowledge of HIV transmission and support public health approaches to preventing and treating HIV.

(14) The Global Commission on HIV and the Law was launched in June 2010 to examine laws and practices that criminalize people living with and vulnerable to HIV and to develop evidence-based recommendations for effective HIV responses. The Commission calls for ''governments, civil society and international bodies to repeal punitive laws and enact laws that facilitate and enable effective responses to HIV prevention, care and treatment services for all who need them''. The Commission recommends against the enactment of ''laws that explicitly criminalize HIV transmission, exposure or non-disclosure of HIV status, which are counterproductive''.

(15) In February 2019, the Department of Health and Human Services (HHS) launched ''Ending the HIV Epidemic: A Plan for America'', a new

initiative with an ambitious goal to end the domestic HIV epidemic in 10 years by reducing new cases of HIV by 75 percent by 2025 and by 90 percent by 2030. In this plan, HHS notes that stigma ''can be a debilitating barrier preventing people living with, or at risk for, HIV from receiving the health care, services, and respect they need and deserve''. Many of the States and jurisdictions identified as a priority for the first 5 years of the plan have stigma-based criminal statutes for perceived exposure to HIV. These statutes run counter to the goals of this new initiative and stand in the way of ending the domestic HIV epidemic.

(b) SENSE OF CONGRESS REGARDING LAWS OR REGULATIONS DIRECTED AT PEOPLE LIVING WITH HIV.—It is the sense of Congress that Federal and State laws, policies, and regulations regarding people living with HIV—

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and

(2) should instead demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(A) the multiple factors that lead to HIV transmission;

(B) the relative risk of demonstrated HIV transmission routes;

(C) the current health implications of living with HIV;

(D) the associated benefits of treatment and support services for people living with HIV; and

(E) the impact of punitive HIV-specific laws, policies, regulations, and judicial precedents and decisions on public health, on people living with or affected by HIV, and on their families and communities.

(c) REVIEW OF FEDERAL AND STATE LAWS.—

(1) REVIEW OF FEDERAL AND STATE LAWS.—

(A) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense acting jointly (in this section referred to as the ''designated officials'') shall initiate a national review of Federal and State laws, including the Uniform Code of Military Justice (referred to in 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:

(i) Each State.

(ii) State attorneys general (or their 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

been disproportionately subject to HIV-specific arrests and prosecution.

(vii) Legal advocacy and HIV/AIDS service organizations that work with people living with HIV/AIDS.

(viii) Nongovernmental health organizations that work on behalf of people living with HIV/AIDS, including syringe services programs, LGBTQ-focused health organizations, and organizations who serve people who engage in sex work.

(ix) Trade organizations or associations representing persons or entities described in clauses (i) through (vii).

(C) RELATION TO OTHER REVIEWS.—In carrying out the review under subparagraph (A), the designated officials may utilize other existing reviews of criminal and related civil commitment cases involving people living with HIV, including any such review conducted by any Federal or State agency or any public health, legal advocacy, or trade organization or association if the designated officials determines that such reviews were conducted in accordance 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

person that has an undetectable viral load cannot transmit HIV;

(III) the current health implications of living with HIV, including data disaggregated by race and ethnicity;

(IV) the current status of providing protection to people who engage in survival sex work against whom condom possession has been used as evidence of intent to commit a crime;

(V) States that have the classification of mandatory sex offenders;

(VI) the associated benefits of treatment and support services for people living with HIV; and

(VII) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities, including people who are in abusive, dependent, violent, or nonconsensual relationships and

are unable to both negotiate the use of condoms and status disclosure.

(iii) An analysis of the public health and legal implications of such laws, policies, regulations, and judicial precedents and decisions, including an analysis of the consequences of having a similar penal scheme applied to comparable situations involving other communicable diseases.

(iv) An analysis of the proportionality of punishments imposed under HIV-specific laws, policies, regulations, and judicial precedents, taking into consideration penalties attached to violation of State laws against similar degrees of endangerment or harm, such as driving while intoxicated or transmission of other communicable diseases, or more serious harms, such as vehicular manslaughter offenses.

(B) An analysis of common elements shared between State laws, policies, regulations, and judicial precedents.

(C) A set of best practice recommendations directed to State governments, including State attorneys general, public health officials, and

judicial officers, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV are in accordance with the principles set forth in subsection (b).

(D) Recommendations for adjustments to the UCMJ, including discontinuing the use of a service member's HIV diagnosis as the basis for prosecution, enhanced penalties, or discharge from military service, in order to ensure that laws, policies, regulations, and judicial precedents regarding people living with HIV are in accordance with the principles set forth in subsection (b). Such recommendations should include any necessary and appropriate changes to ''Orders to Follow Preventative Medicine Requirements''.

(3) GUIDANCE.—Not later than 90 days after the date of the release of the report required by paragraph (2), the Attorney General and the Secretary of Health and Human Services shall jointly develop and publicly release updated guidance for States based on the set of best practice recommendations required under paragraph (2)(C) in order to assist States dealing with criminal and re-

lated civil commitment cases regarding people living with HIV.

(4) MONITORING AND EVALUATION SYSTEM.—Not later than 60 days after the date of the release of the guidance required under paragraph (3), the Attorney General and the Secretary of Health and Human Services shall jointly establish an integrated monitoring and evaluation system that includes, where appropriate, objective and quantifiable performance goals and indicators to measure progress toward statewide implementation in each State of the best practice recommendations required under paragraph (2)(C).

(5) MODERNIZATION OF FEDERAL LAWS, POLICIES, AND REGULATIONS.—Not later than 90 days after the date of the release of the report required under paragraph (2), the designated officials shall develop and transmit to the President and the Congress, and make publicly available, such proposals as may be necessary to implement adjustments to Federal laws, policies, or regulations, including the UCMJ, based on the recommendations required under paragraph (2)(D), either through Executive order or through changes to statutory law.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to discourage the prosecution of individuals who intentionally transmit or attempt to transmit HIV to another individual.

(e) NO ADDITIONAL APPROPRIATIONS AUTHORIZED.—This section shall not be construed to increase the amount of appropriations that are authorized to be appropriated for any fiscal year.

SEC. 7216. EXPANDING SUPPORT FOR CONDOMS IN PRISONS.

(a) SENSE OF CONGRESS REGARDING DISTRIBUTION OF SEXUAL BARRIER PROTECTION DEVICES IN STATE PRISON SYSTEMS.—It is the sense of the Congress that States shall allow for the legal distribution of sexual barrier protection devices in State correctional facilities to reduce the prevalence and spread of STIs in those facilities.

(b) AUTHORITY TO ALLOW COMMUNITY ORGANIZATIONS TO PROVIDE STI COUNSELING, STI PREVENTION EDUCATION, AND SEXUAL BARRIER PROTECTION DEVICES IN FEDERAL CORRECTIONAL FACILITIES.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—Not later than 30 days after the date of enactment of this Act, the Attorney General shall direct the Director of the Bureau of Prisons to allow community organizations to, in accordance with all relevant Fed-

eral laws and regulations that govern visitation in Federal correctional facilities—

(A) distribute sexual barrier protection devices in Federal correctional facilities; and

(B) engage in STI counseling and STI prevention education in Federal correctional facilities.

(2) INFORMATION REQUIREMENT.—Any community organization permitted to distribute sexual barrier protection devices under paragraph (1) shall ensure that the individuals to whom the devices are distributed are informed about the proper use and disposal of sexual barrier protection devices in accordance with established public health practices. Any community organization conducting STI counseling or STI prevention education under paragraph (1) shall offer comprehensive sexuality education.

(3) POSSESSION OF DEVICE PROTECTED.—A Federal correctional facility may not, because of the possession or use of a sexual barrier protection device—

(A) take adverse action against an incarcerated individual; or

(B) consider possession or use as evidence of prohibited activity for the purpose of any

Federal correctional facility administrative proceeding.

(4) IMPLEMENTATION.—The Attorney General and the Director of the Bureau of Prisons shall implement this section according to established public health practices in a manner that protects the health, safety, and privacy of incarcerated individuals and of correctional facility staff.

(c) SURVEY OF AND REPORT ON CORRECTIONAL FACILITY PROGRAMS AIMED AT REDUCING THE SPREAD OF STIS.—

(1) SURVEY.—Not later than 180 days after the date of enactment of this Act, and annually thereafter for 5 years, the Attorney General, after consulting with the Secretary of Health and Human Services, State officials, and community organizations, shall, to the maximum extent practicable, conduct a survey of all Federal and State correctional facilities, to determine the following:

(A) COUNSELING, TREATMENT, AND SUPPORTIVE SERVICES.—Whether the correctional facility—

(i) requires incarcerated individuals to participate in counseling, treatment, and supportive services related to STIs; or

(ii) offers such programs to incarcerated individuals.

(B) ACCESS TO SEXUAL BARRIER PROTECTION DEVICES.—Whether incarcerated individuals can—

(i) possess sexual barrier protection devices;

(ii) purchase sexual barrier protection devices;

(iii) purchase sexual barrier protection devices at a reduced cost; or

(iv) obtain sexual barrier protection devices without cost.

(C) INCIDENCE OF SEXUAL VIOLENCE.—The incidence of sexual violence and assault committed by incarcerated individuals and by correctional facility staff.

(D) PREVENTION EDUCATION OFFERED.—The type of prevention education, information, or training offered to incarcerated individuals and correctional facility staff regarding sexual violence and the spread of STIs, including whether such education, information, or training—

(i) constitutes comprehensive sexuality education;

(ii) is compulsory for new incarcerated individuals and for new correctional facility staff; and

(iii) is offered on an ongoing basis.

(E) STI TESTING.—Whether the correctional facility tests incarcerated individuals for STIs or gives them the option to undergo such testing—

(i) at intake;

(ii) on a regular basis; and

(iii) prior to release.

(F) STI TEST RESULTS.—The number of incarcerated individuals who are tested for STIs and the outcome of such tests at each correctional facility, disaggregated to include results for—

(i) the type of STI tested for;

(ii) the race and ethnicity of an individual tested;

(iii) the age of an individual tested; and

(iv) the gender of the individual tested.

(G) PRERELEASE REFERRAL POLICY.—Whether incarcerated individuals are informed prior to release about STI-related services or other health services in their communities, including free and low-cost counseling and treatment options.

(H) PRERELEASE REFERRALS MADE.—The number of referrals to community-based organizations or public health facilities offering STI-related or other health services provided to incarcerated individuals prior to release, and the type of counseling or treatment for which the referral was made.

(I) REINSTATEMENT OF MEDICAID BENEFITS.—Whether—

(i) the correctional facility assists incarcerated individuals that were enrolled in the State Medicaid program prior to their incarceration in reinstating their enrollment upon release; and

(ii) such individuals receive referrals as described in subparagraph (G) to entities that accept the State Medicaid program, including, if applicable—

(I) the number of such individuals, including those diagnosed with HIV, that have been reinstated;

(II) a list of obstacles to reinstating enrollment or to making determinations of eligibility for reinstatement, if any; and

(III) the number of individuals denied enrollment.

(J) OTHER ACTIONS TAKEN.—Whether the correctional facility has taken any other action, in conjunction with community organizations or otherwise, to reduce the prevalence and spread of STIs in that facility.

(2) PRIVACY.—In conducting the survey under paragraph (1), the Attorney General shall not request or retain the identity of any individual who has sought or been offered counseling, treatment, testing, or prevention education information regarding an STI (including information about sexual barrier protection devices), or who has tested positive for an STI.

(3) REPORT.—

(A) IN GENERAL.—The Attorney General shall transmit to Congress and make publicly

available the results of the survey required under paragraph (1), both for the United States as a whole and disaggregated as to each State and each correctional facility.

(B) DEADLINES.—To the maximum extent possible, the Attorney General shall—

(i) issue the first report under subparagraph (A) not later than 1 year after the date of enactment of this Act; and

(ii) issue reports under subparagraph (A) annually thereafter for 5 years.

(d) STRATEGY.—

(1) DIRECTIVE TO ATTORNEY GENERAL.—The Attorney General, in consultation with the Secretary of Health and Human Services, State officials, and community organizations, shall develop and implement a 5-year strategy to reduce the prevalence and spread of STIs in Federal and State correctional facilities. To the maximum extent possible, the strategy shall be developed, transmitted to Congress, and made publicly available not later than 180 days after the transmission of the first report required under subsection (c)(3).

(2) CONTENTS OF STRATEGY.—The strategy developed under paragraph (1) shall include the following:

(A) PREVENTION EDUCATION.—A plan for improving prevention education, information, and training offered to incarcerated individuals and correctional facility staff, including information and training on sexual violence and the spread of STIs, and comprehensive sexuality education.

(B) SEXUAL BARRIER PROTECTION DEVICE ACCESS.—A plan for expanding access to sexual barrier protection devices in correctional facilities.

(C) SEXUAL VIOLENCE REDUCTION.—A plan for reducing the incidence of sexual violence among incarcerated individuals and correctional facility staff.

(D) COUNSELING AND SUPPORTIVE SERVICES.—A plan for expanding access to counseling and supportive services related to STIs in correctional facilities.

(E) TESTING.—A plan for testing incarcerated individuals for STIs during intake, during

regular health exams, and prior to release that—

(i) is conducted in accordance with guidelines established by the Centers for Disease Control and Prevention;

(ii) includes pretest counseling;

(iii) requires that incarcerated individuals are notified of their option to decline testing at any time;

(iv) requires that incarcerated individuals are confidentially notified of their test results in a timely manner; and

(v) ensures that incarcerated individuals testing positive for STIs receive post-test counseling, care, treatment, and supportive services.

(F) TREATMENT.—A plan for ensuring that correctional facilities have the necessary medicine and equipment to treat and monitor STIs and for ensuring that incarcerated individuals living with or testing positive for STIs receive and have access to care and treatment services.

(G) STRATEGIES FOR DEMOGRAPHIC GROUPS.—A plan for developing and 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

diagnosed with HIV while incarcerated in a correctional facility, are automatically enrolled in such program upon their release.

(J) OTHER PLANS.—Any other plans developed by the Attorney General for reducing the spread of STIs or improving the quality of health care in correctional facilities.

(K) MONITORING SYSTEM.—A monitoring system that establishes performance goals related to reducing the prevalence and spread of STIs in correctional facilities and which, where feasible, expresses such goals in quantifiable form.

(L) MONITORING SYSTEM PERFORMANCE INDICATORS.—Performance indicators that measure or assess the achievement of the performance goals described in subparagraph (K).

(M) COST ESTIMATE.—A detailed estimate of the funding necessary to implement the strategy at the Federal and State levels for all 5 years, including the amount of funds required by community organizations to implement the parts of the strategy in which they take part.

(3) REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Attorney General shall transmit to Congress and make publicly available an annual progress report regarding the implementation and effectiveness of the strategy described in paragraph (1). The progress report shall include an evaluation of the implementation of the strategy using the monitoring system and performance indicators provided for in subparagraphs (K) and (L) of paragraph (2).

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2023 through 2027.

(2) AVAILABILITY OF FUNDS.—Amounts made available under paragraph (1) are authorized to remain available until expended.

(f) DEFINITIONS.—In this section:

(1) COMMUNITY ORGANIZATION.—The term ''community organization'' means a public health care facility or a nonprofit organization that provides health- or STI-related services according to established public health standards.

(2) COMPREHENSIVE SEXUALITY EDUCATION.—The term ''comprehensive sexuality education'' means sexuality education—

(A) that includes information about abstinence and about the proper use and disposal of sexual barrier protection devices; and

(B) that is—

(i) evidence-based;

(ii) medically accurate;

(iii) age and developmentally appropriate;

(iv) gender and identity sensitive;

(v) culturally and linguistically appropriate; and

(vi) structured to promote critical thinking, self-esteem, respect for others, and the development of healthy attitudes and relationships.

(3) CORRECTIONAL FACILITY.—The term ''correctional facility'' means any prison, penitentiary, adult detention facility, juvenile detention facility, jail, or other facility to which individuals may be sent after conviction of a crime or act of juvenile delinquency within the United States.

(4) INCARCERATED INDIVIDUAL.—The term ''incarcerated individual'' means any individual who is serving a sentence in a correctional facility after conviction of a crime.

(5) SEXUAL BARRIER PROTECTION DEVICE.—The term ''sexual barrier protection device'' means any physical device approved, cleared, or otherwise authorized by the Food and Drug Administration that has not been tampered with and which reduces the probability of STI transmission or infection between sexual partners, including female condoms, male condoms, and dental dams.

(6) SEXUALLY TRANSMITTED INFECTION.—The term ''sexually transmitted infection'' or ''STI'' means any disease or infection that is commonly transmitted through sexual activity, including HIV, gonorrhea, chlamydia, syphilis, genital herpes, viral hepatitis, and human papillomavirus.

(7) STATE.—The term ''State'' includes the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the United States Virgin Islands.

(8) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means the State plan (or

a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 7217. AUTOMATIC REINSTATEMENT OR ENROLLMENT IN MEDICAID FOR PEOPLE WHO TEST POSITIVE FOR HIV BEFORE REENTERING COMMUNITIES.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(17) ENROLLMENT OF EX-OFFENDERS.—

''(A) AUTOMATIC ENROLLMENT OR REINSTATEMENT.—

''(i) IN GENERAL.—The State plan shall provide for the automatic enrollment or reinstatement of enrollment of an eligible individual—

''(I) if such individual is scheduled to be released from a public institution due to the completion of sentence, not less than 30 days prior to the scheduled date of the release; and

''(II) if such individual is to be released from a public institution on parole or on probation, as soon as possible after the date on which the

determination to release such individual was made, and before the date such individual is released.

''(ii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

''(I) on or before the date by which the individual would be enrolled under clause (i), such clause shall not apply to such individual; or

''(II) after such date, the State may terminate the enrollment of such individual.

''(B) RELATIONSHIP OF ENROLLMENT TO PAYMENT FOR SERVICES.—

''(i) IN GENERAL.—Subject to subparagraph (A)(ii), an eligible individual who is enrolled, or whose enrollment is reinstated, under subparagraph (A) shall be eligible for all services for which medical assistance is provided under the State plan after the date that the eligible individual is released from the public institution.

''(ii) RELATIONSHIP TO PAYMENT PROHIBITION FOR INMATES.—No provision

of this paragraph may be construed to permit payment for care or services for which payment is excluded under subdivision (A) following the last numbered paragraph of section 1905(a).

''(C) TREATMENT OF CONTINUOUS ELIGIBILITY.—

''(i) SUSPENSION FOR INMATES.—Any period of continuous eligibility under this title shall be suspended on the date an individual enrolled under this title becomes an inmate of a public institution (except as a patient of a medical institution).

''(ii) DETERMINATION OF REMAINING PERIOD.—Notwithstanding any changes to State law related to continuous eligibility during the time that an individual is an inmate of a public institution (except as a patient of a medical institution), subject to clause (iii), with respect to an eligible individual who was subject to a suspension under clause (i), on the date that such individual is released from a public institution the suspension of continuous eligibility under such clause shall be lifted for a pe-

riod that is equal to the time remaining in the period of continuous eligibility for such individual on the date that such period was suspended under such clause.

''(iii) EXCEPTION.—If a State makes a determination that an individual is not eligible to be enrolled under the State plan—

''(I) on or before the date that the suspension of continuous eligibility is lifted under clause (ii), such clause shall not apply to such individual; or

''(II) after such date, the State may terminate the enrollment of such individual.

''(D) AUTOMATIC ENROLLMENT OR REINSTATEMENT OF ENROLLMENT DEFINED.—For purposes of this paragraph, the term 'automatic enrollment or reinstatement of enrollment' means that the State determines eligibility for medical assistance under the State plan without a program application from, or on behalf of, the eligible individual, but an individual can only be automatically enrolled in the State Medicaid plan if the individual affirmatively consents to

being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or through any other means specified by the Secretary.

''(E) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this paragraph, the term 'eligible individual' means an individual who is an inmate of a public institution (except as a patient in a medical institution)—

''(i) who was enrolled under the State plan for medical assistance immediately before becoming an inmate of such an institution; or

''(ii) who is diagnosed with human immunodeficiency virus.''.

(b) SUPPLEMENTAL FUNDING FOR STATE IMPLEMENTATION OF AUTOMATIC REINSTATEMENT OF MEDICAID BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (3), with respect to a State, for each of the first 4 calendar quarters in which the State plan meets the requirements of paragraph (17) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) (as added by subsection (a)), the Federal matching payments (including payments based on the Federal

medical assistance percentage) made to such State under section 1903 of the Social Security Act (42 U.S.C. 1396b) for the State expenditures described in paragraph (2) shall be increased by 5 percentage points.

(2) EXPENDITURES.—The expenditures described in this paragraph are the following:

(A) Expenditures for which payment is available under section 1903 of the Social Security Act (42 U.S.C. 1396b) and which are attributable to strengthening the State's enrollment and administrative resources for the purpose of improving processes for enrolling (or reinstating the enrollment of) eligible individuals (as such term is defined in subparagraph (E) of paragraph (16) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) (as amended by subsection (a))).

(B) Expenditures for medical assistance (as such term is defined in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a))) provided to such eligible individuals.

(3) REQUIREMENTS; LIMITATION.—

(A) REPORT.—A State is not eligible for an increase in its Federal matching payments

under paragraph (1) unless the State agrees to submit to the Secretary of Health and Human Services, and make publicly available, a report that contains the information required under paragraph (4) by the end of the 1-year period during which the State receives increased Federal matching payments in accordance with that paragraph.

(B) MAINTENANCE OF ELIGIBILITY.—

(i) IN GENERAL.—Subject to clause (ii), a State is not eligible for an increase in its Federal matching payments under paragraph (1) if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or waiver of such a plan, are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan or waiver as in effect on the date of enactment of this Act.

(ii) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—A State that has restricted eligibility standards, methodologies, or procedures under its State plan

under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or a waiver of such plan, after the date of enactment of this Act, is no longer ineligible under clause (i) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on such date.

(C) LIMITATION OF MATCHING PAYMENTS TO 100 PERCENT.—In no case shall an increase in Federal matching payments under paragraph (1) result in Federal matching payments that exceed 100 percent of State expenditures.

(4) REQUIRED REPORT INFORMATION.—The information that is required in the report under paragraph (3)(A) shall include—

(A) the results of an evaluation of the impact of the implementation of the requirements of paragraph (17) of section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) on improving the State's processes for enrolling indi-

viduals who are released from public institutions under the State Medicaid plan;

(B) the number of individuals who were automatically enrolled (or whose enrollment was reinstated) under such paragraph during the 1-year period during which the State received increased payments under this subsection; and

(C) any other information that is required by the Secretary of Health and Human Services.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect 180 days after the date of the enactment of this Act.

(2) RULE FOR CHANGES REQUIRING STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements

of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 7218. STOP HIV IN PRISON.

(a) SHORT TITLE.—This section may be cited as the ''Stop HIV in Prison Act''.

(b) HIV POLICY.—The Director of the Bureau of Prisons (referred to in this section as the ''Director'') shall develop a comprehensive policy to provide HIV testing, treatment, and prevention for inmates within the correctional setting and upon reentry.

(c) PURPOSE.—The purposes of the policy required to be developed under subsection (b) shall be as follows:

(1) To stop the spread of HIV among inmates.

(2) To protect guards and other personnel at correctional facilities from HIV infection.

(3) To provide comprehensive medical treatment to inmates who are living with HIV.

(4) To promote HIV awareness and prevention among inmates.

(5) To encourage inmates to take personal responsibility for their health.

(6) To reduce the risk that inmates will transmit HIV to other persons in the community following their release from a correctional facility.

(d) CONSULTATION.—The Director shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, the Office of National AIDS Policy, and the Centers for Disease Control and Prevention regarding the development of the policy required under subsection (b).

(e) TIME LIMIT.—Not later than 1 year after the date of enactment of this Act, the Director shall draft appropriate regulations to implement the policy required to be developed under subsection (b).

(f) REQUIREMENTS FOR POLICY.—The policy required to be developed under subsection (b) shall provide for the following:

(1) TESTING AND COUNSELING UPON INTAKE.—

(A) Health care personnel shall provide routine HIV testing to all inmates as a part of a comprehensive medical examination imme-

diately following admission to a facility. Health care personnel need not provide routine HIV testing to an inmate who is transferred to a facility from another facility if the inmate's medical records are transferred with the inmate and indicate that the inmate has been tested previously.

(B) With respect to all inmates admitted to a facility prior to the effective date of the policy—

(i) health care personnel shall provide routine HIV testing by not later than 180 days after such effective date; and

(ii) HIV testing described in clause (i) may be performed in conjunction with other health services provided to these inmates by health care personnel.

(C) All HIV tests under this paragraph shall comply with the opt-out provision under paragraph (9).

(2) PRE-TEST AND POST-TEST COUNSELING.—Health care personnel shall provide confidential pre-test and post-test counseling to all inmates who are tested for HIV. Counseling may be included with

other general health counseling provided to inmates by health care personnel.

(3) HIV PREVENTION EDUCATION.—

(A) Health care personnel shall improve HIV awareness through frequent educational programs for all inmates. HIV educational programs may be provided by community-based organizations, local health departments, and inmate peer educators.

(B) HIV educational materials shall be made available to all inmates at orientation, at health care clinics, at regular educational programs, and prior to release. Both written and audiovisual materials shall be made available to all inmates.

(C)(i) The HIV educational programs and materials under this paragraph shall include information on—

(I) modes of transmission, including transmission through tattooing, sexual contact, and intravenous drug use;

(II) prevention methods;

(III) treatment; and

(IV) disease progression.

(ii) The programs and materials shall be culturally sensitive, written or designed for low-literacy levels, available in a variety of languages, and present scientifically accurate information in a clear and understandable manner.

(4) HIV TESTING UPON REQUEST.—

(A) Health care personnel shall allow inmates to obtain HIV tests upon request once per year or whenever an inmate has a reason to believe the inmate may have been exposed to HIV. Health care personnel shall, both orally and in writing, inform inmates, during orientation and periodically throughout incarceration, of their right to obtain HIV tests.

(B) Health care personnel shall encourage inmates to request HIV tests if the inmate is sexually active, has been raped, uses intravenous drugs, receives a tattoo, or if the inmate is concerned that the inmate may have been exposed to HIV.

(C) An inmate's request for an HIV test shall not be considered an indication that the inmate has put themselves at risk of infection

or committed a violation of the rules of the correctional facility.

(5) HIV TESTING OF PREGNANT WOMAN.—

(A) Health care personnel shall provide routine HIV testing to all inmates who become pregnant.

(B) All HIV tests under this paragraph shall comply with the opt-out provision under paragraph (9).

(6) COMPREHENSIVE TREATMENT.—

(A) Health care personnel shall provide all inmates who test positive for HIV—

(i) timely, comprehensive medical treatment;

(ii) confidential counseling on managing their medical condition and preventing its transmission to other persons; and

(iii) voluntary partner notification services.

(B) Health care provided under this paragraph shall be consistent with Department of Health and Human Services guidelines and standard medical practice. Health care personnel shall discuss treatment options, the im-

portance of adherence to antiretroviral therapy, and the side effects of medications with inmates receiving treatment.

(C) Health care personnel and pharmacy personnel shall ensure that the facility formulary contains all Food and Drug Administration-approved medications necessary to provide comprehensive treatment for inmates living with HIV, and that the facility maintains adequate supplies of such medications to meet inmates' medical needs. Health care personnel and pharmacy personnel shall also develop and implement automatic renewal systems for these medications to prevent interruptions in care.

(D) Correctional staff, health care personnel, and pharmacy personnel shall develop and implement distribution procedures to ensure timely and confidential access to medications.

(7) PROTECTION OF CONFIDENTIALITY.—

(A) Health care personnel shall develop and implement procedures to ensure the confidentiality of inmate tests, diagnoses, and treatment. Health care personnel and correctional staff shall receive regular training on the

implementation of these procedures. Penalties for violations of inmate confidentiality by health care personnel or correctional staff shall be specified and strictly enforced.

(B) HIV testing, counseling, and treatment shall be provided in a confidential setting where other routine health services are provided and in a manner that allows the inmate to request and obtain these services as routine medical services.

(8) TESTING, COUNSELING, AND REFERRAL PRIOR TO REENTRY.—

(A) Health care personnel shall provide routine HIV testing to all inmates not earlier than 90 days prior to their release and reentry into the community. Inmates who are already known to be infected need not be tested again. This requirement may be waived if an inmate's release occurs without sufficient notice to the Director to allow health care personnel to perform a routine HIV test and notify the inmate of the results.

(B) All HIV tests under this paragraph shall comply with the opt-out provision under paragraph (9).

(C) With respect to all inmates who test positive for HIV and all inmates who already are known to have HIV, health care personnel shall provide—

(i) confidential prerelease counseling on managing their medical condition in the community, accessing appropriate treatment and services in the community, and preventing the transmission of their condition to family members and other persons in the community;

(ii) referrals to appropriate health care providers and social service agencies in the community that meet the inmate's individual needs, including voluntary partner notification services and prevention counseling services for people living with HIV; and

(iii) a 30-day supply of any medically necessary medications the inmate is currently receiving.

(9) OPT-OUT PROVISION.—Inmates shall have the right to refuse routine HIV testing. Inmates shall be informed both orally and in writing of this right. Oral and written disclosure of this right may

be included with other general health information and counseling provided to inmates by health care personnel. If an inmate refuses a routine test for HIV, health care personnel shall make a note of the inmate's refusal in the inmate's confidential medical records. However, the inmate's refusal shall not be considered a violation of the rules of the correctional facility or result in disciplinary action.

(10) EXCLUSION OF TESTS PERFORMED UNDER SECTION 4014(b) FROM THE DEFINITION OF ROUTINE HIV TESTING.—HIV testing of an inmate under section 4014(b) of title 18, United States Code, is not routine HIV testing for the purposes of the opt-out provision under paragraph (9). Health care personnel shall document the reason for testing under section 4014(b) of title 18, United States Code, in the inmate's confidential medical records.

(11) TIMELY NOTIFICATION OF TEST RESULTS.—Health care personnel shall provide timely notification to inmates of the results of HIV tests.

(g) CHANGES IN EXISTING LAW.—

(1) SCREENING IN GENERAL.—Section 4014(a) of title 18, United States Code, is amended—

(A) by striking ''for a period of 6 months or more'';

(B) by striking ", as appropriate,"; and

(C) by striking "if such individual is determined to be at risk for infection with such virus in accordance with the guidelines issued by the Bureau of Prisons relating to infectious disease management" and inserting "unless the individual declines. The Attorney General shall also cause such individual to be so tested before release from that incarceration unless the individual declines.".

(2) INADMISSIBILITY OF HIV TEST RESULTS IN CIVIL AND CRIMINAL PROCEEDINGS.—Section 4014(d) of title 18, United States Code, is amended by inserting "or under the Stop HIV in Prison Act" after "under this section".

(3) SCREENING AS PART OF ROUTINE SCREENING.—Section 4014(e) of title 18, United States Code, is amended by adding at the end the following: "Such rules shall also provide that the initial test under this section be performed as part of the routine health screening conducted at intake.".

(h) REPORTING REQUIREMENTS.—

(1) REPORT ON HEPATITIS, LIVER, AND OTHER DISEASES.—Not later than 1 year after the date of enactment of this Act, the Director shall submit to

Congress a report on the policies and procedures of the Bureau of Prisons to provide testing, treatment, and prevention education programs for hepatitis, liver failure, and other liver-related diseases transmitted through sexual activity, intravenous drug use, or other means. The Director shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, the Office of National AIDS Policy, and the Centers for Disease Control and Prevention regarding the development of this report.

(2) ANNUAL REPORTS.—

(A) GENERALLY.—Not later than 2 years after the date of enactment of this Act, and annually thereafter, the Director submit to Congress a report on the incidence among inmates of diseases transmitted through sexual activity and intravenous drug use.

(B) MATTERS PERTAINING TO VARIOUS DISEASES.—Each report under subparagraph (A) shall discuss—

(i) the incidence among inmates of HIV, hepatitis, and other diseases transmitted through sexual activity and intravenous drug use; and

(ii) updates on the testing, treatment, and prevention education programs for these diseases conducted by the Bureau of Prisons.

(C) MATTERS PERTAINING TO HIV ONLY.—Each report under subparagraph (A) shall also include—

(i) the number of inmates who tested positive for HIV upon intake;

(ii) the number of inmates who tested positive for HIV prior to reentry;

(iii) the number of inmates who were not tested for HIV prior to reentry because they were released without sufficient notice;

(iv) the number of inmates who opted-out of taking an HIV test;

(v) the number of inmates who were tested under section 4014(b) of title 18, United States Code; and

(vi) the number of inmates under treatment for HIV.

(D) CONSULTATION.—The Director shall consult with appropriate officials of the Department of Health and Human Services, the Office

of National Drug Control Policy, the Office of National AIDS Policy, and the Centers for Disease Control and Prevention regarding the development of each report under subparagraph (A).

SEC. 7219. TRANSFER OF FUNDS FOR IMPLEMENTATION OF ENDING THE HIV EPIDEMIC: A PLAN FOR AMERICA.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by inserting after section 241 (42 U.S.C. 238j) the following:

"SEC. 241A. TRANSFER OF FUNDS FOR IMPLEMENTATION OF NATIONAL HIV/AIDS STRATEGY.

''(a) TRANSFER AUTHORIZATION.—Of the discretionary appropriations made available to the Department of Health and Human Services for any fiscal year for programs and activities that, as determined by the Secretary, pertain to HIV, the Secretary may transfer up to 1 percent of such appropriations to the Office of the Assistant Secretary for Health for implementation of the Ending the HIV Epidemic: A Plan for America.

''(b) CONGRESSIONAL NOTIFICATION.—Not less than 30 days before making any transfer under this section, the Secretary shall give notice of the transfer to the Congress.

''(c) DEFINITIONS.—In this section, the term 'Ending the HIV Epidemic: A Plan for America' means the initiative of the Department of Health and Human Services that seeks to reduce the number of new HIV infections in the United States by 75 percent by 2025, and then by at least 90 percent by 2030, for an estimated 250,000 total HIV infections averted.''.

SEC. 7220. PREP ACCESS AND COVERAGE.

(a) COVERAGE OF HIV TESTING AND PREVENTION SERVICES.—

(1) PRIVATE INSURANCE.—

(A) IN GENERAL.—Section 2713(a) of the Public Health Service Act (42 U.S.C. 300gg–13(a)) is amended—

(i) in paragraph (2), by striking ''; and'' and inserting a semicolon;

(ii) in paragraph (3), by striking the period and inserting a semicolon;

(iii) in paragraph (4), by striking the period and inserting a semicolon;

(iv) in paragraph (5), by striking the period and inserting ''; and''; and

(v) by adding at the end the following:

''(6) any prescription drug approved by the Food and Drug Administration for the prevention of

HIV (other than a drug subject to preauthorization requirements consistent with section 2729A), administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.''.

(B) PROHIBITION ON PREAUTHORIZATION REQUIREMENTS.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.), as amended by section 7602(d), is amended by adding at the end the following:

''SEC. 2729A. PROHIBITION ON PREAUTHORIZATION REQUIREMENTS WITH RESPECT TO CERTAIN SERVICES.

''A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not impose any preauthorization requirements with respect to coverage of the services described in section 2713(a)(1)(E), except that a plan or issuer may impose preauthorization requirements with respect to coverage of a particular drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act or section 351(a)

of this Act if such plan or issuer provides coverage without any preauthorization requirements for a drug that is therapeutically equivalent.''.

(2) COVERAGE UNDER FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—Section 8904 of title 5, United States Code, is amended by adding at the end the following:

''(c) Any health benefits plan offered under this chapter shall include benefits for, and may not impose any cost sharing requirements for, any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.''.

(3) MEDICAID.—

(A) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as previously amended by this Act, is amended—

(i) in subsection (a)(4)—

(I) by striking ''; and (D)'' and inserting ''; (D)'';

(II) by striking ''; and (E)'' and inserting ''; (E)'';

(III) by striking ''; and (F)'' and inserting ''; (F)''; and

(IV) by striking the semicolon at the end and inserting ''; and (G) HIV prevention services;''; and

(ii) by adding at the end the following new subsection:

''(pp) HIV PREVENTION SERVICES.—For purposes of subsection (a)(4)(G), the term 'HIV prevention services' means prescription drugs for the prevention of HIV acquisition, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.''.

(B) NO COST-SHARING.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(i) in section 1916, by inserting ''HIV prevention services described in section 1905(a)(4)(G),'' after ''section 1905(a)(4)(C),'' each place it appears; and

(ii) in section 1916A(b)(3)(B), by adding at the end the following new clause:

''(xii) HIV prevention services described in section 1905(a)(4)(G).''.

(C) INCLUSION IN BENCHMARK COVERAGE.—Section 1937(b)(7) of the Social Security Act (42 U.S.C. 1396u–7(b)(7)) is amended—

(i) in the paragraph header, by inserting ''AND HIV PREVENTION SERVICES'' after ''SUPPLIES''; and

(ii) by striking ''includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section'' and inserting ''includes medical assistance for HIV prevention services described in section 1905(a)(4)(G), and includes, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section''.

(4) CHIP.—

(A) IN GENERAL.—Section 2103 of the Social Security Act (42 U.S.C. 1397cc), as amended by section 2007(d)(5), is amended—

(i) in subsection (a), by striking ''and (12)'' and inserting ''(12), and (13)''; and

(ii) in subsection (c), by adding at the end the following new paragraph:

''(13) HIV PREVENTION SERVICES.—Regardless of the type of coverage elected by a State under subsection (a), the child health assistance provided for a targeted low-income child, and, in the case of a State that elects to provide pregnancy-related assistance pursuant to section 2112, the pregnancy-related assistance provided for a targeted low-income pregnant woman (as such terms are defined for purposes of such section), shall include coverage of HIV prevention services (as defined in section 1905(jj)).''.

(B) NO COST-SHARING.—Section 2103(e)(2) of the Social Security Act (42 U.S.C. 1397cc(e)(2)) is amended by inserting ''HIV prevention services described in subsection (c)(13),'' before ''or for pregnancy-related assistance''.

(C) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by paragraph (3) and this paragraph shall take effect on January 1, 2023.

(ii) DELAY PERMITTED IF STATE LEGISLATION REQUIRED.—In the case of a State plan approved under title XIX or XXI of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of the failure of the plan to meet such additional requirements before the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State legislature that ends after the 1-year period beginning with the date of the enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the

session is deemed to be a separate regular session of the State legislature.

(5) COVERAGE AND ELIMINATION OF COST-SHARING UNDER MEDICARE.—

(A) COVERAGE OF HIV PREVENTION SERVICES UNDER PART B.—

(i) COVERAGE.—

(I) 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) and 6011(a)(1), is amended—

(aa) in subparagraph (II), by striking ''and'' at the end;

(bb) in subparagraph (JJ), by striking the period at the end and inserting ''; and''; and

(cc) by adding at the end the following new subparagraph:

''(KK) HIV prevention services (as defined in subsection (ppp));''.

(II) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 2007(b), 4221(a), 4251(c)(2), and

6011(a)(2), is amended by adding at the end the following new subsection:

''(ppp) HIV PREVENTION SERVICES.—The term 'HIV prevention services' means—

''(1) drugs or biologicals approved by the Food and Drug Administration for the prevention of HIV;

''(2) administrative fees for such drugs;

''(3) laboratory and other diagnostic procedures associated with the use of such drugs; and

''(4) clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.''.

(ii) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by sections 4251(c)(3) and 6011(a)(4), is amended—

(I) by striking ''and'' and before ''(FF)''; and

(II) by inserting before the semicolon at the end the following: ''and (GG) with respect to HIV prevention services (as defined in section 1861(ppp)), the amount paid shall be

100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the service or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are covered OPD services (as defined in subsection (t)(1)(B)), the amount determined under subsection (t)''.

(iii) EXEMPTION FROM PART B DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(I) in paragraph (11), by striking ''and'' at the end; and

(II) in paragraph (12), by striking the period at the end and inserting '', and (13) such deductible shall not apply with respect to HIV prevention services (as defined in section 1861(lll).''.

(iv) EFFECTIVE DATE.—The amendments made by this subparagraph shall

apply to items and services furnished on or after January 1, 2023.

(B) ELIMINATION OF COST-SHARING FOR DRUGS FOR THE PREVENTION OF HIV UNDER PART D.—

(i) IN GENERAL.—Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(I) in paragraph (1)(A), in the matter preceding clause (i), by striking ''The coverage'' and inserting ''Subject to paragraph (8), the coverage'';

(II) in paragraph (2)—

(aa) in subparagraph (A), in the matter preceding clause (i), by striking ''and (D)'' and inserting ''and (D) and paragraph (8)'';

(bb) in subparagraph (C)(i), in the matter preceding subclause (I), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (8)''; and

(cc) in subparagraph (D)(i), in the matter preceding subclause (I), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (8)'';

(III) in paragraph (3)(A), in the matter preceding clause (i), by striking ''and (4)'' and inserting ''(4), and (8)'';

(IV) in paragraph (4)(A)(i), in the matter preceding subclause (I), by striking ''The coverage'' and inserting ''Subject to paragraph (8), the coverage''; and

(V) by adding at the end the following new paragraph:

''(8) ELIMINATION OF COST-SHARING FOR DRUGS FOR THE PREVENTION OF HIV.—

''(A) IN GENERAL.—For plan year 2023 and each subsequent plan year, there shall be no cost-sharing under this part (including under section 1814D–14) for covered part D 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

''Subject to section 1860D–2(b)(8), in the case''; and

(II) in paragraph (2), in the matter preceding subparagraph (A), by striking ''In the case'' and inserting ''Subject to section 1860D–2(b)(8), in the case''.

(6) COVERAGE OF HIV PREVENTION TREATMENT BY DEPARTMENT OF VETERANS AFFAIRS.—

(A) ELIMINATION OF MEDICATION COPAYMENTS.—Section 1722A(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

''(5) Paragraph (1) does not apply to a medication for the prevention of HIV.''.

(B) ELIMINATION OF HOSPITAL CARE AND MEDICAL SERVICES COPAYMENTS.—Section 1710 of such title is amended—

(i) in subsection (f)—

(I) by redesignating paragraph (5) as paragraph (6); and

(II) by inserting after paragraph (4) the following new paragraph (5):

''(5) A veteran shall not be liable to the United States under this subsection for any amounts for laboratory and

other diagnostic procedures associated with the use of any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, or for laboratory or other diagnostic procedures associated with the use of such drugs, or clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.''; and

(ii) in subsection (g)(3), by adding at the end the following new subparagraph:

''(C) Any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.''.

(C) INCLUSION AS PREVENTIVE HEALTH SERVICE.—Section 1701(9) of such title is amended—

(i) in subparagraph (K), by striking ''; and'' and inserting a semicolon;

(ii) by redesignating subparagraph (L) as subparagraph (M); and

(iii) by inserting after subparagraph (K) the following new subparagraph (L):

''(L) any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation; and''.

(7) COVERAGE OF HIV PREVENTION TREATMENT BY DEPARTMENT OF DEFENSE.—

(A) IN GENERAL.—Chapter 55 of title 10, United States Code, is amended by inserting after section 1079c the following new section:

''§ 1079d. Coverage of HIV prevention treatment

''(a) IN GENERAL.—The Secretary of Defense shall ensure coverage under the TRICARE program of HIV prevention treatment described in subsection (b) for any beneficiary under section 1074(a) of this title.

''(b) HIV PREVENTION TREATMENT DESCRIBED.—HIV prevention treatment described in this subsection in-

cludes any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation.

''(c) NO COST-SHARING.—Notwithstanding section 1075, 1075a, or 1074g(a)(6) of this title or any other provision of law, there is no cost-sharing requirement for HIV prevention treatment covered under this section.''.

(B) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1079c the following new item:

''1079d. Coverage of HIV prevention treatment.''.

(8) INDIAN HEALTH SERVICE TESTING, MONITORING, AND PRESCRIPTION DRUGS FOR THE PREVENTION OF HIV.—Title II of the Indian Health Care Improvement Act is amended by inserting after section 223 (25 U.S.C. 1621v) the following:

''SEC. 224. TESTING, MONITORING, AND PRESCRIPTION DRUGS FOR THE PREVENTION OF HIV.

''(a) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, shall provide, without limitation, funding for any prescription

drug approved by the Food and Drug Administration for the prevention of human immunodeficiency virus (commonly known as 'HIV'), administrative fees for that drug, laboratory and other diagnostic procedures associated with the use of that drug, and clinical follow-up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.''.

(9) EFFECTIVE DATE.—The amendments made by paragraphs (1), (2), (5), (6), (7), and (8) shall take effect with respect to plan years beginning on or after January 1, 2023.

(b) PROHIBITION ON DENIAL OF COVERAGE OR INCREASE IN PREMIUMS OF LIFE, DISABILITY, OR LONG-TERM CARE INSURANCE FOR INDIVIDUALS TAKING MEDICATION FOR THE PREVENTION OF HIV ACQUISITION.—

(1) PROHIBITION.—Notwithstanding any other provision of law, it shall be unlawful to—

(A) decline or limit coverage of a person under any life insurance policy, disability insurance policy, or long-term care insurance policy, on account of the individual taking medication

for the purpose of preventing the acquisition of HIV;

(B) preclude an individual from taking medication for the purpose of preventing the acquisition of HIV as a condition of receiving a life insurance policy, disability insurance policy, or long-term care insurance policy;

(C) consider whether an individual is taking medication for the purpose of preventing the acquisition of HIV in determining the premium rate for coverage of such individual under a life insurance policy, disability insurance policy, or long-term care insurance policy; or

(D) otherwise discriminate in the offering, issuance, cancellation, amount of such coverage, price, or any other condition of a life insurance policy, disability insurance policy, or long-term care insurance policy for an individual, based solely and without any additional actuarial risks upon whether the individual is taking medication for the purpose of preventing the acquisition of HIV.

(2) ENFORCEMENT.—A State insurance regulator may take such actions to enforce paragraph (1)

as are specifically authorized under the laws of such State.

(3) DEFINITIONS.—In this subsection:

(A) DISABILITY INSURANCE POLICY.—The term ''disability insurance policy'' means a contract under which an entity promises to pay a person a sum of money in the event that an illness or injury resulting in a disability prevents such person from working.

(B) LIFE INSURANCE POLICY.—The term ''life insurance policy'' means a contract under which an entity promises to pay a designated beneficiary a sum of money upon the death of the insured.

(C) LONG-TERM CARE INSURANCE POLICY.—The term ''long-term care insurance policy'' means a contract for which the only insurance protection provided under the contract is coverage of qualified long-term care services (as defined in section 7702B(c) of the Internal Revenue Code of 1986).

(c) PATIENT CONFIDENTIALITY.—The Secretary of Health and Human Services shall amend the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C.

1320d–2 note), as necessary, to ensure that individuals are able to access the benefits described in section 2713(a)(1)(E) of the Public Health Service Act (as amended by section 7602(d)) under a family plan without any other individual enrolled in such family plan, including a primary subscriber or policyholder of such plan, being informed of such use of such benefits.

(d) PRE-EXPOSURE PROPHYLAXIS AND POST-EXPOSURE PROPHYLAXIS FUNDING.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 7153, is further amended by adding at the end the following:

"SEC. 399V–10. PRE-EXPOSURE PROPHYLAXIS AND POST-EXPOSURE PROPHYLAXIS FUNDING.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary shall establish a program that awards grants to States, territories, Indian Tribes, and directly eligible entities for the establishment and support of pre-exposure prophylaxis (referred to in this section as 'PrEP') and post-exposure prophylaxis (referred to in this section as 'PEP') HIV programs.

"(b) APPLICATIONS.—To be eligible to receive a grant under subsection (a), a State, territory, Indian Tribe, or directly eligible entity shall—

''(1) submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan describing how any funds awarded will be used to increase access to PrEP for uninsured and underinsured individuals and reduce disparities in access to PrEP and PEP for uninsured and underinsured individuals and reduce disparities in access to PrEP and PEP; and

''(2) appoint a PrEP and PEP grant administrator to manage the program.

''(c) DIRECTLY ELIGIBLE ENTITY.—For purposes of this section, the term 'directly eligible entity'—

''(1) means a Federally qualified health center or other nonprofit entity engaged in providing PrEP and PEP information and services; and

''(2) may include—

''(A) a Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)));

''(B) a family planning grantee (other than States) funded under section 1001 of the Public Health Service Act (42 U.S.C. 300);

"(C) a rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)));

"(D) a health facility operated by or pursuant to a contract with the Indian Health Service;

"(E) a community-based organization, clinic, hospital, or other health facility that provides services to individuals at risk for or living with HIV; and

"(F) a nonprofit private entity providing comprehensive primary care to populations at risk of HIV, including faith-based and community-based organizations.

"(d) AWARDS.—In determining whether to award a grant, and the grant amount for each grant awarded, the Secretary shall consider the grant application and the need for PrEP and PEP services in the area, the number of uninsured and underinsured individuals in the area, and how the State, territory, or Indian Tribe coordinates PrEP and PEP activities with the directly funded entity, if the State, territory, or Indian Tribe applies for the funds.

"(e) USE OF FUNDS.—

''(1) IN GENERAL.—Any State, territory, Indian Tribe, or directly eligible entity that is awarded funds under subsection (a) shall use such funds for eligible PrEP and PEP expenses.

''(2) ELIGIBLE PREP EXPENSES.—The Secretary shall publish a list of expenses that qualify as eligible PrEP and PEP expenses for purposes of this section, which shall include—

''(A) any prescription drug approved by the Food and Drug Administration for the prevention of HIV, administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation;

''(B) outreach and public education activities directed toward populations overrepresented in the domestic HIV epidemic that increase awareness about the existence of PrEP and PEP, provide education about access to and health care coverage of PrEP and PEP, PrEP and PEP adherence programs, and counter

stigma associated with the use of PrEP and PEP; and

''(C) outreach activities directed toward physicians and other providers that provide education about PrEP and PEP.

''(f) REPORT TO CONGRESS.—The Secretary shall, in each of the first 5 years beginning one year after the date of the enactment of this section, submit to Congress, and make public on the internet website of the Department of Health and Human Services, a report on the impact of any grants provided to States, territories, and Indian Tribes and directly eligible entities for the establishment and support of pre-exposure prophylaxis programs under this section.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2023 through 2028.''.

(e) CLARIFICATION.—This section, including the amendments made by this section, shall apply notwithstanding any other provision of law, including Public Law 103–141.

(f) PRIVATE RIGHT OF ACTION.—Any person aggrieved by a violation of this section, including the amendments made by this section, may commence a civil action

in an appropriate United States District Court or other court of competent jurisdiction to obtain relief as allowed by law as either an individual or member of a class. If the plaintiff is the prevailing party in such an action, the court shall order the defendant to pay the costs and reasonable attorney fees of the plaintiff.

Subtitle F—Diabetes

SEC. 7251. RESEARCH, TREATMENT, AND EDUCATION.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by adding at the end the following new section:

"SEC. 434B. DIABETES IN MINORITY POPULATIONS.

''(a) IN GENERAL.—The Director of NIH shall expand, intensify, and support ongoing research and other activities with respect to prediabetes and diabetes, particularly type 2, in minority populations.

''(b) RESEARCH.—

''(1) DESCRIPTION.—Research under subsection (a) shall include investigation into—

''(A) the causes of diabetes, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to increased rates of diabetes in minority populations; and

"(B) the causes of increased incidence of diabetes complications in minority populations, and possible interventions to decrease such incidence.

"(2) INCLUSION OF MINORITY PARTICIPANTS.—In conducting and supporting research described in subsection (a), the Director of NIH shall seek to include minority participants as study subjects in clinical trials.

"(c) REPORT; COMPREHENSIVE PLAN.—

"(1) IN GENERAL.—The Diabetes Mellitus Interagency Coordinating Committee shall—

"(A) prepare and submit to the Congress, not later than 6 months after the date of enactment of this section, a report on Federal research and public health activities with respect to prediabetes and diabetes in minority populations; and

"(B) develop and submit to Congress, not later than 1 year after the date of enactment of this section, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to address prediabetes and diabetes in minority populations.

''(2) CONTENTS.—The report under paragraph (1)(A) shall at minimum address each of the following:

''(A) Research on diabetes and prediabetes in minority populations, including such research on—

''(i) genetic, behavioral, socio-economic, and environmental factors;

''(ii) prevention of diabetes within these populations and who have individuals at increased risk of developing diabetes;

''(iii) prevention of complications among individuals in these populations who have already developed diabetes; and

''(iv) barriers to health care access and diabetes treatment within populations at increased risk of developing diabetes.

''(B) Surveillance and data collection on diabetes and prediabetes in minority populations, including with respect to—

''(i) efforts to better determine the prevalence of diabetes among Asian-American and Pacific Islander subgroups; and

''(ii) efforts to coordinate data collection on the American Indian population.

"(C) Community-based interventions to address diabetes and prediabetes targeting minority populations, including—

"(i) the evidence base for such interventions;

"(ii) the cultural appropriateness of such interventions; and

"(iii) efforts to educate the public on the causes and consequences of diabetes.

"(D) Education and training programs for health professionals (including community health workers) on the prevention and management of diabetes and its related complications that is supported by the Health Resources and Services Administration, including such programs supported by—

"(i) the National Health Service Corps; or

"(ii) the community health centers program under section 330.

"(d) EDUCATION.—The Director of NIH shall—

"(1) through the National Institute on Minority Health and Health Disparities and the National Diabetes Education Program—

''(A) make grants to programs funded under section 464z–4 for the purpose of establishing a medical education program for health care professionals to be more involved in weight counseling, obesity research, nutrition, and shared decision-making; and

''(B) provide for the participation of minority health professionals in diabetes-focused research programs; and

''(2) make grants to programs that establish a professional pipeline that will increase the participation of minority individuals in diabetes-focused health fields by expanding Minority Access to Research Careers program internships and mentoring opportunities for the purposes of recruitment.

''(e) DEFINITIONS.—For purposes of this section:

''(1) DIABETES MELLITUS INTERAGENCY COORDINATING COMMITTEE.—The 'Diabetes Mellitus Interagency Coordinating Committee' means the Diabetes Mellitus Interagency Coordinating Committee established under section 429.

''(2) MINORITY POPULATION.—The term 'minority population' means a racial and ethnic minority group, as defined in section 1707.''.

SEC. 7252. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.), as amended by section 7101, is further amended by inserting after section 317W the following section:

"SEC. 317X. DIABETES IN MINORITY POPULATIONS.

"(a) RESEARCH AND OTHER ACTIVITIES.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct and support research and public health activities with respect to diabetes in minority populations.

"(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) regarding diabetes in minority populations shall include the following:

"(A) Further enhancing the National Health and Nutrition Examination Survey by oversampling Asian Americans, Native Hawaiians, and Pacific Islanders in appropriate geographic areas to better determine the prevalence of diabetes in such populations as well as to improve the data collection of diabetes penetration disaggregated into major ethnic groups within such populations. The Secretary shall ensure that any such oversampling does not re-

duce the oversampling of other minority populations including African-American and Latino populations.

''(B) Through the Division of Diabetes Translation—

''(i) providing for prevention research to better understand how to influence health care systems changes to improve quality of care being delivered to such populations;

''(ii) carrying out model demonstration projects to design, implement, and evaluate effective diabetes prevention and control interventions for minority populations, including culturally appropriate community-based interventions;

''(iii) developing and implementing a strategic plan to reduce diabetes in minority populations through applied research to reduce disparities and culturally and linguistically appropriate community-based interventions;

''(iv) supporting, through the national diabetes prevention program under section 399V–3, diabetes prevention program sites

in underserved regions highly impacted by diabetes; and

''(v) implementing, through the national diabetes prevention program under section 399V–3, a demonstration program developing new metrics measuring health outcomes related to diabetes that can be stratified by specific minority populations.

''(b) EDUCATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall direct the Division of Diabetes Translation to conduct and support both programs to educate the public on diabetes in minority populations and programs to educate minority populations about the causes and effects of diabetes.

''(c) DIABETES; HEALTH PROMOTION, PREVENTION INITIATIVES, AND ACCESS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and the National Diabetes Education Program, shall conduct and support programs to educate specific minority populations through culturally appropriate and linguistically appropriate information campaigns and initiatives about prevention of, and managing, diabetes.

''(d) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707.''.

SEC. 7253. PROGRAMS TO EDUCATE HEALTH PROVIDERS ON THE CAUSES AND EFFECTS OF DIABETES IN MINORITY POPULATIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 7220, is further amended by adding at the end the following new section:

''SEC. 399V–11. PROGRAMS TO EDUCATE HEALTH PROVIDERS ON THE CAUSES AND EFFECTS OF DIABETES IN MINORITY POPULATIONS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct and support programs described in subsection (b) to educate health professionals on the causes and effects of diabetes in minority populations.

''(b) PROGRAMS.—Programs described in this subsection, with respect to education on diabetes in minority populations, shall include the following:

''(1) Giving priority, under the primary care training and enhancement program under section 747—

"(A) to awarding grants to focus on or address diabetes; and

"(B) to adding minority populations to the list of vulnerable populations that should be served by such grants.

"(2) Providing additional funds for the Health Careers Opportunity Program, the Centers of Excellence, and the Minority Faculty Fellowship Program to partner with the Office of Minority Health under section 1707 and the National Institutes of Health to strengthen programs for career opportunities focused on diabetes treatment and care within underserved regions highly impacted by diabetes.

"(3) Developing a diabetes focus within, and providing additional funds for, the National Health Service Corps scholarship program—

"(A) to place individuals in areas that are disproportionately affected by diabetes and to provide diabetes treatment and care in such areas; and

"(B) to provide such individuals continuing medical education specific to diabetes care.".

SEC. 7254. RESEARCH, EDUCATION, AND OTHER ACTIVITIES REGARDING DIABETES IN AMERICAN INDIAN POPULATIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 7253, is further amended by adding at the end the following section:

''SEC. 399V–12. RESEARCH, EDUCATION, AND OTHER ACTIVITIES REGARDING DIABETES IN AMERICAN INDIAN POPULATIONS.

''In addition to activities under sections 317X, 399V–11, and 434B, the Secretary, acting through the Indian Health Service and in collaboration with other appropriate Federal agencies, shall—

''(1) conduct and support research and other activities with respect to diabetes; and

''(2) coordinate the collection of data on clinically and culturally appropriate diabetes treatment, care, prevention, and services by health care professionals to the American Indian population.''.

SEC. 7255. UPDATED REPORT ON HEALTH DISPARITIES.

The Secretary of Health and Human Services shall seek to enter into an arrangement with the National Academy of Medicine under which the National Academy will—

(1) not later than 1 year after the date of enactment of this Act, submit to Congress an updated

version of the 2003 report entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care''; and

(2) in such updated version, address how racial and ethnic health disparities have changed since the publication of the original report.

Subtitle G—Lung Disease

SEC. 7301. NATIONAL ASTHMA BURDEN.

Congress finds as follows:

(1) The prevalence of asthma has increased since 1980 and affects more than 26,000,000 people in the United States.

(2) Significant disparities in asthma morbidity and mortality exist for both adults and children particularly for low-income and minority populations, particularly African Americans and Puerto Ricans.

(3) African-American children are twice as likely to have asthma as White children.

(4) In 2016, almost 4,500,000 non-Hispanic African Americans reported having asthma. African Americans with asthma are 3 times as likely to visit the emergency department and twice as likely to get hospitalized as White patients with asthma.

(5) Puerto Ricans are 3.4 times as likely to die from asthma compared with all other Hispanic or

Latino groups. Overall Hispanic Americans are 30 percent more likely to be hospitalized for asthma than non-Hispanic Whites.

(6) The majority of adults with asthma are women.

SEC. 7302. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317I of the Public Health Service Act (42 U.S.C. 247b–10) is amended to read as follows:

"SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

''(a) PROGRAM FOR PROVIDING INFORMATION AND EDUCATION TO THE PUBLIC.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with State and local health departments to conduct activities, including the provision of information and education to the public regarding asthma including—

''(1) deterring the harmful consequences of uncontrolled asthma; and

''(2) disseminating health education and information regarding prevention of asthma episodes and strategies for managing asthma.

''(b) DEVELOPMENT OF STATE ASTHMA PLANS.—The Secretary, acting through the Director of the Centers

for Disease Control and Prevention, shall collaborate with State and local health departments to develop State plans incorporating public health responses to reduce the burden of asthma, particularly regarding disproportionately affected populations.

''(c) COMPILATION OF DATA.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, in cooperation with State and local public health officials—

''(1) conduct asthma surveillance activities to collect data on the prevalence and severity of asthma, the effectiveness of public health asthma interventions, and the quality of asthma management, including—

''(A) collection of data among people with asthma to monitor the impact on health and quality of life;

''(B) surveillance of health care facilities; and

''(C) collection of data not containing individually identifiable information from electronic health records or other electronic communications;

''(2) compile and annually publish data regarding the prevalence and incidence of childhood asth-

ma, the child mortality rate, and the number of hospital admissions and emergency department visits by children associated with asthma nationally and in each State and at the county level by age, sex, race, and ethnicity, as well as lifetime and current prevalence; and

''(3) compile and annually publish data regarding the prevalence and incidence of adult asthma, the adult mortality rate, and the number of hospital admissions and emergency department visits by adults associated with asthma nationally and in each State and at the county level by age, sex, race, ethnicity, industry, and occupation, as well as lifetime and current prevalence.

''(d) COORDINATION OF DATA COLLECTION.—The Director of the Centers for Disease Control and Prevention, in conjunction with State and local health departments, shall coordinate data collection activities under paragraphs (2) and (3) of subsection (c) so as to maximize comparability of results.

''(e) COLLABORATION.—

''(1) IN GENERAL.—The Centers for Disease Control and Prevention may collaborate with national, State, and local nonprofit organizations to

provide information and education about asthma, and to strengthen such collaborations when possible.

''(2) SPECIFIC ACTIVITIES.—The Director of the Centers for Disease Control and Prevention, acting through the Division of Population Health of the Centers, may expand activities relating to asthma with non-Federal partners, especially State-level entities.

''(f) REPORTS TO CONGRESS.—

''(1) IN GENERAL.—Not later than 3 years after the date of the enactment of the Health Equity and Accountability Act of 2022, and once 2 years thereafter, the Secretary shall, in consultation with patient groups, nonprofit organizations, medical societies, and other relevant governmental and nongovernmental entities, submit to Congress a report that—

''(A) catalogs, with respect to asthma prevention, management, and surveillance—

''(i) the activities of the Federal Government, including an assessment of the progress of the Federal Government and States, with respect to achieving the goals of the Healthy People 2030 initiative; and

"(ii) the activities of other entities that participate in the program under this section, including nonprofit organizations, patient advocacy groups, and medical societies; and

"(B) makes recommendations for the future direction of asthma activities, in consultation with researchers from the National Institutes of Health and other member bodies of the Asthma Disparities Subcommittee, including—

"(i) a description of how the Federal Government may improve its response to asthma, including identifying any barriers that may exist;

"(ii) a description of how the Federal Government may continue, expand, and improve its private-public partnerships with respect to asthma including identifying any barriers that may exist;

"(iii) identification of steps that may be taken to reduce the—

"(I) morbidity, mortality, and overall prevalence of asthma;

"(II) financial burden of asthma on society;

"(III) burden of asthma on disproportionately affected areas, particularly those in medically underserved populations (as defined in section 330(b)(3)); and

"(IV) burden of asthma as a chronic disease that can be worsened by environmental exposures;

"(iv) the identification of programs and policies that have achieved the steps described under clause (iii), and steps that may be taken to expand such programs and policies to benefit larger populations; and

"(v) recommendations for future research and interventions.

"(2) SUBSEQUENT REPORTS.—

"(A) CONGRESSIONAL REQUEST.—During the 5-year period following the submission of the second report under paragraph (1), the Secretary shall submit updates and revisions of the report upon the request of the Congress.

"(B) FIVE-YEAR REEVALUATION.—At the end of the 5-year period referred to in subparagraph (A), the Secretary shall—

"(i) evaluate the analyses and recommendations made in previous reports; and

"(ii) determine whether an additional report is needed and if so submit such an updated report to the Congress, including appropriate recommendations.

"(g) AUTHORIZATION OF APPROPRIATIONS FUNDING.—In addition to any other authorization of appropriations that is available to the Centers for Disease Control and Prevention for the purpose of carrying out this section, there is authorized to be appropriated to such Centers $65,000,000 for the period of fiscal years 2023 through 2027 for the purpose of carrying out this section.".

SEC. 7303. INFLUENZA AND PNEUMONIA VACCINATION CAMPAIGN.

(a) IN GENERAL.—The Secretary of Health and Human Services shall—

(1) enhance the annual campaign by the Department of Health and Human Services to increase the number of people vaccinated each year for influenza and pneumonia; and

(2) include in such campaign the use of written educational materials, public service announcements,

physician education, and any other means which the Secretary deems effective.

(b) MATERIALS AND ANNOUNCEMENTS.—In carrying out the annual campaign described in subsection (a), the Secretary of Health and Human Services shall ensure that—

(1) educational materials and public service announcements are readily and widely available in communities experiencing disparities in the incidence and mortality rates of influenza and pneumonia; and

(2) the campaign uses targeted, culturally appropriate messages and messengers to reach underserved communities.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

SEC. 7304. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.

(a) FINDINGS.—Congress finds as follows:

(1) Chronic obstructive pulmonary disease (referred to in this subsection as ''COPD'') refers to chronic bronchitis and emphysema, incurable diseases that make it difficult to exhale all the air from one's lungs, and that can cause persistent coughing, shortness of breath, and sputum.

(2) COPD exacerbations—episodes of acute difficulty breathing and moderate to severe fatigue—are dangerous, and their treatment often requires hospitalization.

(3) While smoking is the primary risk factor for COPD, other risk factors include air pollution, occupational exposures, heredity, a history of childhood respiratory infections, and socioeconomic status.

(4) It is estimated that over 16,000,000 adults in the United States have COPD.

(5) COPD is a leading cause of death in the United States, claiming over 156,000 lives in 2019.

(6) Since 2000, deaths for women with COPD have exceeded deaths in men.

(7) Although African Americans have a lower prevalence of COPD in the United States, researchers have shown that African Americans may be underdiagnosed. Furthermore, research has shown that African Americans develop COPD with less cumulative smoke exposure and at a younger age.

(b) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies, prevention, diagnosis, surveillance, and public and professional awareness activities regarding chronic obstructive pulmonary disease.

(c) CHRONIC DISEASE PREVENTION PROGRAMS.—The Director of the National Heart, Lung, and Blood Institute shall carry out the following:

(1) Conduct public education and awareness activities with patient and professional organizations to stimulate earlier diagnosis and improve patient outcomes from treatment of chronic obstructive pulmonary disease. To the extent known and relevant, such public education and awareness activities shall reflect differences in chronic obstructive pulmonary disease by cause (tobacco, environmental, occupational, biological, and genetic) and include a focus on outreach to undiagnosed and, as appropriate, minority populations.

(2) Supplement and expand upon the activities of the National Heart, Lung, and Blood Institute by making grants to nonprofit organizations, State and local jurisdictions, and Indian Tribes for the purpose of reducing the burden of chronic obstructive pulmonary disease, especially in disproportionately impacted communities, through public health interventions and related activities.

(3) Coordinate with the Centers for Disease Control and Prevention, the Indian Health Service, the Health Resources and Services Administration,

and the Department of Veterans Affairs to develop pilot programs to demonstrate best practices for the diagnosis and management of chronic obstructive pulmonary disease.

(4) Develop improved techniques and identify best practices, in coordination with the Secretary of Veterans Affairs, for assisting chronic obstructive pulmonary disease patients to successfully stop smoking, including identification of subpopulations with different needs. Initiatives under this paragraph may include research to determine whether successful smoking cessation strategies are different for chronic obstructive pulmonary disease patients compared to such strategies for patients with other chronic diseases.

(d) ENVIRONMENTAL AND OCCUPATIONAL HEALTH PROGRAMS.—The Director of the Centers for Disease Control and Prevention shall—

(1) support research into the environmental and occupational causes and biological mechanisms that contribute to chronic obstructive pulmonary disease; and

(2) develop and disseminate public health interventions that will lessen the impact of environmental

and occupational causes of chronic obstructive pulmonary disease.

(e) DATA COLLECTION.—Not later than 180 days after the date of enactment of this Act, the Director of the National Heart, Lung, and Blood Institute and the Director of the Centers for Disease Control and Prevention, acting jointly, shall assess the depth and quality of information on chronic obstructive pulmonary disease that is collected in surveys and population studies conducted by the Centers for Disease Control and Prevention, including whether there are additional opportunities for information to be collected in the National Health and Nutrition Examination Survey, the National Health Interview Survey, and the Behavioral Risk Factors Surveillance System surveys.

(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.

Subtitle H—Tuberculosis

SEC. 7351. ELIMINATION OF ALL FORMS OF TUBERCULOSIS.

(a) SHORT TITLE.—This subtitle may be cited as the ''End Tuberculosis Act''.

(b) FINDINGS.—Congress makes the following findings:

(1) In the United States, 7,174 people were diagnosed with tuberculosis (referred to in this section as ''TB'') in 2020.

(2) Disparities in TB exist and significantly impact minority communities in the United States. The Centers for Disease Control and Prevention (referred to in this section as ''CDC'') finds that 89 percent of people diagnosed with TB disease in 2020 self-identified as racial and ethnic minorities.

(3) African Americans comprised 19.6 percent of people diagnosed with TB disease during 2020. The population-adjusted rate of TB among African Americans is 1.5 times higher than the national total, and 8.0 times higher than among Whites.

(4) Asian Americans, Native Hawaiians, and other Pacific Islanders comprised 37.4 percent of people diagnosed with TB disease during 2020. The population-adjusted rate of TB among Asian Americans is 6 times higher than the national total, and 33.25 times higher than among Whites. The population-adjusted rate of TB among Native Hawaiians and other Pacific Islanders is 8.5 times higher than the national total, and 46.75 times higher than among Whites.

(5) Hispanics and Latinos comprised 29.7 percent of people diagnosed with TB disease during 2020. The population-adjusted rate of TB among Hispanics and Latinos is 1.6 times higher than the national total, and 8.75 times higher than among Whites.

(6) TB is both preventable and curable, but the current rate of decline of TB in the United States remains too slow to achieve TB elimination in this century.

(7) TB is transmitted through the air when a person who has TB disease in their lungs coughs or sneezes. People who are in close proximity to the person with TB can breathe in the TB bacteria, and the bacteria will initially settle in their lungs. Living conditions related to poverty, such as crowded housing and poor ventilation, can greatly increase the risk of transmission. Without proper and timely diagnosis and access to treatment, the TB bacteria may grow and spread to other parts of their body.

(8) As many as 13,000,000 people in the United States may have latent TB infection (referred to in this section as ''LTBI''). People with LTBI have TB bacteria in their bodies, but their immune system is containing the bacteria, and they

are not sick, nor do they have any current risk of spreading TB to others. LTBI can activate into infectious, life-threatening TB if not treated. Modeling has shown that eliminating TB is not possible without addressing LTBI.

(9) Comorbidities associated with TB include cancer, diabetes mellitus, and HIV. People with these medical conditions and compromised immune systems are more likely to develop active TB disease and to have worse outcomes from TB. Many of the communities placed at highest risk of other adverse health outcomes and injustices are also disproportionately impacted by TB, and these include people experiencing homelessness and housing instability, people in congregate living and carceral settings, and people born outside of the United States.

(10) Forms of active TB that do not show drug resistance are classified as drug-susceptible TB (referred to in this section as ''DS–TB''). Drug-resistant TB (referred to in this section as ''DR–TB'') is a rising threat to the public health of the United States. DR–TB that exhibits resistance to two or more first-line drugs is referred to as multi-drug resistant TB (referred to in this section as ''MDR–TB''). MDR–TB that also is resistant to at least

one fluoroquinolone, and at least one additional group A second-line medicine is classified as extensively drug-resistant TB (referred to in this section as ''XDR–TB'').

(11) Approximately 56 people in the United States were diagnosed with MDR–TB in 2020. One person was diagnosed with XDR–TB in the same year.

(12) In the United States, $503,000,000 was spent in 2020 to treat TB; direct treatment costs average $20,211 to treat a patient with DS–TB, $182,186 to treat a patient with MDR–TB, and $567,708 to treat a patient with XDR–TB. When factoring in productivity losses during treatment, DS–TB averages $24,661, MDR–TB averages $347,324, and XDR–TB averages $729,039. Treatment is often difficult, with daily complex multi-pill regimens, with side-effects ranging from hearing and vision loss to mental health issues.

(13) Recognizing the public health, economic, and societal costs to the threat of MDR–TB, the National Action Plan to Combat MDR–TB was developed by the White House to provide the United States with a comprehensive three-pronged strategy to address MDR–TB by strengthening domestic ca-

pacity to combat MDR–TB; improve international capacity and cooperation to combat MDR–TB; and accelerate basic and applied research and development for new therapies, diagnostics, and prevention strategies to combat MDR–TB.

(14) Additional Federal support is necessary to expand TB control efforts in case finding and treatment to address LTBI in a national prevention initiative. Key policy and research breakthroughs increase the success of a TB prevention initiative: the U.S. Preventative Services Task Force recommendation's ''B'' rating, screening for LTBI among high-risk adults as a covered service increases the likelihood that impacted racial and ethnic minority groups can get tested for TB; a new, shorter course treatment regimen reduces the length of treatment for LTBI from every day for 6 to 9 months to one dose per week for 12 weeks, increasing the likelihood of treatment completion; and the use of blood-based diagnostic tests, Interferon-gamma release assays or IGRAs, increases the ability to detect LTBI among patients in affected communities.

(15) The right to health, and the right to science as a necessary human right to help achieve the right to health, is enshrined in Articles 25 and

27 of the Universal Declaration of Human Rights. These fundamental human rights cannot be achieved when anyone lacks access to TB prevention or treatment, and when the benefits of scientific innovation are not extended to people with all forms of TB.

SEC. 7352. ADDITIONAL FUNDING FOR STATES IN COMBATING AND ELIMINATING TUBERCULOSIS.

Section 317E(h) of the Public Health Act (42 U.S.C. 247b–6(h)) is amended by adding at the end the following:

''(3) ADDITIONAL FUNDING FOR STATES IN COMBATING AND ELIMINATING TUBERCULOSIS.—In addition to amounts otherwise authorized to be appropriated to carry out this section, there are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2023 through 2024.''.

SEC. 7353. STRENGTHENING CLINICAL RESEARCH FUNDING FOR TUBERCULOSIS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expand and intensify support for current and prospective research activities of the National Institutes of Health, the Biomedical Advanced Research and Development Authority, and the Centers for Disease Control and Prevention Division of Tuberculosis Elimination to develop new therapeutics, diagnostics, vaccines,

and other prevention modalities in addressing all forms of tuberculosis (referred to in this section as ''TB'').

(b) INCLUDED RESEARCH ACTIVITIES.—Research activities under subsection (a) shall include—

(1) research and development, and pathways to approval, for novel, safe drugs and drug regimens for the treatment of TB, including in adolescent and pediatric populations and in pregnant and lactating people;

(2) research to develop rapid diagnostic tests for all forms of TB, including diagnostics that can be used for pediatric populations and people living with HIV, diagnostics that can detect extra pulmonary TB and drug resistance, and diagnostics that can be used at the point of care;

(3) research to advance basic knowledge of the pathogenesis of TB and its major comorbidities, including HIV and diabetes mellitus;

(4) research to improve knowledge and understandings of the role of latency in TB and the factors that increase the risk of latent TB infection progressing to active, symptomatic TB disease;

(5) awarding grants and contracts to specifically develop new and needed vaccines to address TB;

(6) awarding grants and contracts to support the training and development of clinical researchers whose research improves the landscape of tools to combat TB; and

(7) awarding grants and contracts to support capacity-building and develop clinical trial site infrastructure in the United States and in TB endemic countries to support the aforementioned research activities.

Subtitle I—Osteoarthritis and Musculoskeletal Diseases

SEC. 7401. FINDINGS.

Congress finds as follows:

(1) Eighty percent of African-American women and nearly 74 percent of Hispanic men are either overweight or obese, speeding the onset and progression of knee arthritis.

(2) Arthritis affects 58,500,000 people in the United States, and that number will rise to 78,000,000 by the year 2040.

(3) 32,500,000 people in the United States suffer from osteoarthritis, the most common form of arthritis, making it the leading cause of disability in the United States. Osteoarthritis is sometimes referred to as degenerative joint disease.

(4) Obesity accelerates the onset of arthritis: 70 percent of obese adults with mild osteoarthritis of the knee at age 60 will develop advanced end-stage disease by age 80. In contrast, just 43 percent of non-obese adults will have end-stage disease over the same time period.

(5) Arthritis affects 1 in 4 people in the United States and is the single greatest cause of chronic pain and disability in the United States.

(6) Women, Black Americans, and Hispanics have more severe arthritis and functional limitations. These same individuals are more likely to be obese and diabetic, and have a higher incidence of heart diseases.

(7) Arthritis costs $304,000,000,000 a year, including $140,000,000,000 in direct costs (medical) and $164,000,000,000 in indirect costs (lost earnings).

(8) Obesity and other chronic health conditions exacerbate the debilitating impact of arthritis, leading to inactivity, loss of independence, and a perpetual cycle of comorbid chronic conditions.

(9) Sixty-one percent of arthritis sufferers are women, and women represent 64 percent of an estimated 43,000,000 annual visits to physicians' offices

and outpatient clinics where arthritis was the primary diagnosis. Women also represented 60 percent of approximately 1,000,000 hospitalizations that occurred in 2003 for which arthritis was the primary diagnosis.

(10) Women ages 65 and older have up to 2½ times more disabilities than men of the same age. Higher rates of obesity and arthritis among this group explained up to 48 percent of the gender gap in disability, above all other common chronic health conditions.

(11) The primary indication for total knee arthroplasty (referred to in this section as ''TKA''), also known as knee replacement, is relief of significant, disabling pain caused by severe arthritis.

(12) Knee replacement is surgery for people with severe knee damage. Knee replacement can relieve pain and allow an individual to be more active. The process for a total knee replacement involves the surgeon removing damaged cartilage and bone from the surface of the knee joint and replacing the cartilage and bone with a man-made surface of metal and plastic. In a partial knee replacement, the surgeon only replaces part of the knee joint.

(13) Total hip replacement, also called total hip arthroplasty (referred to in this section as ''THA''), is used if hip pain interferes with daily activities and more conservative treatments have not helped. Arthritis damage is the most common reason to need hip replacement.

(14) The odds of a family practice physician recommending TKA to a male patient with moderate arthritis are twice that of a female patient, while the odds of an orthopedic surgeon recommending TKA to a male patient with moderate arthritis are 22 times that of a female patient.

(15) Black Americans with doctor-diagnosed arthritis have a higher prevalence of severe pain attributable to arthritis, compared with White Americans (34.0 percent versus 22.6 percent). Black Americans, compared to White Americans, report a higher proportion of work limitations (39.5 percent versus 28.0 percent) and a higher prevalence of arthritis-attributable work limitation (6.6 percent versus 4.6 percent).

(16) Hispanics are 50 percent more likely than non-Hispanic Whites to report needing assistance with at least one instrumental activity of daily living and to have difficulty walking.

(17) Black Americans and Hispanics were 1.3 times more likely to have activity limitation, 1.6 times more likely to have work limitations, and 1.9 times more likely to have severe joint pain than Whites.

(18) In 2003, the National Academy of Medicine reported that the rates of TKA and THA among Black American and Hispanic patients are significantly lower than for Whites—even for those with equitable health care coverage such as through Medicare or the Department of Veterans Affairs.

(19) According to the Centers for Disease Control and Prevention, in 2000, Black American Medicare enrollees were 37 percent less likely than White Medicare enrollees to undergo total knee replacements. In 2006, the disparity increased to 39 percent.

(20) Even after adjusting for insurance and health access, Hispanics and Black Americans are almost 50 percent less likely to undergo total knee replacement than Whites.

SEC. 7402. OSTEOARTHRITIS AND OTHER MUSCULOSKELETAL HEALTH-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) EDUCATION AND AWARENESS ACTIVITIES.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall direct the National Center for Chronic Disease Prevention and Health Promotion to conduct and expand the Health Community Program and Arthritis Program to educate the public on—

(1) the causes of, preventive health actions for, and effects of arthritis, lupus, and other musculoskeletal conditions in minority patient populations; and

(2) the effects of such conditions on other comorbidities including obesity, hypertension, and cardiovascular disease.

(b) PROGRAMS ON ARTHRITIS AND MUSCULOSKELETAL CONDITIONS.—Education and awareness programs of the Centers for Disease Control and Prevention on arthritis and other musculoskeletal conditions in minority communities shall—

(1) be culturally and linguistically appropriate to minority patients, targeting musculoskeletal

health promotion and prevention programs of each major ethnic group, including—

(A) Native Americans and Alaska Natives;

(B) Asian Americans;

(C) African Americans and Blacks;

(D) Hispanic and Latino Americans; and

(E) Native Hawaiians and Pacific Islanders; and

(2) include public awareness campaigns directed toward these patient populations that emphasize the importance of musculoskeletal health, physical activity, diet and healthy lifestyle, and weight reduction for overweight and obese patients.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as are necessary for fiscal year 2023 and each subsequent fiscal year.

SEC. 7403. GRANTS FOR COMPREHENSIVE OSTEOARTHRITIS AND MUSCULOSKELETAL DISEASE HEALTH EDUCATION WITHIN HEALTH PROFESSIONS SCHOOLS.

(a) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), in coordination with the Secretary of Education, shall award grants, on a competitive basis, to

academic health science centers, health professions schools, and institutions of higher education to enable such centers, schools, and institutions to provide people with comprehensive education on arthritis and musculoskeletal health, particularly—

(1) obesity-related musculoskeletal diseases;

(2) arthritis and osteoarthritis;

(3) arthritis and musculoskeletal health disparities; and

(4) the relationship between arthritis and musculoskeletal diseases and metabolic activity, psychological health, and comorbidities such as diabetes, cardiovascular disease, lupus, and hypertension.

(b) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(c) APPLICATIONS.—An academic health science center, health professions school, or institution of higher education seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to an institution of higher education that—

(1) has an enrollment of needy students, as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

(2) is a Hispanic-serving institution, as defined in section 502(a) of such Act (20 U.S.C. 1101a(a));

(3) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(4) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(5) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(6) is a Predominately Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(7) is a Native American-serving, non-Tribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(8) is an Asian American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(9) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an en-

rollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(e) USES OF FUNDS.—An academic health science center, health professions school, or institution of higher education receiving a grant under this section may use the grant funds to integrate issues relating to comprehensive arthritis and musculoskeletal health into the academic or support sectors of the center, school, or institution in order to reach a large number of students, by carrying out 1 or more of the following activities:

(1) Developing educational content for issues relating to comprehensive arthritis and musculoskeletal health education that will be incorporated into first-year orientation or core courses.

(2) Creating innovative technology-based approaches to deliver arthritis and musculoskeletal health education to students, faculty, and staff.

(3) Developing and employing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to arthritis and musculoskeletal health disorders, and their relationship to diabetes, hypertension, cardiovascular disease, psychological health, and other comorbid conditions.

(f) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide health professions students with comprehensive arthritis and musculoskeletal health education funded under this section.

(2) REPORT ELEMENTS.—The report described in paragraph (1) shall include information about—

(A) the number of entities that are receiving a grant under this section;

(B) the specific activities supported by grants under this section;

(C) the number of students served by programs supported by grants under this section; and

(D) the status of evaluations of such programs.

(g) DEFINITION OF INSTITUTION OF HIGHER EDUCATION.—In this section, the term ''institution of higher education'' has the meaning given such term in section 101(b) of the Higher Education Act of 1965 (20 U.S.C. 1001(b)).

Subtitle J—Sleep and Circadian Rhythm Disorders

SEC. 7451. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This subtitle may be cited as the ''Sleep and Circadian Rhythm Disorders Health Disparities Act''.

(b) FINDINGS.—Congress finds the following:

(1) Decrements in sleep health such as sleep apnea, insufficient sleep time, and insomnia, affect 50,000,000 to 70,000,000 adults in the United States. An estimated 25,000,000 adults in the United States have sleep apnea, a chronic disorder characterized by one or more pauses in breathing which can last from a few seconds to minutes. They may occur 30 times or more an hour, disrupting sleep and resulting in excessive daytime sleepiness and loss in productivity.

(2) Seventy percent of high school students are not getting enough sleep on school nights, while 35 percent of people in the United States get fewer than 7 hours of sleep per night, and roughly 1,550 fatal motor vehicle crashes per year are caused by drowsy drivers.

(3) Insufficient sleep and insomnia are more prevalent in women. Women who are pregnant and

have sleep apnea are at an increased risk of cardiovascular complications during pregnancy. The impact of disparities in sleep health is associated with a growing number of health problems, including the following:

(A) Hypertension.

(B) Cancer.

(C) Stroke.

(D) Cardiac arrhythmia.

(E) Chronic heart failure and heart disease.

(F) Diabetes.

(G) Cognitive functioning and behavior.

(H) Depression and bipolar disorder.

(I) Substance abuse.

(4) A sleep disparity exists in that poor sleep quality is strongly associated with poverty, race, and social determinants of health. Factors such as employment, education, and health status, amongst others, significantly mediated this effect only in poor subjects, suggesting a differential vulnerability to these factors in poor relative to nonpoor individuals in the context of sleep quality.

(5) Black Americans sleep worse than White Americans. Black Americans take longer to fall

asleep, report poorer sleep quality, have more light and less deep sleep, and nap more often and longer.

(6) Black Americans and individuals in lower socioeconomic status groups may be at an increased risk for sleep disturbances and associated health consequences.

(7) Among young Black Americans, the likelihood of having sleep disordered breathing and exhibiting risk factors for poor sleep is twice that in young White Americans. Frequent snoring is more common among Black American and Hispanic women and Hispanic men compared to non-Hispanic White Americans, independent of other factors including obesity.

(8) Black Americans with sleep-disordered breathing develop symptoms at a younger age than Caucasians but appear less likely to be diagnosed and treated in a timely manner. This delay may at least in part be due to reduced access to care.

(9) Sleep loss contributes to increased risk for chronic conditions such as obesity, diabetes, and hypertension, all of which have increased prevalence in underserved, underrepresented minorities. Racial and ethnic disparities related to obesity may also

contribute to disparities in health outcomes related to sleep-disordered breathing.

(10) Underrepresented minorities in the United States report an insomnia rate of 12.9 percent compared to only 6.6 percent for White Americans.

(11) Black women have a higher incidence of insomnia than Black men, perhaps related in part to higher risk for chronic persisting symptoms.

SEC. 7452. SLEEP AND CIRCADIAN RHYTHM DISORDERS RESEARCH ACTIVITIES OF THE NATIONAL INSTITUTES OF HEALTH.

(a) IN GENERAL.—The Director of the National Institutes of Health, acting through the Director of the National Heart, Lung, and Blood Institute, shall—

(1) continue to expand research activities addressing sleep health disparities; and

(2) continue implementation of the NIH Sleep Disorders Research Plan across all institutes and centers of the National Institutes of Health to improve treatment and prevention of sleep health disparities.

(b) REQUIRED RESEARCH ACTIVITIES.—In conducting or supporting research relating to sleep and circadian rhythm, the Director of the National Heart, Lung, and Blood Institute shall—

(1) advance epidemiology and clinical research to achieve a more complete understanding of disparities in domains of sleep health and across population subgroups for which cardiovascular and metabolic health disparities exist, including—

(A) prevalence and severity of sleep apnea;

(B) habitual sleep duration;

(C) sleep timing and regularity; and

(D) insomnia;

(2) develop study designs and analytical approaches to explain and predict multilevel and life-course determinants of sleep health and to elucidate the sleep-related causes of cardiovascular and metabolic health disparities across the age spectrum, including such determinants and causes that are—

(A) environmental;

(B) biological or genetic;

(C) psychosocial;

(D) societal;

(E) political; or

(F) economic;

(3) determine the contribution of sleep impairments such as sleep apnea, insufficient sleep duration, irregular sleep schedules, and insomnia to un-

explained disparities in cardiovascular and metabolic risk and disease outcomes;

(4) develop study designs, data sampling and collection tools, and analytical approaches to optimize understanding of mediating and moderating factors, and feedback mechanisms coupling sleep to cardiovascular and metabolic health disparities;

(5) advance research to understand cultural and linguistic barriers (on the person, provider, or system level) to access to care, medical diagnosis, and treatment of sleep disorders in diverse population groups;

(6) develop and test multilevel interventions (including sleep health education in diverse communities) to reduce disparities in sleep health that will impact the ability to improve disparities in cardiovascular and metabolic risk or disease;

(7) create opportunities to integrate sleep and health disparity science by strategically utilizing resources (involving existing or anticipated cohorts) and exchanging scientific data and ideas (including through cross-over into scientific meetings); and

(8) enhance the diversity and foster career development of young investigators involved in sleep and health disparities science.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2023 and each subsequent fiscal year.

SEC. 7453. SLEEP AND CIRCADIAN RHYTHM HEALTH DISPARITIES-RELATED ACTIVITIES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies and prevention, diagnosis, surveillance, and public and professional awareness activities regarding sleep and circadian rhythm disorders.

(b) FINDINGS.—Congress finds as follows:

(1) Sleep disorders and sleep deficiency unrelated to a primary sleep disorder are underdiagnosed and are increasingly detrimental to health status.

(2) The consequences to society include additional diseases, motor vehicle accidents, decreased longevity, elevated direct medical costs, and indirect costs related to work absenteeism and property damage.

(c) REQUIRED SURVEILLANCE AND EDUCATION AWARENESS ACTIVITIES.—In conducting or supporting research relating to sleep and circadian rhythm disorders

surveillance and education awareness activities, the Director of the Centers for Disease Control and Prevention shall—

(1) ensure that such activities are culturally and linguistically appropriate to minority patients, targeting sleep and circadian rhythm health promotion and prevention programs of each major ethnic group, including—

(A) Native Americans and Alaska Natives;

(B) Asian Americans;

(C) African Americans and Blacks;

(D) Hispanic and Latino-Americans; and

(E) Native Hawaiians and Pacific Islanders;

(2) collect and compile national and State surveillance data on sleep disorders health disparities;

(3) continue to develop and implement new sleep questions in public health surveillance systems to increase public awareness of sleep health and sleep disorders and their impact on health;

(4) publish monthly reports highlighting geographic, racial, and ethnic disparities in sleep health, as well as relationships between insufficient sleep and chronic disease, health risk behaviors, and other

outcomes as determined necessary by the Director; and

(5) include public awareness campaigns that inform patient populations from major ethnic groups about the prevalence of sleep and circadian rhythm disorders and emphasize the importance of sleep health.

(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal year 2023 and each subsequent fiscal year.

SEC. 7454. GRANTS FOR COMPREHENSIVE SLEEP AND CIRCADIAN HEALTH EDUCATION WITHIN HEALTH PROFESSIONS SCHOOLS.

(a) PROGRAM AUTHORIZED.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in coordination with the Secretary of Education, shall award grants, on a competitive basis, to academic health science centers, health professions schools, and institutions of higher education to enable such centers, schools, and institutions to provide people with comprehensive education on sleep and circadian health, particularly—

(1) poor sleep health;

(2) sleep disorders;

(3) sleep health disparities; and

(4) the relationship between sleep and circadian health on metabolic activity, neurological activity, comorbidities, and other diseases.

(b) DURATION.—Grants awarded under this section shall be for a period of 5 years.

(c) APPLICATIONS.—An academic health science center, health professions school, or institution of higher education seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to an institution of higher education that—

(1) has an enrollment of needy students, as defined in section 318(b) of the Higher Education Act of 1965 (20 U.S.C. 1059e(b));

(2) is a Hispanic-serving institution, as defined in section 502(a) of such Act (20 U.S.C. 1101a(a));

(3) is a Tribal College or University, as defined in section 316(b) of such Act (20 U.S.C. 1059c(b));

(4) is an Alaska Native-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(5) is a Native Hawaiian-serving institution, as defined in section 317(b) of such Act (20 U.S.C. 1059d(b));

(6) is a Predominately Black Institution, as defined in section 318(b) of such Act (20 U.S.C. 1059e(b));

(7) is a Native American-serving, nontribal institution, as defined in section 319(b) of such Act (20 U.S.C. 1059f(b));

(8) is an Asian American and Native American Pacific Islander-serving institution, as defined in section 320(b) of such Act (20 U.S.C. 1059g(b)); or

(9) is a minority institution, as defined in section 365 of such Act (20 U.S.C. 1067k), with an enrollment of needy students, as defined in section 312 of such Act (20 U.S.C. 1058).

(e) USES OF FUNDS.—An academic health science center, health professions school, or institution of higher education receiving a grant under this section may use the grant funds to integrate issues relating to comprehensive sleep and circadian health into the academic or support sectors of the center, school, or institution, in order to reach a large number of students, by carrying out 1 or more of the following activities:

(1) Developing educational content for issues relating to comprehensive sleep and circadian health education that will be incorporated into first-year orientation or core courses.

(2) Creating innovative technology-based approaches to deliver sleep health education to students, faculty, and staff.

(3) Developing and employing peer-outreach and education programs to generate discussion, educate, and raise awareness among students about issues relating to poor quality sleep, sleep and circadian disorders, and the role sleep health plays in other diseases and comorbidities.

(f) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter for a period of 5 years, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the activities to provide health professions students with comprehensive sleep and circadian health education funded under this section.

(2) REPORT ELEMENTS.—The report described in paragraph (1) shall include information about—

(A) the number of entities that are receiving a grant under this section;

(B) the specific activities supported by grants under this section;

(C) the number of students served by programs supported by grants under this section; and

(D) the status of evaluations of programs supported by such grants.

(g) DEFINITION OF INSTITUTION OF HIGHER EDUCATION.—In this section, the term ''institution of higher education'' has the meaning given such term in section 101(b) of the Higher Education Act of 1965 (20 U.S.C. 1001(b)).

SEC. 7455. REPORT ON IMPACT OF SLEEP AND CIRCADIAN HEALTH DISORDERS IN VULNERABLE AND RACIAL/ETHNIC POPULATIONS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress and the President a report on the impact of sleep and circadian health disorders for racial and ethnic minority communities and other vulnerable populations.

(b) CONTENTS.—The report under subsection (a) shall include information on the—

(1) progress that has been made in reducing the impact of sleep and circadian health disorders in such communities and populations;

(2) opportunities that exist to make additional progress in reducing the impact of sleep and circadian health disorders in such communities and populations;

(3) challenges that may impede such additional progress; and

(4) Federal funding necessary to achieve substantial reductions in sleep and circadian health disorders in racial and ethnic minority communities.

Subtitle K—Kidney Disease Research, Surveillance, Prevention, and Treatment

SEC. 7501. KIDNEY DISEASE, RESEARCH, SURVEILLANCE, PREVENTION, AND TREATMENT.

(a) SHORT TITLE.—This subtitle may be cited as the ''Kidney Disease Research, Surveillance, Prevention and Treatment Improvement Act of 2022''.

(b) FINDINGS.—Congress makes the following findings:

(1) Kidney diseases impact 37,000,000 individuals in the United States.

(2) Black Americans comprise just 13 percent of the United States population, but 33 percent of the United States dialysis patient population. Compared to White Americans, kidney failure prevalence is about 3.7 times greater in Black Americans, 1.4 times greater in Native Americans, and 1.5 times greater in Asian Americans.

(3) Peritoneal dialysis and home hemodialysis use is 40–50 percent lower among Black Americans and Hispanics.

(4) Every racial and ethnic minority group in the United States is significantly less likely to be treated with home dialysis than Whites, and demographic and clinical characteristics are insufficient to explain this differential use.

(5) Black Americans on dialysis, irrespective of dialysis modality, and Hispanics undergoing PD or in-center HD, are significantly less likely than their White counterparts to receive a kidney transplant.

(6) Black Americans, Hispanics, and Asian Americans are less likely to receive living donor kidney transplants than Whites. Efforts to reduce disparities in live donor kidney transplantation for Black American, Hispanic, and Asian patients with kidney failure have been largely unsuccessful.

(7) Medicare and Medicaid patients are less likely to receive a preemptive transplant from a deceased donor compared to private insurance patients (5 percent and 11 percent versus 24 percent), and Black and Hispanic patients are less likely to receive a preemptive transplant from a deceased donor compared with White patients even after changes to the kidney allocation system (5 percent of Black patients and 5 percent of Hispanic patients compared with 18 percent of White patients).

(8) Low-income populations are significantly more likely to progress to kidney failure.

(9) Low socioeconomic status is associated with increased incidence of chronic kidney disease, progression to kidney failure, inadequate dialysis treatment, and reduced access to kidney transplantation.

(10) The 3 goals of Executive Order 13879 of July 10, 2019 (84 Fed. Reg. 33817; relating to Advancing American Kidney Health), recognize the need for more transplants, better prevention and education, and improved access to treatment modalities.

SEC. 7502. KIDNEY DISEASE RESEARCH IN MINORITY POPULATIONS.

(a) IN GENERAL.—

(1) RESEARCH AND TRAINING CENTERS.—Section 431(c)(3) of the Public Health Service Act (42 U.S.C. 285c–5(c)(3)) is amended—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking ''and'' at the end; and

(C) by adding at the end the following:

''(D) improving data science through improvement in bioinformatics, data integration, and data sharing;

''(E) defining the chronic kidney disease mechanism and identifying new therapeutic targets for chronic kidney disease using specific tools, including mapping the genetic architecture of kidney function and disease and translating genetic maps to disease-causing genes and mechanisms, especially among minority populations;

''(F) improving models of human disease including better humanized animal models, improved reproducibility, and functional characterization of kidney organoids, and accelerating the development of in vivo imaging technologies; and

''(G) developing cell-specific drug delivery systems and gene editing, including targeted systems for the delivery of therapeutic compounds to specific kidney compartments or cell types and accelerating the implementation of gene editing and gene therapy for the treatment of kidney diseases in vivo; and''.

(2) INCLUSION OF MINORITY PARTICIPANTS.—In conducting and supporting research described in the amendment made by paragraph (1), the Director of the National Institutes of Health shall work with the Director of the National Institute on Minority Health and Health Disparities to improve the number of minority participants as study subjects in clinical trials. Such work may include—

(A) developing and sustaining clinical trial consortia that can recruit patients with chronic kidney disease to ensure adequate capacity for assessment of kidney outcomes and increase the enrollment of underrepresented populations;

(B) encouraging the use of novel designs in clinical trials to enhance the recruitment and retention of underrepresented populations which will enhance the generalizability of study findings;

(C) supporting outreach initiatives that incorporate acknowledgment of both historical and current grounds for participation reluctance, and that prioritize demonstrating trustworthiness, in order to enhance the ability to promote and effectively convey the benefits of clinical research participation;

(D) completing clinical trials that test interventions to improve patient quality of life and address patient-reported outcomes; and

(E) encouraging inclusion of persons with chronic kidney disease in clinical trials of treatments for nonkidney diseases.

(b) REPORT; COMPREHENSIVE PLAN.—Section 429 of the Public Health Services Act (42 U.S.C. 285c–3) is amended by adding at the end the following:

''(c) REPORT BY KIDNEY, UROLOGIC, AND HEMATOLOGIC DISEASES COORDINATING COMMITTEE.—

''(1) IN GENERAL.—The Kidney, Urologic, and Hematologic Diseases Coordinating Committee, in coordination with the Chronic Kidney Disease Initiative at the Centers for Disease Control and Prevention, shall—

''(A) prepare and submit to the Congress, not later than 6 months after the date of enact-

ment of this subsection, a report on Federal research and public health activities with respect to kidney disease in minority populations; and

"(B) develop and submit to the Congress, the Secretary, the Director of the National Institutes of Health, and the Advisory Board established under section 430 for the diseases for which the Committee was established, not later than 1 year after the date of enactment of this subsection, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to address kidney disease in minority populations.

"(2) CONTENTS.—The report under paragraph (1)(A) shall at minimum address each of the following:

"(A) Research on kidney disease in minority populations, including such research on—

"(i) genetic, behavioral, and environmental factors;

"(ii) prevention and complications among individuals within these populations who have already developed kidney disease;

"(iii) the delivery of evidenced-based care for all chronic kidney disease stages,

especially in underrepresented and underserved populations;

''(iv) expanding support for a root-cause analysis approach to disparities, including causes, detection, and management of chronic kidney disease for underserved populations;

''(v) developing research teams that engage with community organizations to develop and implement interventions which halt or delay development and progression of chronic kidney disease; and

''(vi) continued support of observational studies of kidney disease measures and outcomes.

''(B) Surveillance and data collection on kidney disease in minority populations, including with respect to—

''(i) efforts to better determine the prevalence of kidney disease among Asian-American and Pacific Islander subgroups; and

''(ii) efforts to coordinate data collection on the American Indian population.

"(C) Community-based interventions to address kidney disease targeting minority populations, including—

"(i) the evidence bases for such interventions;

"(ii) the cultural appropriateness of such interventions; and

"(iii) efforts to educate the public on the causes and consequences of kidney disease.

"(D) Education and training programs for health professionals (including community health workers) on the prevention and management of kidney disease and its related complications that are supported by the Health Resources and Services Administration, including such programs supported by the Bureau of Health Workforce, the Bureau of Primary Health Care, and the Health Systems Bureau. This shall include—

"(i) identification of effective strategies to increase implementation of proven therapies to slow chronic kidney disease incidence and progression, especially in high-risk underrepresented populations; and

"(ii) identification of effective practice improvement strategies in large and small health systems to reduce chronic kidney disease incidence and progression.".

SEC. 7503. KIDNEY DISEASE ACTION PLAN.

(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall conduct, support, and expand public health strategies, prevention, diagnosis, surveillance, and public and professional awareness activities regarding kidney disease.

(b) NATIONAL ACTION PLAN.—

(1) DEVELOPMENT.—Pursuant to section 426 of the Public Health Service Act (42 U.S.C. 285c), not later than 2 years after the date of the enactment of this Act, the Director of the National Institute of Diabetes and Digestive and Kidney Diseases, in consultation with the Director of the National Institute on Minority Health and Health Disparities and the Director of the Centers for Disease Control and Prevention, shall develop a national action plan to address kidney disease in the United States with participation from patients, caregivers, health professionals, patient advocacy organizations, researchers, providers, public health professionals, and other stakeholders.

(2) CONTENTS.—At a minimum, such plan shall include recommendations for—

(A) public health interventions for the purpose of implementation of the national plan;

(B) biomedical, health services, and public health research on kidney disease; and

(C) inclusion of kidney disease in the health data collections of all Federal agencies.

(c) KIDNEY DISEASE PREVENTION PROGRAMS.—The Director of the Centers for Disease Control and Prevention, through the Chronic Kidney Disease Initiative, shall carry out the following:

(1) Conduct public education and awareness activities with patient and professional organizations to stimulate earlier diagnosis and improve patient outcomes from treatment of kidney disease. To the extent known and relevant, such public education and awareness activities shall reflect differences in kidney disease by cause (such as hypertension, diabetes, lupus nephritis, COVID–19, and polycystic kidney disease) and include a focus on outreach to undiagnosed and, as appropriate, minority populations.

(2) Supplement and expand upon the activities of the Centers for Disease Control and Prevention

by making grants to nonprofit organizations, State and local jurisdictions, and Indian Tribes for the purpose of reducing the burden of kidney disease, especially in disproportionately impacted communities, through public health interventions and related activities.

(3) Coordinate with the National Institute of Diabetes and Digestive and Kidney Diseases, the Indian Health Service, the Health Resources and Services Administration, and the Department of Veterans Affairs to develop pilot programs to demonstrate best practices for the diagnosis and management of kidney disease.

(4) Develop improved techniques and identify best practices, in coordination with the Secretary of Veterans Affairs, for assisting kidney disease patients.

(d) DATA COLLECTION.—Not later than 180 days after the date of enactment of this Act, the Director of the National Institute of Diabetes and Digestive and Kidney Diseases and the Director of the Centers for Disease Control and Prevention, acting jointly, shall assess the depth and quality of information on kidney disease that is collected in surveys and population studies conducted by the Centers for Disease Control and Prevention, includ-

ing whether there are additional opportunities for information to be collected in the National Health and Nutrition Examination Survey, the National Health Interview Survey, and the Behavioral Risk Factor Surveillance System surveys. The Director of the National Institute of Diabetes and Digestive and Kidney Diseases shall include the results of such assessment in the national action plan under subsection (b).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $1,000,000 for fiscal year 2023, $1,000,000 for fiscal year 2024, $1,000,000 for fiscal year 2025, $1,000,000 for fiscal year 2026, and $1,000,000 for fiscal year 2027.

SEC. 7504. HOME DIALYSIS AND INCREASING END-STAGE RENAL DISEASE TREATMENT MODALITIES IN MINORITY COMMUNITIES ACTION PLAN.

(a) IN GENERAL.—Section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) is amended by adding at the end the following new subparagraph:

''(J)(i) For services furnished on or after the date which is 1 year after the date of the enactment of this subparagraph which are staff-assisted home dialysis (as defined in clause (iv)(III)), the Secretary shall increase the single payment that would otherwise apply under this paragraph for renal dialysis

services furnished to new and respite individuals in accordance with the payment system established under clause (iii) by qualified providers.

''(ii)(I) Subject to subclause (II), staff-assisted home dialysis may only be furnished during—

''(aa) with respect to an individual described in subclause (iv)(I)(aa), one 90-day period which may be renewed up to two 30-day periods; and

''(bb) with respect to an individual described in subclause (iv)(I)(bb) and not withstanding whether such an individual receives any respite care under part A, any 30-day period.

''(II) Notwithstanding the limits described in subclause (I), staff-assisted home dialysis may be furnished for as long as the Secretary determines appropriate to an individual who—

''(aa) is blind;

''(bb) has a cognitive or neurological impairment (including a stroke, Alzheimer's, dementia, amyotrophic lateral sclerosis, or any other impairment determined by the Secretary); or

"(cc) has any other illness or injury that reduces mobility (including cerebral palsy, spinal cord injuries, or any other illness or injury determined by the Secretary).

"(iii) The Secretary shall establish an add-on to the single payment under this paragraph through regulations to determine the amounts payable to qualified providers for staff-assisted home dialysis. In establishing such system add-on payment, the Secretary may consider—

"(I) the costs of furnishing staff-assisted home dialysis;

"(II) consultations with dialysis providers, dialysis patients, private payers, and Medicare Advantage plans;

"(III) payment amounts for similar items and services under parts A and B; and

"(IV) payment amounts established by Medicare Advantage plans under part C, group health plans, and health insurance coverage offered by health insurance issuers.

"(iv) In this subparagraph:

"(I) The term 'new and respite individual' means an individual described in subsection (a) who is—

"(aa) initiating either peritoneal or home hemodialysis;

"(bb) receiving home dialysis and is unable to self-dialyze due to illness, injury, caregiver issues, or other temporary circumstances; or

"(cc) returning to home dialysis after a period of hospitalization.

"(II) The term 'qualified provider' means a trained professional (as determined by the Secretary, including nurses and certified patient technicians) who furnishes renal dialysis services and—

"(aa) meets requirements (as determined by the Secretary) that ensures competency in patient care and modality usage; and

"(bb) provides in-person assistance to a patient for an appropriate number of dialysis sessions (as determined by the Secretary) at least 75 percent of staff-assisted home dialysis sessions during a period described in clause (ii)(I).

"(III)(aa) The term 'staff-assisted home dialysis' means home dialysis using trained pro-

fessionals to assist individuals who have been determined to have end stage renal disease, and the frequency of such home dialysis is determined by such professionals in coordination with the patient and his or her care partner, and outlined in a patient plan of care.

''(bb) The term 'care partner' means anyone who is designated by the patient who assists the individual with the furnishing of home dialysis.

''(cc) The term 'patient plan of care' has the meaning given such term in section 494.90 of title 42, Code of Federal Regulations.''.

(b) PATIENT EDUCATION AND TRAINING RELATING TO STAFF-ASSISTED HOME DIALYSIS.—Section 1881(b)(5) of the Social Security Act (42 U.S.C. 1395rr(b)(5)) is amended—

(1) in subparagraph (C), by striking at the end ''and'';

(2) in subparagraph (D), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following:

''(E) educate patients of the opportunity to receive staff-assisted home dialysis (as defined in paragraph (14)(J)(iv)(III)) during the period

beginning 30 days after the first day such facility furnishes renal dialysis services to an individual and ending 60 days after such day; and

''(F) provide for nurses, certified patient technicians, social workers and or other professionals to train patients and their care partners in skills and procedures needed to perform home dialysis (as defined in paragraph (14)(J)(iv)(III)) treatment—

''(i) regularly and independently;

''(ii) through telehealth services or through group training (as described in the interpretive guidance relating to tag number V590 of 'Advance Copy–End Stage Renal Disease (ESRD) Program Interpretive Guidance Version 1.1' (published on 10 October 3, 2008)) in accordance with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

''(iii) in the home or residence of a patient, in a dialysis facility, or the place

in which the patient intends to receive perform staff-assisted home dialysis.''.

(c) NATIONAL ACTION PLAN.—

(1) DEVELOPMENT.—Not later than 2 years after the date of the enactment of this Act, the Director of the National Institute of Diabetes and Digestive and Kidney Diseases, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop a national action plan to increase the number of home dialyzers and choice in dialysis treatment modality in the United States with participation from patients, caregivers, health professionals, patient advocacy organizations, researchers, providers, public health professionals, and other stakeholders in minority communities.

(2) CONTENTS.—At a minimum, such plan shall include recommendations for—

(A) public health officials for the purpose of implementation of the national plan;

(B) biomedical, health services, and public health research on home dialysis and modalities in minority communities; and

(C) inclusion of dialysis location and modality in the health data collections of all Federal agencies.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $1,000,000 for fiscal year 2023, $1,000,000 for fiscal year 2024, $1,000,000 for fiscal year 2025, $1,000,000 for fiscal year 2026, and $1,000,000 for fiscal year 2027.

SEC. 7505. INCREASING KIDNEY TRANSPLANTS IN MINORITY POPULATIONS.

(a) IN GENERAL.—The Director of the National Institutes of Health shall expand, intensify, and support ongoing research and other activities with respect to kidney transplants in minority populations.

(b) CMS DATA COLLECTION AND REPORTING.—The Centers for Medicare & Medicaid Services shall collect and report annual data on dialysis facility and nephrologist performance on transplant referral, with an emphasis on data relating to patients of color.

(c) OPTN DATA COLLECTION AND REPORTING.—The Organ Procurement and Transplantation Network shall collect and the Scientific Registry of Transplant Recipients shall report annual data, broken down by demographic and socioeconomic characteristics, on individual transplant center performance as it relates to patients referred, evaluated, waitlisted, and successfully transplanted.

(d) TRANSPLANT CENTER DATA.—Each organ transplant center shall report on the percent of appropriate waitlisted patients (including socioeconomic and demographic data) giving and receiving annual informed consent for offers for suboptimal kidneys (such as kidneys with a kidney donor profile index of greater than 85 percent or kidney age 50 with diabetes, or age greater than 60).

(e) ORGAN PROCUREMENT ORGANIZATION DATA.—Each organ procurement organization shall report annual data on referrals, refusals (patient or doctor), and acceptance of organs by hospital, ZIP Code, race, ethnicity, and age strata except as prohibited by need for confidentiality.

(f) DATA TRANSPARENCY FOR PATIENTS.—Each organ transplant center shall provide to each patient of such center, on an annual basis—

(1) the number of times an organ was offered to the patient, declined, and transplanted into another patient from organs within a 500 mile radius; and

(2) the number of times an organ was offered to and declined for the patient from a low risk donor which was subsequently transplanted into another patient.

(g) IMPROVED TRANSPLANTATION EDUCATION.—The Centers for Medicare & Medicaid Services shall certify a nonbiased, third-party organization to accredit organ transplant education.

(h) RESEARCH.—Research under subsection (a) shall include investigation into—

(1) the causes of lower rates of kidney transplants in minority populations, including socioeconomic, geographic, clinical, environmental, genetic, and other factors that may contribute to lower rates of kidney transplants in minority populations; and

(2) possible interventions to increase kidney transplants.

(i) REPORT; COMPREHENSIVE PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall—

(A) prepare and submit to the Congress, not later than 6 months after the date of enactment of this section, a report on Federal research and public health activities with respect to kidney transplants as a treatment for end-stage renal disease in minority populations; and

(B) develop and submit to the Congress, not later than 1 year after the date of enact-

ment of this section, an effective and comprehensive Federal plan (including all appropriate Federal health programs) to increase the number of kidney transplants in minority populations.

(2) CONTENTS.—The report under paragraph (1)(A) shall at a minimum address each of the following:

(A) Research on kidney transplants in minority populations, including such research on financial, insurance coverage, genetic, behavioral, and environmental factors.

(B) Surveillance and data collection on kidney transplants in minority populations, including with respect to—

(i) efforts to increase kidney transplants among Asian-American and Pacific Islander subgroups with end-stage renal disease; and

(ii) efforts to increase kidney transplants in the American Indian population.

(C) Community-based efforts to increase kidney transplants targeting minority populations, including—

(i) the evidence base for such increases;

(ii) the cultural appropriateness of such increases; and

(iii) efforts to educate the public on kidney transplants.

(D) Education and training programs for health professionals (including community health workers) on the kidney transplants that are supported by the Health Resources and Services Administration, including such programs supported by the Bureau of Health Workforce, the Bureau of Primary Health Care, and the Health Systems Bureau.

SEC. 7506. ENVIRONMENTAL AND OCCUPATIONAL HEALTH PROGRAMS.

The Director of the Centers for Disease Control and Prevention shall—

(1) support research into the environmental and occupational causes and biological mechanisms that contribute to kidney disease; and

(2) develop and disseminate public health interventions that will lessen the impact of environmental and occupational causes of kidney disease.

SEC. 7507. UNDERSTANDING THE TREATMENT PATTERNS ASSOCIATED WITH PROVIDING CARE AND TREATMENT OF KIDNEY FAILURE IN MINORITY POPULATIONS.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on treatment patterns associated with providing care, under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), under the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.), and through private health insurance, to minority populations that are disproportionately affected by kidney failure.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), together with such recommendations as the Secretary determines to be appropriate.

SEC. 7508. IMPROVING ACCESS IN UNDERSERVED AREAS.

(a) DEFINITION OF PRIMARY CARE SERVICES.—Section 331(a)(3)(D) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(D)) is amended by inserting ''nephrology,'' after ''dentistry,''.

(b) NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.—Section 338A(a)(2) of the Public Health Service Act (42 U.S.C. 254l(a)(2)) is amended by insert-

ing ‘‘, which may include kidney health professionals’’ before the period at the end.

(c) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.—Section 338B(a)(2) of the Public Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended by inserting ‘‘, which may include kidney health professionals’’ before the period at the end.

SEC. 7509. THE JACK REYNOLDS MEMORIAL MEDIGAP EXPANSION ACT; MEDIGAP COVERAGE FOR BENEFICIARIES WITH END-STAGE RENAL DISEASE.

(a) GUARANTEED AVAILABILITY OF MEDIGAP POLICIES TO ALL ESRD MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking ‘‘is 65’’ and all that follows through the period at the end and inserting the following: ‘‘is—

‘‘(i) 65 years of age or older and is enrolled for benefits under part B; or

‘‘(ii) is entitled to benefits under 226A(b) and is enrolled for benefits under part B.’’; and

(ii) in subparagraph (D), in the matter preceding clause (i), by inserting ''(or is entitled to benefits under 226A(b))'' after ''is 65 years of age or older''; and

(B) in paragraph (3)(B)—

(i) in clause (ii), by inserting ''(or is entitled to benefits under 226A(b))'' after ''is 65 years of age or older''; and

(ii) in clause (vi), by inserting ''(or under 226A(b))'' after ''at age 65''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to Medicare supplemental policies effective on or after January 1, 2023.

(b) ADDITIONAL ENROLLMENT PERIOD FOR CERTAIN INDIVIDUALS.—

(1) ONE-TIME ENROLLMENT PERIOD.—

(A) IN GENERAL.—In the case of an individual described in paragraph (2), the Secretary of Health and Human Services shall establish a one-time enrollment period during which such an individual may enroll in any Medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395ss) of the individual's choosing.

(B) ENROLLMENT PERIOD.—The enrollment period established under subparagraph (A) shall begin on January 1, 2023, and shall end June 30, 2023.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is an individual who—

(A) is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act under section 226A(b) of such Act (42 U.S.C. 426–1(b));

(B) is enrolled for benefits under part B of such title XVIII; and

(C) would not, but for the provisions of, and amendments made by, subsection (a) be eligible for the guaranteed issue of a Medicare supplemental policy under paragraph (2) or (3) of section 1882(s) of such Act (42 U.S.C. 1395ss(s)).

Subtitle L—Diversity in Clinical Trials

SEC. 7551. FDA REVIEW OF CLINICAL TRIAL BEST PRACTICES.

The Commissioner of Food and Drugs shall—

(1) aggregate information on the accumulated experience of sponsors of drugs that develop and

execute clinical trial diversity plans during drug development;

(2) include in such aggregated information an analysis from the perspectives of the Food and Drug Administration and such sponsors of which actions worked or which did not work to enhance clinical trial diversity;

(3) not later than September 30, 2024, convene a public meeting, including representatives from the regulated industry and patient organizations, to discuss findings and recommendations for specific actions that have led to measurable improvements in the representation of racial and ethnic populations in clinical research; and

(4) not later than September 30, 2025, update the guidance of the Food and Drug Administration titled ''Enhancing the Diversity of Clinical Trial Populations—Eligibility Criteria, Enrollment Practices, and Trial Designs'' to align such guidance with findings and recommendations that were discussed at the meeting under paragraph (3).

SEC. 7552. DIVERSIFYING INVESTIGATIONS VIA EQUITABLE RESEARCH STUDIES FOR EVERYONE TRIALS ACT.

(a) GUIDANCE ON DECENTRALIZED CLINICAL TRIALS.—

(1) DEFINITION.—In this subsection, the term ''decentralized clinical trials'' includes clinical trials that are executed through a broad spectrum of options, such as telemedicine or other mobile or digital technologies, to allow for the remote collection and assessment of clinical trial data from participants, including in the home or office setting.

(2) GUIDANCE.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Commissioner of Food and Drugs (referred to in this section as the ''Commissioner''), shall issue a draft guidance that addresses how to conduct decentralized clinical trials with meaningful demographic diversity, including racial, ethnic, age, gender, and geographic diversity in patient engagement, enrollment, and participation, including how to appropriately use digital health technologies or other remote assessment options, such as telemedicine, to support such trials. Not later than 6 months after

the date the public comment period for the draft guidance ends, the Secretary shall issue a final guidance.

(3) CONTENT OF GUIDANCE.—The guidance under paragraph (2) shall address the following:

(A) Strategies to engage with prospective clinical trial participants and community partners, such as patient advocacy groups with diverse representation, to incorporate input of such patients and partners into the design of decentralized clinical trials.

(B) Recommendations for—

(i) protocol design approaches;

(ii) appropriate clinical endpoints;

(iii) institutional review board composition and ensuring that such boards include members with expertise in decentralized clinical trials;

(iv) delegation of clinical research organization responsibilities and suitable proxies for clinical research organizations; and

(v) simplifying informed consent.

(C) Recommendations for how digital health technology or other remote assessment

options, such as telemedicine, could support decentralized clinical trials, including guidance on appropriate technological platforms and mediums, data collection and use, data integrity, and communication to study participants through digital technology.

(D) Recommendations for appropriate methods of patient recruitment and retention, including institutional review board oversight, patient communication, and the role of study participants and community partners as advocates to facilitate clinical trial recruitment, particularly with respect to underrepresented populations.

(E) Information regarding when and how a study sponsor may solicit a meeting with the Secretary regarding the issues described in subparagraphs (A) through (D).

(4) INTERNATIONAL HARMONIZATION.—After issuing the final guidance under paragraph (2), the Secretary, acting through the Commissioner, may work with foreign regulators pursuant to existing memoranda of understanding governing exchange of information to facilitate international harmonization of the regulation of decentralized clinical trials and

use of digital health technology or other remote assessment options.

(b) ENCOURAGEMENT OF CLINICAL TRIAL ENROLLMENT BY RACIALLY AND ETHNICALLY DIVERSE POPULATIONS.—

(1) NO COST PROVISION OF DIGITAL HEALTH TECHNOLOGIES.—The free provision of digital health technologies by drug or device manufacturers to their clinical trial participants shall not be considered a violation of section 1128A of the Social Security Act (commonly known as the ''Civil Monetary Penalties Law'') (42 U.S.C. 1320a–7a), section 1128B of the Social Security Act (42 U.S.C. 1320a–7b), or sections 3729 through 3733 of title 31, United States Code, (commonly known as the ''False Claims Act''), provided that—

(A) the use of digital health technologies will facilitate in any phase of clinical development the inclusion of diversity of patient populations, such as underrepresented racial and ethnic minorities, low-income populations, and the elderly;

(B) the digital health technologies will facilitate individuals participation, or are necessary to such participation;

(C) all features of the digital health technologies that are unrelated to use in the clinical trial are disabled or only allowed to remain activated to model real-world usage of the digital technology; and

(D) the clinical trial sponsor requires participants to return, purchase, or disable the digital health technologies by the conclusion of the trial.

(2) GRANTS AND CONTRACTS.—

(A) IN GENERAL.—The Secretary may issue grants to, and enter into contracts with, entities to support community education, outreach, and recruitment activities for clinical trials with respect to drugs, including vaccines for diseases or conditions which have a disproportionate impact on underrepresented populations (including on racial and ethnic minority populations), including for the diagnosis, prevention, or treatment of COVID–19. Such activities may include—

(i) working with community clinical trial sites, including community health centers, academic health centers, and other facilities;

(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 ethnical 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

communities that are traditionally underrepresented in clinical trials, such as Tribal areas.

(C) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for fiscal years 2023 and 2024 such sums as may be necessary to carry out this paragraph.

(c) CLARIFICATION THAT CERTAIN REMUNERATION RELATED TO PARTICIPATION IN CLINICAL TRIALS DOES NOT CONSTITUTE REMUNERATION UNDER THE FEDERAL CIVIL MONEY PENALTIES LAW.—

(1) IN GENERAL.—Section 1128A(i)(6)(F) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(F)) is amended by inserting ''(including remuneration offered or transferred to an individual to promote the participation in an approved clinical trial, as defined in subsection (d) of the first section 2709 of the Public Health Service Act (relating to coverage for individuals participating in approved clinical trials), as so designated by section 1563(c)(10)(C) of the Patient Protection and Affordable Care Act, that is registered with the database of clinical trials maintained by the National Library of Medicine (or any successor database), so long as such remuneration facilitates equitable inclu-

sion of patients from all relevant demographic and socioeconomic populations and is related to patient participation in the approved clinical trial)'' after ''promotes access to care''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to remuneration provided on or after the date of the enactment of this Act.

(d) NATIONAL ACADEMY OF MEDICINE STUDY.—

(1) IN GENERAL.—The Secretary shall seek to enter into an arrangement with the National Academy of Medicine under which the National Academy agrees to study and propose a design for a national interoperable data platform to improve access to health data, and other relevant data needs, during public health emergencies.

(2) REPORT.—The arrangement under paragraph (1) shall provide for submission by the National Academy of Medicine to the Secretary and Congress, not later than 120 days after the date of enactment of this Act, of a report on the results of the study under paragraph (1) and the design proposed based on such study.

SEC. 7553. CLINICAL TRIAL DIVERSITY.

(a) DIVERSITY REQUIREMENTS FOR APPLICATIONS FOR FEDERAL FUNDING FOR CLINICAL TRIALS.—

(1) APPLICATIONS.—Beginning on the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the National Institutes of Health (in this subsection referred to as the ''Secretary''), shall require that an entity seeking to conduct a clinical trial investigating a drug or device (as those terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)) or biological product (as defined in section 351(i) of the Public Health Service Act (42 U.S.C. 262(i))) that is funded by the National Institutes of Health and conducted at any national research institute or national center, to submit an application (or renewal thereof) for such funding that includes—

(A) clear and measurable goals for the recruitment and retention of participants that reflect—

(i) the race, ethnicity, age, and gender or sex of patients with the disease or condition being investigated; or

(ii) the race, ethnicity, age, and gender or sex of the general population of the

United States if the prevalence of the disease or condition is not known;

(B) a rationale for the goals specified under subparagraph (A) that specifies—

(i) how investigators will calculate the number of participants for each population category that reflect the population groups specified in subparagraph (A); and

(ii) strategies that will be used to enroll and retain participants across the different racial, ethnic, age, and gender or sex categories;

(C) a detailed plan for how the clinical trial will achieve the goals specified under subparagraph (A) that specifies—

(i) the requirements for researchers, in conducting the trial to analyze the population groups specified in subparagraph (A) separately;

(ii) the role of community partners or community institutional review boards in reviewing the plans; and

(iii) how the trial will recruit a study population that is—

(I) in proportion to the prevalence of the disease or condition in such groups relative to the prevalence of the disease or condition in the overall population of the United States;

(II) in sufficient numbers to obtain clinically and statistically meaningful determinations of the safety and effectiveness of the drug being studied in the respective race, ethnicity, age, and gender or sex groups; and

(III) consistent with the guidance under section 505(b)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(1)) and guidance issued by the National Institutes of Health on the inclusion of women and minorities in clinical trials;

(D) the entity's plan for implementing, or an explanation of why the entity cannot implement, alternative clinical trial follow-up requirements that are less burdensome for trial participants, such as—

(i) requiring fewer follow-up visits;

(ii) allowing phone follow-up or home visits by nurse trial coordinators (in lieu of in-person visits by patients);

(iii) allowing for online follow-up options;

(iv) permitting the patient's primary care provider to perform some of the follow-up visit requirements and to reimburse the patient for any out-of-pocket costs incurred by the patient for such follow-up visits;

(v) allowing for weekend hours for required follow-up visits;

(vi) allowing virtual or telemedicine visits;

(vii) use of wearable technology to record key health parameters; and

(viii) use of alternate labs or imaging centers, which may be closer to the residence of the patients participating in the trial; and

(E) the entity's education and training requirements for researchers and other individuals conducting or supporting the clinical trial with respect to diversity and health inequities in

underrepresented populations, including a requirement to consult with, and review materials made available by, such committees, task forces, and working groups other entities the Secretary determines are appropriate, including the following:

(i) The Equity Committee of the National Institutes of Health.

(ii) The National Advisory Council on Minority Health and Health Disparities.

(iii) The Advisory Committee on Research on Women's Health.

(iv) The Sexual & Gender Minority Research Coordinating Committee of the National Institutes of Health.

(v) The Tribal Health Research Coordinating Committee of the National Institutes of Health.

(2) TERMS.—

(A) IN GENERAL.—As a condition on the receipt of funding through the National Institutes of Health, as described in paragraph (1), with respect to a clinical trial, the sponsor of the clinical trial shall agree to terms requiring that—

(i) the aggregate demographic information of trial participants be shared on an annual basis with the Secretary while participant recruitment and data collection in such trial is ongoing, and that such information is provided with respect to—

(I) underrepresented populations, including populations grouped by race, ethnicity, age, sex, gender identity and expression, geographic region, primary written and spoken language, disability status, sexual orientation, socioeconomic status, occupation, and other relevant factors; and

(II) such populations that reflect the prevalence of the disease or condition that is the subject of the clinical trial involved (as available and as appropriate to the scientific objective for the study, as determined by the Director of the National Institutes of Health);

(ii) the sponsor submits to the program officer and grants management specialist of the specific National Institutes of

Health national research institute or national center, as frequently as such officer or specialist determines necessary, the retention rate of participants in the clinical trial, disaggregated by race, ethnicity, gender or sex, and age;

(iii) both the clinical trial researchers and the applicant reviewers complete education and training programs on diversity in clinical trials; and

(iv) at the conclusion of the trial, the sponsor submits to the Secretary the number of participants in the trial, disaggregated by race, ethnicity, age, and gender or sex.

(B) PRIVACY PROTECTIONS.—Any data shared under subparagraph (A) may not include any individually identifiable information or protected health information with respect to clinical trial participants and shall only be disclosed to the extent allowed under Federal privacy laws.

(3) EXCEPTION.—In lieu of submitting an application under paragraph (1) and documentation of goals as required by subparagraph (A) of such para-

graph, an applicant may provide reasoning (other than cost) for why the recruitment of each of the population groups specified in subparagraph (A) of paragraph (1) is not necessary and why such recruitment is not scientifically justified or possible.

(4) PUBLICATION.—The Secretary shall—

(A) publish on a public website of the National Institutes of Health, upon receipt of an application to which paragraph (1) applies or reasoning under paragraph (3)—

(i) a summary of the disease being targeted in the clinical trial that is the subject of the application and the prevalence of such disease across race, ethnicity, gender or sex, age, and clinical trial representation in each such category;

(ii) the goals specified in such application, as required by paragraph (1)(A); or

(iii) the reasoning described in paragraph (3); and

(B) ensure that, in publishing information relating to an application or reasoning under subparagraph (A), the design of the study involved is not disclosed.

(5) REMEDIATION.—

(A) IN GENERAL.—In the case of a clinical trial subject to paragraph (1) that fails to meet the condition specified pursuant to paragraph (1) by such date as may be agreed upon by the sponsor of the trial and the program officer and grants management specialist of the specific National Institutes of Health national research institute or national center, the Secretary shall require the sponsor of that clinical trial, not later than 60 days after such date occurs—

(i) to develop, in consultation with the Secretary and advocacy and community-based organizations representing individuals who are members of relevant demographic groups specified in paragraph (1)(A), a strategic plan to increase participation in such clinical trial of such individuals; and

(ii) to submit to the Secretary, such strategic plan.

(B) PUBLICATION.—The Secretary shall make publicly available on the website of the National Institutes of Health, the strategic plan received under subparagraph (A) as soon as possible after receipt. The Secretary shall en-

sure that, in publishing such plan under the preceding sentence, the design of the study involved is not disclosed.

(C) IMPLEMENTATION.—The sponsor of the clinical trial that is the subject of the strategic plan published under subparagraph (B), shall, not later than 60 days after such date as may be agreed upon by the sponsor of the trial and the appropriate program officer and grants management specialist of the National Institutes of Health, implement the strategic plan.

(D) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to a sponsor of a clinical trial, as necessary for the sponsor to meet the requirements of subparagraph (C).

(6) PENALTIES IN CASE OF FAILURE OF REMEDIATION.—

(A) IN GENERAL.—In the case of a clinical trial subject to paragraph (1) that, after the close of the 60-day period specified in paragraph (5)(C), continues to fail to meet the condition specified pursuant to paragraph (1)(A), the Secretary shall—

(i) hold the noncompeting continuation of funding received through the grant involved;

(ii) apply specific conditions on the award of funds to such sponsor to conduct such clinical trial; or

(iii) terminate such funding.

(B) WAIVER.—

(i) IN GENERAL.—In the case of a clinical trial subject to the penalty under subparagraph (A) that fails to meet the condition referred to in such subparagraph, the sponsor of such clinical trial may, prior to the conclusion of the 60-day period referred to in subparagraph (A), submit an application to the relevant program officer and grants specialist requesting a waiver of such condition. Such an application shall specify reasoning for why the recruitment of each of the population groups specified in subparagraph (A) of paragraph (1) is not necessary or why such recruitment is not scientifically justified or possible.

(ii) REVIEW.—Not later than 30 days after a date agreed upon by the sponsor of the trial and the appropriate program officer and grants management specialist of the National Institutes of Health, the Secretary shall—

(I) complete the review of such application; and

(II) make a determination to approve or deny the application.

(iii) NO ADDITIONAL PENALTIES.—No additional penalties may be applied with respect to a sponsor of a clinical trial under subparagraph (A) during the 30-day period specified in clause (ii).

(C) TERMINATION OF FUNDING.—In the case of a clinical trial described in subparagraph (B)(i), the Secretary may elect to terminate funding described in paragraph (1) for the clinical trial if no request for a waiver under subparagraph (B) is received by the conclusion 60-day period referred to in subparagraph (A).

(7) WAIVER FOR CERTAIN CLINICAL TRIALS.—

(A) IN GENERAL.—In the case of a clinical trial that received funding through the National

Institutes of Health and is ongoing as of the date of the enactment of this Act, the sponsor of such clinical trial is exempt from the requirements of (and associated penalties imposed by) this section.

(B) REPORT.—The Secretary shall include in the triennial report required to be submitted under section 403 of the Public Health Service Act (42 U.S.C. 283), a list of all clinical trials receiving funding through the National Institutes of Health—

(i) that requested and received waivers under this subsection; or

(ii) with respect to which funding has been terminated pursuant to this subsection.

(8) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study that—

(i) examines which actions Federal agencies have taken to address barriers to participation in federally-funded clinical trials by the demographic groups specified in paragraph (1)(A); and

(ii) identifies challenges, if any, in implementing such actions.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the findings of the study conducted under subparagraph (A).

(9) NONDISCRIMINATION.—Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116) shall apply with respect to a clinical trial subject to paragraph (1).

(b) ELIMINATING COST BARRIERS.—

(1) STUDY ON MODERNIZATION OF HUMAN SUBJECT REGULATIONS.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the National Institutes of Health (referred to in this subsection as the ''Secretary''), shall conduct and complete a study on—

(A) the need for review of human subject regulations specified in part 46 of title 45, Code of Federal Regulations (or successor regulations), and related guidance;

(B) the modernization of such regulations and guidance to establish updated guidelines for

reimbursement of out-of-pocket expenses of human subjects, compensation of human subjects for time spent participating in the clinical trial, and incentives for recruitment of human subjects; and

(C) the need for updated safe harbor rules under section 1001.952 of title 42, Code of Federal Regulations (or successor regulations) and section 1128B of the Social Security Act (commonly referred to as the Federal Anti-Kickback Statute (42 U.S.C. 1320a–7b)) with respect to the assistance provided under this subsection.

(2) REIMBURSEMENT FOR COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—As a condition on receipt of any funding provided through the National Institutes of Health to conduct a clinical trial investigating a drug or device (as those terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321)) or biological product (as defined in section 351(i) of the Public Health Service Act (42 U.S.C. 262(i))), the Secretary shall require that the sponsor of such clinical trial—

(A) works with institutional review boards and program officers of the National Institutes of Health to determine when reimbursement for the costs associated with clinical trial participation is warranted; and

(B) subject to paragraph (3), provides to clinical trial participants reimbursement for expenses (using funds other than funds supplied through the National Institutes of Health) incurred as a result of that participation, which may include—

(i) missed or forgone salary;

(ii) language assistance, including interpreter services;

(iii) food expenses;

(iv) childcare expenses;

(v) lodging expenses;

(vi) transportation expenses; or

(vii) other expenses as identified by the participant, subject to review by the clinical trial sponsor, at its discretion, on a case-by-case basis.

(3) PROVISION OF COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

(A) APPLICATION AND DOCUMENTATION.—

(i) IN GENERAL.—A sponsor of a clinical trial to which subsection (a)(1) applies, may require that, in order to receive reimbursement as described in paragraph (2), a participant complete an application and share with the sponsor such documentation of expenses described in such paragraph, as the sponsor may require.

(ii) TIMING.—Not later than 30 days after the date on which a sponsor of a clinical trial receives an application under clause (i), the sponsor shall—

(I) review the application; and

(II) provide for reimbursement of eligible expenses documented in such application, as determined at the discretion of the clinical trial sponsor on a case-by-case basis.

(B) ENFORCEMENT.—A sponsor of a clinical trial to which subsection (a)(1) applies, shall submit on an annual basis, as part of the progress reports submitted to the Secretary pursuant to section 402(j) of the Public Health

Service Act (42 U.S.C. 282(j)), during the data collection period of the clinical trial, to the Secretary an accounting of the reimbursements made to clinical trial participants under subparagraph (A). Such data shall—

(i) include relevant aggregate data with respect to each population group specified in subsection (a)(2)(A)(i) when such data will not compromise the identities of study participants and in a manner consistent with applicable privacy protections; and

(ii) not later than 6 months after receipt by the Secretary, be published on a public website of the National Institutes of Health.

(c) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—

(1) NATIONAL CAMPAIGN.—The Secretary of Health and Human Services, acting through the Director of the National Institutes of Health and the Commissioner of Food and Drugs (referred to in this subsection as the ''Secretary''), in consultation with the stakeholders specified in paragraph (5), shall carry out a national campaign to increase the

awareness and knowledge of individuals in the United States with respect to the need for diverse clinical trials among the demographic groups identified pursuant to subsection (a)(1)(A).

(2) REQUIREMENTS.—The national campaign conducted shall include—

(A) the development and distribution of written educational materials, and the development and placing of public service announcements, that are intended to encourage individuals who are members of the demographic groups identified pursuant to subsection (a)(2)(A)(i)(I) to seek to participate in clinical trials;

(B) such efforts as are reasonable and necessary to ensure meaningful access by consumers with limited English proficiency;

(C) the development and distribution of best practices and training for recruiting underrepresented study populations, including a method for sharing such best practices among clinical trial sponsors, providers, community-based organizations who assist with recruitment, and with the public; and

(D) the conduct of focus groups to better understand the concerns and fears of certain underrepresented groups who may be reluctant to participate in clinical trials.

(3) HEALTH INEQUITIES.—In developing the national campaign under paragraph (1), the Secretary shall recognize and address—

(A) health inequities among individuals who are members of the population groups specified in subsection (a)(2)(A)(i) with respect to access to care and participation in clinical trials; and

(B) any barriers in access to care and participation in clinical trials that are specific to individuals who are members of such groups.

(4) GRANTS.—The Secretary shall establish a program to award grants to nonprofit private entities, including community based organizations and faith communities, institutions of higher education eligible to receive funds under section 371 of the Higher Education Act of 1965 (20 U.S.C. 1067q) and national organizations that serve underrepresented populations and community pharmacies to enable such entities—

(A) to test alternative outreach and education strategies to increase the awareness and knowledge of individuals in the United States, with respect to the need for diverse clinical trials that reflect the race, ethnicity, age, and gender or sex of patients with the disease or condition being investigated; and

(B) to cover administrative costs of such entities in assisting in diversifying clinical trials subject to subsection (a).

(5) STAKEHOLDERS SPECIFIED.—The stakeholders specified in this paragraph are the following:

(A) Representatives of the Health Resources Services Administration, the Office of Minority Health of the Department of Health and Human Services, the Centers for Disease Control and Prevention, and the National Institutes of Health.

(B) Community-based resources and advocates.

(6) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $10,000,000 for each of fiscal years 2023 through 2026.

(d) DEFINITIONS.—In this section:

(1) CLINICAL TRIAL.—The term ''clinical trial'' means a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

(2) SPONSOR.—The term ''sponsor'' has the meaning given such term in section 50.3 of title 21, Code of Federal Regulations (or successor regulations).

SEC. 7554. PATIENT EXPERIENCE DATA.

(a) POLICY.—Section 569C of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c) is amended—

(1) by redesignating subsections (b) and (c) as subsections (c) and (d), respectively; and

(2) by inserting after subsection (a) the following new subsection:

''(b) COLLECTION, SUBMISSION, AND USE OF DATA.—

''(1) IN GENERAL.—The Secretary shall—

''(A) for any drug for which an exemption is granted for investigational use under section 505(i) of this Act or section 351(a) of the Public Health Service Act, require the sponsor of

the drug to collect standardized patient experience data as part of the clinical trials conducted pursuant to such exemption;

"(B) require any application for the approval or licensing of such drug under section 505(b) of this Act or section 351(a) of the Public Health Service Act to include—

"(i) the standardized patient experience data so collected; and

"(ii) such related information as the Secretary may require; and

"(C) consider patient experience data and related information that is submitted pursuant to subparagraph (B) in deciding whether to approve or license, as applicable, the drug involved.

"(2) APPLICABILITY.—Paragraph (1) applies only with respect to drugs for which a request for an exemption described in paragraph (1)(A) is submitted on or after the date of the enactment of the Health Equity and Accountability Act of 2022, or an application under section 505(b) of this Act or section 351(a) of the Public Health Service Act is filed, as applicable, on or after the day that is 2 years

after the date of the enactment of the Health Equity and Accountability Act of 2022.''.

(b) REGULATIONS.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall promulgate final regulations to implement section 569C(b) of the Federal Food, Drug, and Cosmetic Act, as added by this section.

Subtitle M—Additional Provisions Addressing High Impact Minority Diseases

SEC. 7601. MEDICARE COVERAGE OF MULTI-CANCER EARLY DETECTION SCREENING TESTS.

(a) COVERAGE.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended be sections 2007, 4221, 4251, 6011, and 7220, is amended —

(1) in subsection (s)(2)—

(A) in subparagraph (JJ), by striking ''and'' at the end;

(B) in subparagraph (KK), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(LL) multi-cancer early detection screening tests (as defined in subsection (qqq));''; and

(2) by adding at the end the following new subsection:

''(qqq) MULTI-CANCER EARLY DETECTION SCREENING TESTS.—The term 'multi-cancer early detection screening test' means any of the following tests, approved or cleared by the Food and Drug Administration, furnished to an individual for the purpose of early detection of cancer across many cancer types (as categorized in the Annual Report to the Nation on the Status of Cancer issued by the National Cancer Institute):

''(1) A genomic sequencing blood or blood product test that includes the analysis of cell-free nucleic acids.

''(2) Such other equivalent tests (which are based on urine or other sample of biological material) as the Secretary determines appropriate.''.

(b) PAYMENT AND FREQUENCY LIMIT.—

(1) PAYMENT UNDER FEE SCHEDULE.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(A) in paragraph (1)(A), by inserting after ''(including'' the following: ''multi-cancer early detection screening tests under section 1861(qqq) and including''; and

(B) by adding at the end the following new paragraph:

''(10) No payment may be made under this part for a multi-cancer early detection screening test (as defined in section 1861(qqq)) for an individual if such a test was furnished to the individual during the previous 11 months.''.

(2) CONFORMING AMENDMENT.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P), by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(Q) in the case of multi-cancer early detection screening tests (as defined in section 1861(qqq)), which are performed more frequently than is covered under section 1833(h)(10);''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(c) RULE OF CONSTRUCTION RELATING TO OTHER CANCER SCREENING TESTS.—Nothing in this section, including the amendments made by this section, shall be construed—

(1) in the case of an individual who undergoes a multi-cancer early detection screening test, to affect coverage under part B for other cancer screening tests covered under this section, such as screening tests for breast, cervical, colorectal, lung, or prostate cancer; or

(2) in the case of an individual who undergoes another cancer screening test, to affect coverage for a multi-cancer early detection screening test or the use of such a test as a diagnostic or confirmatory test for a result of the other cancer screening test.

SEC. 7602. AMPUTATION REDUCTION AND COMPASSION ACT.

(a) PERIPHERAL ARTERY DISEASE EDUCATION PROGRAM.— Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 7254, is further amended by adding at the end the following new section:

"SEC. 399V–13. PERIPHERAL ARTERY DISEASE EDUCATION PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, in collaboration with the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Health Resources and Services Administration, shall establish and coordinate a peripheral artery disease education program to support, develop, and implement educational initiatives and outreach strategies that inform health care professionals and the public about the existence of peripheral artery disease and methods to reduce amputations related to such disease, particularly with respect to at-risk populations.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.''.

(b) MEDICARE COVERAGE OF PERIPHERAL ARTERY DISEASE SCREENING TESTS FURNISHED TO AT-RISK BENEFICIARIES WITHOUT IMPOSITION OF COST SHARING REQUIREMENTS.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended be sections 2007, 4221, 4251, 6011, 7220, and 7601, is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (KK), by striking ''and'' at the end;

(ii) in subparagraph (LL), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subparagraph:

''(MM) peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in subsection (rrr)).''; and

(B) by adding at the end the following new subsection:

''(rrr) PERIPHERAL ARTERY DISEASE SCREENING TEST; AT-RISK BENEFICIARY.—(1) The term 'peripheral artery disease screening test' means—

''(A) noninvasive physiologic studies of extremity arteries (commonly referred to as ankle-brachial index testing);

''(B) arterial duplex scans of lower extremity arteries vascular; and

''(C) such other items and services as the Secretary determines, in consultation with relevant stakeholders, to be appropriate for screening for peripheral artery disease for at-risk beneficiaries.

''(2) The term 'at-risk beneficiary' means an individual entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B—

''(A) who is 65 years of age or older;

''(B) who is at least 50 years of age but not older than 64 years of age with risk factors for atherosclerosis (such as diabetes mellitus, a history of smoking, hyperlipidemia, and hypertension) or a family history of peripheral artery disease;

''(C) who is younger than 50 years of age with diabetes mellitus and one additional risk factor for atherosclerosis; or

''(D) with a known atherosclerotic disease in another vascular bed such as coronary, carotid, subclavian, renal, or mesenteric artery stenosis, or abdominal aortic aneurysm.

''(3) The Secretary shall, in consultation with appropriate organizations, establish standards regarding the frequency for peripheral artery disease screening tests described in subsection (s)(2)(II) for purposes of coverage under this title.''.

(2) INCLUSION OF PERIPHERAL ARTERY DISEASE SCREENING TESTS IN INITIAL PREVENTIVE PHYSICAL EXAMINATION.—Section 1861(ww)(2) of

the Social Security Act (42 U.S.C. 1395x(ww)(2)) is amended—

(A) in subparagraph (N), by moving the margins of such subparagraph 2 ems to the left;

(B) by redesignating subparagraph (O) as subparagraph (P); and

(C) by inserting after subparagraph (N) the following new subparagraph:

''(O) Peripheral artery disease screening tests furnished to at risk-beneficiaries (as such terms are defined in subsection (rrr)).''.

(3) PAYMENT.—

(A) IN GENERAL.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)), as amended by sections 4251(c)(3), 6011(a)(4), and 7220, is amended —

(i) in paragraph (1)—

(I) in subparagraph (N), by inserting ''and other than peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1861(lll))'' after ''other than personalized prevention

plan services (as defined in section 1861(hhh)(1))'';

(II) by striking ''and'' before ''(GG)''; and

(III) by inserting before the semicolon at the end the following: '', and (HH) with respect to peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1861(rrr)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''; and

(ii) in paragraph (2)—

(I) in subparagraph (G), by striking ''and'' at the end;

(II) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(III) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to peripheral artery disease screening tests (as defined in paragraph (1) of section 1861(rrr)) furnished by an outpatient department of a hospital to at-risk beneficiaries (as defined in paragraph (2) of such section), the amount determined under paragraph (1)(EE),''.

(B) NO DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 6075, is amended, in the first sentence—

(i) by striking ''and'' before ''(13)''; and

(ii) by inserting '', and (14) such deductible shall not apply with respect to peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1861(rrr))'' before the period at the end.

(C) EXCLUSION FROM PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended—

(i) by striking '', or personalized'' and inserting '', personalized''; and

(ii) by inserting ", or peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1861(rrr))" after "personalized prevention plan services (as defined in section 1861(hhh)(1))".

(D) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 4251(c)(4), is amended by inserting ", (2)(MM)," after "(2)(II)".

(4) EXCLUSION FROM COVERAGE AND MEDICARE AS SECONDARY PAYER FOR TESTS PERFORMED MORE FREQUENTLY THAN ALLOWED.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by section 7601, is amended—

(A) in subparagraph (P), by striking "and" at the end;

(B) in subparagraph (Q), by striking the semicolon at the end and inserting ", and"; and

(C) by adding at the end the following new subparagraph:

"(R) in the case of peripheral artery disease screening tests furnished to at-risk bene-

ficiaries (as such terms are defined in section 1861(rrr)), which are performed more frequently than is covered under such section;''.

(5) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834(n) of the Social Security Act (42 U.S.C. 1395m(n)) is amended—

(A) by redesignating subparagraphs (A) and (B) of paragraph (1) as clauses (i) and (ii), respectively, and moving the margins of such clauses, as so redesignated, 2 ems to the right;

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving the margins of such subparagraphs, as so redesignated, 2 ems to the right;

(C) by striking ''CERTAIN PREVENTIVE SERVICES'' and all that follows through ''any other provision of this title'' and inserting: ''CERTAIN PREVENTIVE SERVICES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title''; and

(D) by adding at the end the following new paragraph:

''(2) INAPPLICABILITY.—The Secretarial authority described in paragraph (1) shall not apply

with respect to preventive services described in section 1861(ww)(2)(O).''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to items and services furnished on or after January 1, 2023.

(c) MEDICAID COVERAGE OF PERIPHERAL ARTERY DISEASE SCREENING TESTS FURNISHED TO AT-RISK BENEFICIARIES WITHOUT IMPOSITION OF COST SHARING REQUIREMENTS.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) as amended by sections 2007(d)(3) and 5201(a)(5)(G)(i), is amended—

(A) in subsection (a)—

(i) by redesignating paragraph (33) as paragraph (34);

(ii) in paragraph (32), by striking ''and'' after the semicolon; and

(iii) by inserting after paragraph (32) the following new paragraph:

''(33) peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in subsection (qq)); and''; and

(B) by adding at the end the following new subsection:

''(qq) PERIPHERAL ARTERY DISEASE SCREENING TEST; AT-RISK BENEFICIARY.—

''(1) PERIPHERAL ARTERY DISEASE SCREENING TEST.—The term 'peripheral artery disease screening test' means—

''(A) noninvasive physiologic studies of extremity arteries (commonly referred to as ankle-brachial index testing);

''(B) arterial duplex scans of lower extremity arteries vascular; and

''(C) such other items and services as the Secretary determines, in consultation with relevant stakeholders, to be appropriate for screening for peripheral artery disease for at-risk beneficiaries.

''(2) AT-RISK BENEFICIARY.—The term 'at-risk beneficiary' means an individual enrolled under a State plan (or a waiver of such plan)—

''(A) who is 65 years of age or older;

''(B) who is at least 50 years of age but not older than 64 years of age with risk factors for atherosclerosis (such as diabetes mellitus, a history of smoking, hyperlipidemia, and hypertension) or a family history of peripheral artery disease;

''(C) who is younger than 50 years of age with diabetes mellitus and one additional risk factor for atherosclerosis; or

''(D) with a known atherosclerotic disease in another vascular bed such as coronary, carotid, subclavian, renal, or mesenteric artery stenosis, or abdominal aortic aneurysm.

''(3) FREQUENCY.—The Secretary shall, in consultation with appropriate organizations, establish standards regarding the frequency for peripheral artery disease screening tests described in subsection (a)(33) for purposes of coverage under a State plan under this title.''.

(2) NO COST SHARING.—

(A) IN GENERAL.—Subsections (a)(2) and (b)(2) of section 1916 of the Social Security Act (42 U.S.C. 1396o), as amended by section 7154(b)(1), are each amended—

(i) in subparagraph (J), by striking ''or'' after the comma at the end;

(ii) in subparagraph (K), by striking ''; and'' and inserting '', or''; and

(iii) by adding at the end the following new subparagraph:

''(L) peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1905(hh)); and''.

(B) APPLICATION TO ALTERNATIVE COST SHARING.—Section 1916A(b)(3)(B) of the Social Security Act (42 U.S.C. 1396o–1(b)(3)(B)), , as amended by section 7154(b)(2), is amended by adding at the end the following new clause:

''(xv) Peripheral artery disease screening tests furnished to at-risk beneficiaries (as such terms are defined in section 1905(qq)).''.

(3) MANDATORY COVERAGE.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), as amended by section 2007(d)(2), is amended by striking ''and (31)'' and inserting ''(31), and (33)''.

(d) REQUIREMENT FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP OR INDIVIDUAL HEALTH INSURANCE COVERAGE TO PROVIDE COVERAGE FOR PERIPHERAL ARTERY DISEASE SCREENING TESTS FURNISHED TO AT-RISK ENROLLEES WITHOUT IMPOSITION OF COST SHARING REQUIREMENTS.—

(1) IN GENERAL.—Section 2713 of the Public Health Service Act (42 U.S.C. 300gg–13) is amended—

(A) by amending subsection (a), as amended by section 7220(a)(1)(A), to read as follows:

''(a) COVERAGE OF PREVENTIVE HEALTH SERVICES.—

''(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum, provide coverage for and shall not impose any cost sharing requirements for—

''(A) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

''(B) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

''(C) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehen-

sive guidelines supported by the Health Resources and Services Administration;

"(D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subparagraph;

"(E) any prescription drug approved by the Food and Drug Administration for the prevention of HIV (other than a drug subject to preauthorization requirements consistent with section 2729A), administrative fees for such drugs, laboratory and other diagnostic procedures associated with the use of such drugs, and clinical follow up and monitoring, including any related services recommended in current United States Public Health Service clinical practice guidelines, without limitation; and

"(F) with respect to at-risk enrollees, peripheral artery disease screening tests.

"(2) PERIPHERAL ARTERY DISEASE SCREENING TEST; AT-RISK ENROLLEE.—For purposes of paragraph (1)(E):

"(A) PERIPHERAL ARTERY DISEASE SCREENING TEST.—The term 'peripheral artery disease screening test' means—

"(i) noninvasive physiologic studies of extremity arteries (commonly referred to as ankle-brachial index testing);

"(ii) arterial duplex scans of lower extremity arteries vascular; and

"(iii) such other items and services as the Secretary determines, in consultation with relevant stakeholders, to be appropriate for screening for peripheral artery disease for at-risk enrollees.

"(B) AT-RISK ENROLLEE.—The term 'at-risk enrollee' means an individual enrolled in a group health plan or group or individual health insurance coverage—

"(i) who is 65 years of age or older;

"(ii) who is at least 50 years of age but not older than 64 years of age with risk factors for atherosclerosis (such as diabetes mellitus, a history of smoking, hyperlipidemia, and hypertension) or a family history of peripheral artery disease;

"(iii) who is younger than 50 years of age with diabetes mellitus and one additional risk factor for atherosclerosis; or

"(iv) with a known atherosclerotic disease in another vascular bed such as coronary, carotid, subclavian, renal, or mesenteric artery stenosis, or abdominal aortic aneurysm.

"(C) FREQUENCY.—The Secretary shall, in consultation with appropriate organizations, establish standards regarding the frequency for peripheral artery disease screening tests described in paragraph (1)(E) for purposes of coverage under this section.

"(3) CLARIFICATION REGARDING BREAST CANCER SCREENING, MAMMOGRAPHY, AND PREVENTION RECOMMENDATIONS.—For the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

"(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit a plan

or issuer from providing coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.''; and

(B) in subsection (b)(1)—

(i) by striking ''subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3)'' and inserting ''subparagraph (A) or (B) of subsection (a)(1) or a guideline under subparagraph (C) of such subsection''; and

(ii) by striking ''described in subsection (a)'' and inserting ''described in subsection (a)(1)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to plan years beginning on or after January 1, 2023.

(e) DISALLOWANCE OF PAYMENT FOR NONTRAUMATIC AMPUTATION SERVICES FURNISHED WITHOUT ANATOMICAL TESTING SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by section 4221(b)(2), is amended by adding at the end the following new subsection:

''(aa) DISALLOWANCE OF PAYMENT FOR NONTRAUMATIC AMPUTATION SERVICES FURNISHED WITHOUT ANATOMICAL TESTING SERVICES.—

''(1) IN GENERAL.—In the case of nontraumatic amputation services furnished by a supplier on or after January 1, 2023, to an individual entitled to, or enrolled for, benefits under part A and enrolled for benefits under this part, for which payment is made under this part, payment may only be made under this part if—

''(A) such supplier furnishes anatomical testing services to such individual during the 3-month period preceding the date on which such nontraumatic amputation services is furnished; or

''(B) such individual has a pre-existing dysfunctional or unsalvageable limb, life-threatening sepsis, intractable infection, extensive gangrene or necrotic tissue loss beyond salvage, a poor functional status, severe dementia, or a short life expectancy after shared decision-making with a health care team and patient, family, or caregiver.

''(2) DEFINITIONS.—In this subsection:

''(A) ANATOMICAL TESTING SERVICES.—The term 'anatomical testing services' means arterial duplex scanning, computed tomography angiography, and magnetic resonance angiography.

''(B) NONTRAUMATIC AMPUTATION SERVICES.—The term 'nontraumatic amputation services' means amputations as a result of atherosclerotic vascular disease or a related comorbidity of such disease (including diabetes).''.

(f) DEVELOPMENT AND IMPLEMENTATION OF QUALITY MEASURES.—

(1) DEVELOPMENT.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall, in consultation with relevant stakeholders, develop quality measures for nontraumatic, lower-limb, major amputation that utilize appropriate diagnostic screening (including peripheral artery disease screening) in order to encourage alternative treatments (including revascularization) in lieu of such an amputation.

(2) IMPLEMENTATION.—After appropriate testing and validation of the measures developed under paragraph (1), the Secretary shall incorporate such measures in quality reporting programs for appro-

priate providers of services and suppliers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including for purposes of—

(A) the merit-based incentive payment system under section 1848(q) of such Act (42 U.S.C. 1395w–4(q));

(B) incentive payments for participation in eligible alternative payment models under section 1833(z) of such Act (42 U.S.C. 1395l(z));

(C) the shared savings program under section 1899 of such Act (42 U.S.C. 1395jjj);

(D) models under section 1115A of such Act (42 U.S.C. 1315a); and

(E) such other payment systems or models as the Secretary may specify.

SEC. 7603. ELIMINATING THE COINSURANCE REQUIREMENT FOR CERTAIN COLORECTAL CANCER SCREENING TESTS FURNISHED UNDER THE MEDICARE PROGRAM.

Section 1833(dd) of the Social Security Act (42 U.S.C. 1395l(dd)) is amended—

(1) in paragraph (1), by striking ''and before January 1, 2030,''; and

(2) in paragraph (2)—

(A) in subparagraph (A), by adding ''and'' at the end;

(B) in subparagraph (B), by striking ''through 2026, 85 percent; and'' and inserting ''and each subsequent year, 100 percent.''; and

(C) by striking subparagraph (C).

SEC. 7604. EXPANDING THE AVAILABILITY OF MEDICAL NUTRITION THERAPY SERVICES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)(V), by striking ''in the case of'' and all that follows through ''organizations''; and

(2) in subsection (vv)—

(A) in paragraph (1)—

(i) by striking ''disease management'' and inserting ''the prevention, management, or treatment of a disease or condition specified in paragraph (4)''; and

(ii) by striking ''by a physician'' and all that follows through the period at the end and inserting the following: ''by a—

''(A) physician (as defined in subsection (r)(1));

''(B) physician assistant;

''(C) nurse practitioner;

''(D) clinical nurse specialist (as defined in subsection (aa)(5)(B)); or

''(E) in the case of such services furnished to manage such a disease or condition that is an eating disorder, a clinical psychologist (as defined by the Secretary).

Such term shall not include any services furnished to an individual for the prevention, management, or treatment of a renal disease if such individual is receiving maintenance dialysis for which payment is made under section 1881.''; and

(B) by adding at the end the following new paragraph:

''(4) For purposes of paragraph (1), the diseases and conditions specified in this paragraph are the following:

''(A) Diabetes and prediabetes.

''(B) A renal disease.

''(C) Obesity (as defined for purposes of subsection (yy)(2)(C) or as otherwise defined by the Secretary).

''(D) Hypertension.

''(E) Dyslipidemia.

''(F) Malnutrition.

''(G) Eating disorders.

''(H) Cancer.

''(I) Gastrointestinal diseases, including celiac disease.

''(J) HIV.

''(K) AIDS.

''(L) Cardiovascular disease.

''(M) Any other disease or condition—

''(i) specified by the Secretary relating to unintentional weight loss;

''(ii) for which the Secretary determines the services described in paragraph (1) to be medically necessary and appropriate for the prevention, management, or treatment of such disease or condition, consistent with any applicable recommendations of the United States Preventive Services Task Force; or

''(iii) for which the Secretary determines the services described in paragraph (1) are medically necessary, consistent with either protocols established by registered dietitians or nutrition professional organizations or with accepted clinical guidelines identified by the Secretary.''.

(b) EXCLUSION MODIFICATION.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by sections 7601 and 7602, is amended—

(1) in subparagraph (Q), by striking ''and'' at the end;

(2) in subparagraph (R), by striking the semicolon at the end and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(S) in the case of medical nutrition therapy services (as defined in section 1861(vv)), which are not furnished for the prevention, management, or treatment of a disease or condition specified in paragraph (4) of such section;''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to items and services furnished on or after January 1, 2023.

SEC. 7605. ENCOURAGING THE DEVELOPMENT AND USE OF DISARM ANTIMICROBIAL DRUGS.

(a) ADDITIONAL PAYMENT FOR DISARM ANTIMICROBIAL DRUGS UNDER MEDICARE.—

(1) IN GENERAL.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended by adding at the end the following new subparagraph:

''(N)(i)(I) Effective for discharges beginning on or after October 1, 2023, or such sooner date as specified by the Secretary, subject to subclause (II), the Secretary shall, after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise), provide for an additional payment under a mechanism (separate from the mechanism established under subparagraph (K)), with respect to such discharges involving any DISARM antimicrobial drug, in an amount equal to—

''(aa) the amount payable under section 1847A for such drug during the calendar quarter in which the discharge occurred; or

''(bb) if no amount for such drug is determined under section 1847A, an amount to be determined by the Secretary in a manner similar to the manner in which payment amounts are determined under section 1847A based on information submitted by the manufacturer or sponsor of such drug (as required under clause (v)).

''(II) In determining the amount payable under section 1847A for purposes of items (aa) and (bb) of subclause (I), subparagraphs (A) and (B) of subsection (b)(1) of such section shall be applied by substituting '102 percent' for '106 percent' each place it appears and para-

graph (8)(B) of such section shall be applied by substituting '2 percent' for '6 percent'.

"(ii) For purposes of this subparagraph, a DISARM antimicrobial drug is—

"(I) a drug—

"(aa) that—

"(AA) is approved by the Food and Drug Administration;

"(BB) is designated by the Food and Drug Administration as a qualified infectious disease product under subsection (d) of section 505E of the Federal Food, Drug, and Cosmetic Act; and

"(CC) has received an extension of its exclusivity period pursuant to subsection (a) of such section; and

"(bb) that has been designated by the Secretary pursuant to the process established under clause (iv)(I)(bb); or

"(II) an antibacterial or antifungal biological product—

"(aa) that is licensed for use, or an antibacterial or antifungal biological product for which an indication is first licensed for use, by the Food and Drug Administration on or after

June 5, 2014, under section 351(a) of the Public Health Service Act for human use to treat serious or life-threatening infections, as determined by the Food and Drug Administration, including those caused by, or likely to be caused by—

''(AA) an antibacterial or antifungal resistant pathogen, including novel or emerging infectious pathogens; or

''(BB) a qualifying pathogen (as defined under section 505E(f) of the Federal Food, Drug, and Cosmetic Act); and

''(bb) has been designated by the Secretary pursuant to the process established under clause (iv)(I)(bb).

''(iii) The mechanism established pursuant to clause (i) shall provide that the additional payment under clause (i) shall—

''(I) with respect to a discharge, only be made to a subsection (d) hospital that, as determined by the Secretary—

''(aa) is participating in the National Healthcare Safety Network Antimicrobial Use and Resistance Module of the Centers for Disease Control and Prevention; and

''(bb) has an antimicrobial stewardship program that aligns with the Core Elements of Hospital Antibiotic Stewardship Programs of the Centers for Disease Control and Prevention or the Antimicrobial Stewardship Standard set by the Joint Commission; and

''(II) apply to discharges occurring on or after October 1 of the year in which the drug or biological product is designated by the Secretary as a DISARM antimicrobial drug.

For purposes of this clause, in the case of a similar reporting program described in item (aa), a subsection (d) hospital shall be treated as participating in such a program if the entity maintaining such program identifies to the Secretary such hospital as so participating.

''(iv)(I) The mechanism established pursuant to clause (i) shall provide for a process for—

''(aa) a manufacturer or sponsor of a drug or biological product to request the Secretary to designate the drug or biological product as a DISARM antimicrobial drug; and

''(bb) the designation (and removal of such designation) by the Secretary of drugs and biological products as DISARM antimicrobial drugs.

''(II) A designation of a drug or biological product as a DISARM antimicrobial drug may be revoked by the Secretary if the Secretary determines that—

''(aa) the drug or biological product no longer meets the requirements for a DISARM antimicrobial drug under clause (ii);

''(bb) the request for such designation contained an untrue statement of material fact; or

''(cc) clinical or other information that was not available to the Secretary at the time such designation was made shows that—

''(AA) such drug or biological product is unsafe for use or not shown to be safe for use for individuals who are entitled to benefits under part A; or

''(BB) an alternative to such drug or biological product is an advance that substantially improves the diagnosis or treatment of such individuals.

''(III) Not later than October 1, 2023, the Secretary shall publish in the Federal Register a list of the DISARM antimicrobial drugs designated under this subparagraph pursuant to the process established under subclause (I)(bb). The Secretary shall annually update such list.

''(v)(I) For purposes of determining additional payment amounts under clause (i), a manufacturer or sponsor of a drug or biological product that submits a request described in clause (iv)(I)(aa) shall submit to the Secretary information described in section 1927(b)(3)(A)(iii).

''(II) The penalties for failure to provide timely information under clause (i) of subparagraph (C) section 1927(b)(3) and for providing false information under clause (ii) of such subparagraph shall apply to manufacturers and sponsors of a drug or biological product under this section with respect to information under subclause (I) in the same manner as such penalties apply to manufacturers under such clauses with respect to information under subparagraph (A) of such section.

''(vi)(I) The mechanism established pursuant to clause (i) shall provide that—

''(aa) except as provided in item (bb), no additional payment shall be made under this subparagraph for discharges involving a DISARM antimicrobial drug if any additional payments have been made for discharges involving such drug as a new medical service or technology under subparagraph (K);

''(bb) additional payments may be made under this subparagraph for discharges involving a DIS-

ARM antimicrobial drug if any additional payments have been made for discharges occurring prior to the date of enactment of this subparagraph involving such drug as a new medical service or technology under subparagraph (K); and

''(cc) no additional payment shall be made under subparagraph (K) for discharges involving a DISARM antimicrobial drug as a new medical service or technology if any additional payments for discharges involving such drug have been made under this subparagraph.''.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(K)(ii)(III) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking ''provide'' and inserting ''subject to subparagraph (N)(vii), provide''.

(b) AUTHORIZATION OF APPROPRIATIONS FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION.—There is authorized to be appropriated to the Centers for Disease Control and Prevention $500,000,000, to remain available until expended, to support establishment and implementation of antimicrobial stewardship programs and data reporting capabilities to the Antimicrobial Use and Resistance option of the CDC National Healthcare Safety Network, especially in critical access hospitals, rural hos-

pitals, and community hospitals, to support detection, surveillance, containment, and prevention of resistant pathogens in the United States and overseas.

(c) STUDY AND REPORTS ON REMOVING BARRIERS TO THE DEVELOPMENT OF DISARM ANTIMICROBIAL DRUGS.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall, in consultation with the Director of the National Institutes of Health, the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, and the Director of the Centers for Disease Control and Prevention, conduct a study over a 5-year period of the barriers that prevent the development of DISARM antimicrobial drugs (as defined in section 1886(d)(5)(N)(ii) of the Social Security Act, as added by subsection (a)), including—

(A) patient outcomes in conjunction with the use of DISARM drugs, including—

(i) duration of stay in the intensive care unit;

(ii) recidivism within 30 days; and

(iii) measures of additional follow up care;

(B) the effectiveness of antimicrobial stewardship and surveillance programs, including—

(i) changes in the percentage of hospitals in the United States with an antimicrobial stewardship program in place that aligns with the Core Elements of Hospital Antibiotic Stewardship Programs, as outlined by the Centers for Disease Control and Prevention;

(ii) changes in inpatient care of clostridioides difficile infection; and

(iii) changes in inpatient rates of resistance to key pathogens; and

(C) considerations relating to Medicare payment reform, including—

(i) changes in the number of qualified antimicrobial products approved;

(ii) changes in wholesale acquisition cost of individual qualified antimicrobial products over time;

(iii) changes in year-over-year volume of individual qualified antimicrobial products sold; and

(iv) the overall cost of qualified antimicrobial products to the Medicare pro-

gram as a proportion of total Medicare part A spending.

(2) REPORT.—Not later than 5 years after the date of the enactment of this section, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 7606. TREAT AND REDUCE OBESITY ACT.

(a) AUTHORITY TO EXPAND HEALTH CARE PROVIDERS QUALIFIED TO FURNISH INTENSIVE BEHAVIORAL THERAPY.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395x(ddd)) is amended by adding at the end the following new paragraph:

''(4)(A) Subject to subparagraph (B), the Secretary may, in addition to qualified primary care physicians and other primary care practitioners, cover intensive behavioral therapy for obesity furnished by any of the following:

''(i) A physician (as defined in subsection (r)(1)) who is not a qualified primary care physician.

''(ii) Any other appropriate health care provider (including a physician assistant, nurse

practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)), a clinical psychologist, a registered dietitian or nutrition professional (as defined in subsection (vv))).

''(iii) An evidence-based, community-based lifestyle counseling program approved by the Secretary.

''(B) In the case of intensive behavioral therapy for obesity furnished by a provider described in clause (ii) or (iii) of subparagraph (A), the Secretary may only cover such therapy if such therapy is furnished—

''(i) upon referral from, and in coordination with, a physician or primary care practitioner operating in a primary care setting or any other setting specified by the Secretary; and

''(ii) in an office setting, a hospital outpatient department, a community-based site that complies with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 264(c) of the Health Insurance Portability and

Accountability Act of 1996, or another setting specified by the Secretary.

''(C) In order to ensure a collaborative effort, the coordination described in subparagraph (B)(i) shall include the health care provider or lifestyle counseling program communicating to the referring physician or primary care practitioner any recommendations or treatment plans made regarding the therapy.''.

(b) MEDICARE PART D COVERAGE OF OBESITY MEDICATION.—

(1) IN GENERAL.—Section 1860D–2(e)(2)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(2)(A)) is amended, in the first sentence—

(A) by striking ''and other than'' and inserting ''other than''; and

(B) by inserting after ''benzodiazepines),'' the following: ''and other than subparagraph (A) of such section if the drug is used for the treatment of obesity (as defined in section 1861(yy)(2)(C)) or for weight loss management for an individual who is overweight (as defined in section 1861(yy)(2)(F)(i)) and has one or more related comorbidities,''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to plan years beginning on or after the date that is 2 years after the date of the enactment of this section.

(c) REPORT TO CONGRESS.—Not later than the date that is 1 year after the date of the enactment of this section, and every 2 years thereafter, the Secretary of Health and Human Services shall submit a report to Congress describing the steps the Secretary has taken to implement the provisions of, and amendments made by, this section. Such report shall also include recommendations for better coordination and leveraging of programs within the Department of Health and Human Services and other Federal agencies that relate in any way to supporting appropriate research and clinical care (such as any interactions between physicians and other health care providers and their patients) to treat, reduce, and prevent obesity in the adult population.

SEC. 7607. INCENTIVES, IMPROVEMENTS, AND OUTREACH TO INCREASE DIVERSITY IN ALZHEIMER'S DISEASE RESEARCH.

(a) IMPROVING ACCESS FOR AND OUTREACH TO UNDERREPRESENTED POPULATIONS.—

(1) EXPANDING ACCESS TO ALZHEIMER'S RESEARCH CENTERS.—

(A) IN GENERAL.—Section 445(a)(1) of the Public Health Service Act (42 U.S.C. 285e–2(a)(1)) is amended—

(i) by striking ''(a)(1) The Director of the Institute may'' and inserting the following:

''(a)(1) The Director of the Institute—

''(A) may'';

(ii) by striking ''disease.'' and inserting ''disease; and''; and

(iii) by adding at the end the following:

''(B) beginning January 1, 2023, shall enter into cooperative agreements and make grants to public or private nonprofit entities under this subsection for the planning, establishment, and operation of new such centers that are located in areas with a higher concentration of minority groups (as determined under section 444(d)(3)(D)), such as entities that are historically Black colleges and universities, Hispanic-serving institutions, Tribal colleges and universities, or centers of excellence for other minority populations.''.

(B) USE OF FUNDING FOR CLINICS TO OPERATE CLINICAL TRIALS.—Section 445(b) of

the Public Health Service Act (42 U.S.C. 285e–2(b)) is amended by adding at the end the following:

"(3) Federal payments made under a cooperative agreement or grant under subsection (a) from funds made available under section 7607(g) of the Health Equity and Accountability Act of 2022 shall, with respect to Alzheimer's disease, be used in part to establish and operate diagnostic and treatment clinics designed—

"(A) to meet the special needs of minority and rural populations and other underserved populations; and

"(B) to operate clinical trials.".

(2) OUTREACH.—

(A) ALZHEIMER'S DISEASE CENTERS.—Section 445(b) of the Public Health Service Act (42 U.S.C. 285e–2(b)), as amended by paragraph (1)(B), is further amended by adding at the end the following new paragraph:

"(4) Federal payments made under a cooperative agreement or grant under subsection (a) shall be used to establish engagement centers to carry out public outreach, education efforts, and dissemination of information for members of minority groups about clinical trial participa-

tion. Activities funded pursuant to the preceding sentence shall include—

''(A) using established mechanisms to encourage members of minority groups to participate in clinical trials on Alzheimer's disease;

''(B) expanding education efforts to make members of minority groups aware of ongoing clinical trials;

''(C) working with trial sponsors to increase the number of recruitment events for members of minority groups;

''(D) conducting outreach to national, State, and local physician professional organizations, especially for members of such organizations who are primary care physicians or physicians who specialize in dementia, to increase awareness of clinical research opportunities for members of minority groups; and

''(E) using community-based participatory research methodologies to engage with minority populations.''.

(B) RESOURCE CENTERS FOR MINORITY AGING RESEARCH.—Section 444(c) of the Public Health Service Act (42 U.S.C. 285e–1(c)) is amended—

(i) by striking ''(c)'' and inserting ''(c)(1)'' ; and

(ii) by adding at the end the following new paragraph:

''(2) The Director of the Institute, acting through the Resource Centers for Minority Aging Research of the Institute, shall carry out public outreach, education efforts, and dissemination of information for members of minority groups about participation in clinical research on Alzheimer's disease carried out or supported under this subpart.''.

(b) INCENTIVES TO INCREASE DIVERSITY IN ALZHEIMER'S DISEASE RESEARCH THROUGH PRINCIPAL INVESTIGATORS AND RESEARCHERS FROM UNDERREPRESENTED POPULATIONS.—

(1) ALZHEIMER'S CLINICAL RESEARCH AND TRAINING AWARDS.—Section 445I of the Public Health Service Act (42 U.S.C. 285e–10a) is amended by adding at the end the following new subsection:

''(d) ENHANCING THE PARTICIPATION OF PRINCIPAL INVESTIGATORS AND RESEARCHERS WHO ARE MEMBERS OF UNDERREPRESENTED POPULATIONS.—

''(1) IN GENERAL.—The Director of the Institute shall enhance diversity in the conduct or sup-

port of clinical research on Alzheimer's disease under this subpart by encouraging the participation of individuals from groups that are underrepresented in the biomedical, clinical, behavioral, and social sciences as principal investigators of such clinical research, as researchers for such clinical research, or both.

''(2) TRAINING FOR PRINCIPAL INVESTIGATORS.—The Director of the Institute shall provide training for principal investigators who are members of a minority group with respect to skills for—

''(A) the design and conduct of clinical research and clinical protocols;

''(B) applying for grants for clinical research; and

''(C) such other areas as the Director of the Institute determines to be appropriate.''.

(2) SENIOR RESEARCHER AWARDS.—Section 445B(a) of the Public Health Service Act (42 U.S.C. 285e–4(a)) is amended by inserting '', including senior researchers who are members of a minority group'' before the period at the end of the first sentence.

(c) INCENTIVES TO INCREASE DIVERSITY IN ALZHEIMER'S DISEASE RESEARCH THROUGH TRIAL SITES.—

Section 444(d) of the Public Health Service Act (42 U.S.C. 285e–1(d)) is amended—

(1) by striking ''(d)'' and inserting ''(d)(1)'' ; and

(2) by adding at the end the following new paragraphs:

''(2) In conducting or supporting clinical research on Alzheimer's disease for purposes of this subpart, in addition to requirements otherwise imposed under this title, including under section 492B, the Director of the Institute shall increase the participation of members of minority groups in such clinical research through one or more of the activities described in paragraph (3).

''(3)(A) The Director of the Institute shall provide incentives for the support of clinical research on Alzheimer's disease with clinical trial sites established in areas with a higher concentration of minority groups, including rural areas if practicable.

''(B) In determining whether to conduct or support clinical research on Alzheimer's disease, the Director of the Institute shall encourage the conduct of clinical research with clinical trial sites in areas described in subparagraph (A) as a higher-level priority criterion among the criteria established to evaluate whether to conduct or support clinical research.

''(C) In determining the amount of funding to be provided for the conduct or support of such clinical research, the Director of the Institute shall provide additional funding for the conduct of such clinical research with clinical trial sites in areas described in subparagraph (A).

''(D) In determining whether an area is an area with a higher concentration of minority groups, the Director of the Institute—

''(i) shall consider the most recent data collected by the Bureau of the Census; and

''(ii) may also consider—

''(I) data from the Centers for Medicare & Medicaid Services on the incidence of Alzheimer's disease in the United States by region; and

''(II) such other data as the Director determines appropriate.

''(4) In order to facilitate the participation of members of minority groups in clinical research supported under this subpart, in addition to activities described in paragraph (3), the Director of the Institute shall—

''(A) ensure that such clinical research uses community-based participatory research methodologies; and

''(B) encourage the use of remote health technologies, including telehealth, remote patient monitoring, and mobile technologies, that reduce or eliminate barriers to participation of members of minority groups in such clinical research.

''(5)(A) Clinical research on Alzheimer's disease conducted or supported under this subpart shall ensure that such research includes outreach activities designed to increase the participation of members of minority groups in such research.

''(B)(i) Each applicant for a grant under this subpart for clinical research on Alzheimer's disease shall submit to the Director of the Institute in the application for such grant—

''(I) a budget for outreach activities to members of minority populations with respect to participation in such clinical research; and

''(II) a description of the plan to conduct such outreach.

''(ii) The Director of the Institute shall encourage applicants for, and recipients of, grants under this subpart to conduct clinical research on Alzheimer's disease to engage with community-based organizations to increase participation of minority populations in such research.

''(6) For purposes of this subpart:

''(A) The term 'clinical research' includes a clinical trial.

''(B) The term 'minority group' has the meaning given such term under section 492B(g).''.

(d) PARTICIPANT ELIGIBILITY CRITERIA.—Section 445I of the Public Health Service Act (42 U.S.C. 285e–10a), as amended by subsection (b)(1), is further amended by adding at the end the following new subsection:

''(e) PARTICIPANT ELIGIBILITY CRITERIA.—The Director of the Institute shall take such actions as are necessary to ensure that clinical research on Alzheimer's disease conducted or supported under this subpart is designed with eligibility criteria that ensure the clinical trial population reflects the diversity of the prospective patient population. Such actions may include the following:

''(1) EXAMINATION OF CRITERIA.—

''(A) IN GENERAL.—An examination of each exclusion criterion to determine if the criterion is necessary to ensure the safety of trial participants or to achieve the study objectives.

''(B) MODIFICATION OF CRITERIA.—In the case of an exclusion criterion that is not necessary to ensure the safety of trial participants or to achieve the study objectives—

"(i) encouraging the modification or elimination of the criterion; or

"(ii) encouraging tailoring the criterion as narrowly as possible to avoid unnecessary limits to the population of the clinical study.

"(2) REQUIREMENT FOR STRONG JUSTIFICATION FOR EXCLUSION.—A review of each exclusion criterion to ensure that populations are included in clinical trials, such as older adults, individuals with a mild form of disease, individuals at the extremes of the weight range, or children, unless there is a strong clinical or scientific justification to exclude them.

"(3) USE OF ADAPTIVE DESIGN.—Encouraging the use of an adaptive clinical trial design that—

"(A) starts with a defined population where there are concerns about safety; and

"(B) may expand to a broader population based on initial data from the trial and external data.".

(e) RESOURCE CENTER FOR SUCCESSFUL STRATEGIES TO INCREASE PARTICIPATION OF UNDERREPRESENTED POPULATIONS IN ALZHEIMER'S DISEASE CLINICAL RESEARCH.—Section 444 of the Public Health

Service Act (42 U.S.C. 285e–1) is amended by adding at the end the following new subsection:

''(e)(1) Acting through the Office of Special Populations and in consultation with the Division of Extramural Activities, the Director of the Institute shall support resource information and technical assistance to grantees under section 445 (relating to Alzheimer's disease centers), other grantees, and prospective grantees, designed to increase the participation of minority populations in clinical research on Alzheimer's disease conducted or supported under this subpart.

''(2) The resource information and technical assistance provided under paragraph (1) shall include the maintenance of a central resource library in order to collect, prepare, analyze, and disseminate information relating to strategies and best practices used by recipients of grants under this subpart and other researchers in the development of the clinical research designed to increase the participation of minority populations in such clinical research.''.

(f) ANNUAL REPORTS.—Section 444 of the Public Health Service Act (42 U.S.C. 285e–1), as amended by subsection (e), is further amended by adding at the end the following new subsection:

''(f)(1)(A) The Director of the Institute shall submit annual reports to the Congress on the impact of the amendments made to this subpart by the Health Equity and Accountability Act of 2022.

''(B) The Secretary shall transmit a copy of each such report to the Advisory Council on Alzheimer's Research, Care, and Services established under section 2(e) of the National Alzheimer's Project Act (Public Law 111–375).

''(2) In each report under paragraph (1), the Director of the Institute shall include information and data on the following matters with respect to clinical trials on Alzheimer's disease conducted during the preceding year:

''(A) The number of participants who are members of a minority group in such clinical trials.

''(B) The number of such clinical trials for which incentives under subsection (d)(3) were made available, the nature of such incentives, the amount of increased funding (if any) made available for research on Alzheimer's disease, and the training provided to principal investigators who are members of a minority group and the amount of funding (if any) for such training.

''(C) The number of such clinical trials for which the principal investigator is a member of a minority group.

''(D) The number of such clinical trials for which a significant percentage of researchers are members of a minority group.

''(E) Modifications to patient eligibility criteria in clinical trial designs under section 445I(e).

''(F) Outreach and education efforts conducted under section 445(b)(4).

''(3) The Director of the Institute shall make each report under paragraph (1) available to the public, including through posting on the appropriate website of the Department of Health and Human Services.''.

(g) AUTHORIZATION OF APPROPRIATIONS.—For each of fiscal years 2023 through 2027, there is authorized to be appropriated to the Secretary of Health and Human Services $60,000,000 to carry out the amendments made by this section, to remain available until expended.

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

SEC. 8001. DEFINITIONS.

In this title:

(1) ACCESS.—The term ''access'', with respect to health information, means access described in sec-

tion 164.524 of title 45, Code of Federal Regulations (or any successor regulations).

(2) CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY.—The term ''certified EHR technology''—

(A) has the meaning given such term in section 3000 of the Public Health Service Act (42 U.S.C. 300jj);

(B) includes the health information infrastructure for interoperability, access, exchange, and use of electronic health information required under title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.); and

(C) is not limited to electronic health records maintained by doctors.

(3) EHR.—The term ''EHR''—

(A) means an electronic health record;

(B) includes the health information infrastructure for interoperability, access, exchange, and use of electronic health information required under title XXX of the Public Health Service Act (42 U.S.C. 300jj et seq.); and

(C) is not limited to electronic health records maintained by doctors.

(4) INTEROPERABILITY.—The term ''interoperability'' has the meaning given such term in section 3000 of the Public Health Service Act (42 U.S.C. 300jj).

Subtitle A—Reducing Health Disparities Through Health IT

SEC. 8101. HRSA ASSISTANCE TO HEALTH CENTERS FOR PROMOTION OF HEALTH IT.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand and intensify the programs and activities of the Administration (directly or through grants or contracts) to provide technical assistance and resources to health centers (as defined in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a))) to adopt and meaningfully use certified EHR technology for the management of chronic diseases and health conditions and reduction of health disparities.

(b) FUNDING INITIATIVES.—The activities under subsection (a) may include funding initiatives, including establishing basic connectivity such as 5G internet for telemedicine capabilities, grant funding to implement the next generation of EHR, and funding for technology hardware.

SEC. 8102. ASSESSMENT OF IMPACT OF HEALTH IT ON RACIAL AND ETHNIC MINORITY COMMUNITIES; OUTREACH AND ADOPTION OF HEALTH IT IN SUCH COMMUNITIES.

(a) NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—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;

(B) include in such evaluation an indication 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

a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan);

(ii) have received incentive payments or incentive payment adjustments under Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in subsection (c)(2));

(iii) are MIPS eligible professionals, as defined in paragraph (1)(C) of section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)), for purposes of the Merit-Based Incentive Payment System under such section; or

(iv) have been recruited by any of the Health Information Technology Regional Extension Centers established under section 3012 of the Public Health Service Act (42 U.S.C. 300jj–32); and

(C) publish the results of such evaluation including the indications under subparagraph (B), the race and ethnicity of such providers, and the populations served by such providers.

(2) EVALUATION OF INTEROPERABILITY.—The evaluation of the level of interoperability described in

paragraph (1)(A) shall consider exchange of electronic health information, usability of exchanged electronic health information, effective application and use of the exchanged electronic health information, and impact on outcomes of interoperability.

(3) CERTIFICATION CRITERION.—Not later than 1 year after the date of enactment of this Act, the National Coordinator shall—

(A) promulgate a certification criterion and module of certified EHR technology that stratifies quality measures for purposes of the Merit-Based Incentive Payment System by disparity characteristics, including race, ethnicity, language, gender, gender identity, sexual orientation, socio-economic status, and disability status, as such characteristics are defined for purposes of certified EHR technology; and

(B) report to the Centers for Medicare & Medicaid Services the quality measures stratified by race and at least 2 other disparity characteristics.

(b) NATIONAL CENTER FOR HEALTH STATISTICS.—As soon as practicable after the date of enactment of this Act, the Director of the National Center for Health Statistics shall provide to Congress a more detailed analysis of

the data presented in National Center for Health Statistics data brief entitled ''Adoption of Certified Electronic Health Record Systems and Electronic Information Sharing in Physician Offices: United States, 2013 and 2014'' (NCHS Data Brief No. 236).

(c) CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—As part of the process of collecting information, with respect to a provider, at registration and attestation for purposes of Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in paragraph (2)) or the Merit-Based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)), the Secretary of Health and Human Services shall collect the race and ethnicity of such provider.

(2) MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS DEFINED.—For purposes of paragraph (1), the term ''Medicare and Medicaid Electronic Health Records Incentive Programs'' means the incentive programs under the following:

(A) Subsection (l)(3) of section 1814(l)(3) of the Social Security Act (42 U.S.C. 1395f).

(B) Subsections (a)(7) and (o) of section 1848 of such Act (42 U.S.C. 1395w–4).

(C) Subsections (l) and (m) of section 1853 of such Act (42 U.S.C. 1395w–23).

(D) Subsections (b)(3)(B)(ix)(I) and (n) of section 1886 of such Act (42 U.S.C. 1395ww).

(E) Subsections (a)(3)(F) and (t) of section 1903 such Act (42 U.S.C. 1396b).

(d) NATIONAL COORDINATOR'S ASSESSMENT OF IMPACT OF HIT.—Section 3001(c)(6)(C) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

(1) in the heading by inserting ", RACIAL AND ETHNIC MINORITY COMMUNITIES," after "HEALTH DISPARITIES";

(2) by inserting ", in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), including people with disabilities in such groups," after "communities with health disparities";

(3) by striking "The National Coordinator" and inserting the following:

"(i) IN GENERAL.—The National Coordinator"; and

(4) by adding at the end the following:

"(ii) CRITERIA.—In any publication under clause (i), the National Coordinator shall include best practices for encouraging partnerships between the Federal Government, States, private entities, national nonprofit intermediaries, and community-based organizations to expand outreach and education for and the adoption of certified EHR technology in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), while also maintaining the accessibility requirements of section 508 of the Rehabilitation Act of 1973 to encourage patient involvement in patient health care. The National Coordinator shall—

"(I) not later than 6 months after the submission of the report required under section 8302 of the Health Equity and Accountability Act of 2022, establish criteria for evaluating the impact of health information technology on communities with a high proportion of individuals from

racial and ethnic minority groups (as so defined) taking into account the findings in such report; and

''(II) not later than 1 year after the submission of such report, publish the results of an evaluation of such impact.''.

SEC. 8103. NONDISCRIMINATION AND HEALTH EQUITY IN HEALTH INFORMATION TECHNOLOGY.

(a) IN GENERAL.—Covered entities shall ensure that electronic and information technology in their health programs or activities does not exclude individuals from participation in, deny individuals the benefits of, or subject individuals to discrimination under any health program or activity on the basis of race, color, national origin, sex, age, or disability.

(b) COVERED ENTITIES.—In this section, the term ''covered entity'' means—

(1) an entity that operates a health program or activity, any part of which receives Federal financial assistance;

(2) an entity established under title I of the Patient Protection and Affordable Care Act (Public Law 114–148) that administers a health program or activity; or

(3) the Department of Health and Human Services.

SEC. 8104. LANGUAGE ACCESS IN HEALTH INFORMATION TECHNOLOGY.

The National Coordinator shall—

(1) not later than 18 months after the date of enactment of this Act, propose a rule for providing access to patients, through certified EHR technology, to their personal health information in a computable format, including using patient portals or third-party applications (as described in section 3009(e) of the Public Health Service Act (42 U.S.C. 300jj–19(e))), in the 10 most common non-English languages;

(2) hold a public hearing to identify best practices for carrying out paragraph (1); and

(3) not later than 6 months after the public hearing under paragraph (2), promulgate a final regulation with respect to paragraph (1).

Subtitle B—Modifications To Achieve Parity in Existing Programs

SEC. 8201. EXTENDING FUNDING TO STRENGTHEN THE HEALTH IT INFRASTRUCTURE IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

Section 3011 of the Public Health Service Act (42 U.S.C. 300jj–31) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting ", including with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))" before the colon at the end; and

(2) by adding at the end the following new subsection:

"(e) ANNUAL REPORT ON EXPENDITURES.—The National Coordinator shall report annually to Congress on activities and expenditures under this section.".

SEC. 8202. EXTENDING COMPETITIVE GRANTS FOR THE DEVELOPMENT OF LOAN PROGRAMS TO FACILITATE ADOPTION OF CERTIFIED EHR TECHNOLOGY BY PROVIDERS SERVING RACIAL AND ETHNIC MINORITY GROUPS.

Section 3014(e) of the Public Health Service Act (42 U.S.C. 300jj–34(e)) is amended, in the matter preceding

paragraph (1), by inserting ", including with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))" after "health care provider to".

SEC. 8203. AUTHORIZATION OF APPROPRIATIONS.

Section 3018 of the Public Health Service Act (42 U.S.C. 300jj–38) is amended by striking "fiscal years 2009 through 2013" and inserting "fiscal years 2023 through 2028".

Subtitle C—Additional Research and Studies

SEC. 8301. DATA COLLECTION AND ASSESSMENTS CONDUCTED IN COORDINATION WITH MINORITY-SERVING INSTITUTIONS.

Section 3001(c)(6) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the end the following new subparagraph:

"(F) DATA COLLECTION AND ASSESSMENTS CONDUCTED IN COORDINATION WITH MINORITY-SERVING INSTITUTIONS.—

"(i) IN GENERAL.—In carrying out subparagraph (C) with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), the National

Coordinator shall, to the greatest extent possible, coordinate with an entity described in clause (ii).

''(ii) MINORITY-SERVING INSTITUTIONS.—For purposes of clause (i), an entity described in this clause is a historically black college or university, a Hispanic-serving institution, a Tribal College or University, or an Asian-American-, Native American-, or Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.''.

SEC. 8302. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) enter into an agreement with the National Academies of Sciences, Engineering, and Medicine to conduct a study on the development, implementation, and effectiveness of health information technology within medically underserved areas; and

(2) submit a report to Congress describing the results of such study, including any recommendations for legislative or administrative action.

(b) STUDY.—The study described in subsection (a)(1) shall—

(1) identify barriers to successful implementation of health information technology in medically underserved areas;

(2) survey a cross-section of individuals in medically underserved areas and report their opinions about the various topics of study;

(3) examine the degree of interoperability among health information technology and users of health information technology in medically underserved areas, including patients, providers, and community services, which such examination shall consider the exchange of electronic health information, usability of exchanged electronic health information, effective application and use of the exchanged electronic health information, and impact on outcomes of interoperability;

(4) examine the impact of health information technology on providing quality care and reducing the cost of care to individuals in such areas, including the impact of such technology on improved

health outcomes for individuals, including which technology worked for which population and how it improved health outcomes for that population;

(5) examine the impact of health information technology on improving health care-related decisions by both patients and providers in such areas;

(6) identify specific best practices for using health information technology to foster the consistent provision of physical accessibility and reasonable policy accommodations in health care to individuals with disabilities in such areas;

(7) assess the feasibility and costs associated with the use of health information technology in such areas;

(8) evaluate whether the adoption and use of qualified electronic health records (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) is effective in reducing health disparities, including analysis of clinical quality measures reported by providers who are participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan), pursuant to pro-

grams to encourage the adoption and use of certified EHR technology;

(9) identify providers in medically underserved areas that are not electing to adopt and use electronic health records and determine what barriers are preventing those providers from adopting and using such records; and

(10) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers in those systems.

(c) MEDICALLY UNDERSERVED AREA.—In this section, the term ''medically underserved area'' means—

(1) a population that has been designated as a medically underserved population under section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(2) an area that has been designated as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e);

(3) an area or population that has been designated as a medically underserved community under section 799B of the Public Health Service Act (42 U.S.C. 295p); or

(4) another area or population that—

(A) experiences significant barriers to accessing quality health services; and

(B) has a high prevalence of diseases or conditions described in title VII, with such diseases or conditions having a disproportionate impact on racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g))) or a subgroup of people with disabilities who have specific functional impairments.

SEC. 8303. ASSESSMENT OF USE AND MISUSE OF DE-IDENTIFIED HEALTH DATA.

(a) IN GENERAL.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) enter into an agreement with the Office of the National Coordinator of Health Information Technology to conduct a study, in consultation with relevant stakeholders, on the impact of digital health technology on medically underserved areas (as defined in section 8302(c)); and

(2) submit a report to Congress describing the results of such study, including any recommendations for legislative or administrative action.

(b) STUDY.—The study described in subsection (a)(1) shall—

(1) examine the overall prevalence, and historical and existing practices and their respective prevalence, of use and misuse of de-identified protected health information to discriminate against or benefit medically underserved areas;

(2) identify best practices and tools to leverage the benefits and prevent misuse of de-identified protected health information to discriminate against medically underserved areas;

(3) examine the overall prevalence, and historical and existing practices and their respective prevalence, of use and misuse of de-identified personal health information other than protected health information to discriminate against or benefit medically underserved areas; and

(4) identify best practices and tools to leverage the benefits and prevent misuse of de-identified personal health information other than protected health information to discriminate against medically underserved areas.

(c) DEFINITION OF PROTECTED HEALTH INFORMATION.—In this section, the term ''protected health information'' has the meaning given such term in section

160.103, title 45, Code of Federal Regulations (or any successor regulations).

Subtitle D—Closing Gaps in Funding To Adopt Certified EHRs

SEC. 8401. EXTENDING MEDICAID EHR INCENTIVE PAYMENTS TO REHABILITATION FACILITIES, LONG-TERM CARE FACILITIES, AND HOME HEALTH AGENCIES.

(a) IN GENERAL.—Section 1903(t)(2)(B) of the Social Security Act (42 U.S.C. 1396b(t)(2)(B)) is amended—

(1) in clause (i), by striking ", or" and inserting a semicolon;

(2) in clause (ii), by striking the period at the end and inserting a semicolon; and

(3) by inserting after clause (ii) the following new clauses:

"(iii) a rehabilitation facility (as defined in section 1886(j)(1)) that furnishes acute or subacute rehabilitation services;

"(iv) a long-term care hospital described in section 1886(d)(1)(B)(iv); or

"(v) a home health agency (as defined in section 1861(o)).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to amounts expended under section 1903(a)(3)(F) of the Social Security Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters beginning on or after the date of the enactment of this Act.

SEC. 8402. EXTENDING PHYSICIAN ASSISTANT ELIGIBILITY FOR MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS.

(a) IN GENERAL.—Section 1903(t)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(t)(3)(B)(v)) is amended to read as follows:

"(v) physician assistant.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to amounts expended under section 1903(a)(3)(F) of the Social Security Act (42 U.S.C. 1396b(a)(3)(F)) for calendar quarters beginning on or after the date of the enactment of this Act.

Subtitle E—Expanding Access to Telehealth Services

SEC. 8501. REMOVING GEOGRAPHIC REQUIREMENTS FOR TELEHEALTH SERVICES.

Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)) is amended—

(1) in clause (i), in the matter preceding subclause (I), by striking ''clause (iii)'' and inserting ''clauses (iii) and (iv)''; and

(2) by adding at the end the following new clause:

''(iv) REMOVAL OF GEOGRAPHIC REQUIREMENTS.—The geographic requirements described in clause (i) shall not apply with respect to telehealth services furnished on or after the first day after the end of the period for which clause (iii) applies.''.

SEC. 8502. EXPANDING ORIGINATING SITES.

(a) EXPANDING THE HOME AS AN ORIGINATING SITE.—Section 1834(m)(4)(C)(ii)(X) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)(X)) is amended to read as follows:

''(X)(aa) Prior to the date described in item (bb), the home of an individual but only for purposes of section 1881(b)(3)(B) or telehealth services described in paragraph (7) or clause (iii).

''(bb) On or after the first day after the end of the period for which

clause (iii) applies, the home of an individual.''.

(b) ALLOWING ADDITIONAL ORIGINATING SITES.—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclause:

''(XII) Any other site determined appropriate by the Secretary at which an eligible telehealth individual is located at the time a telehealth service is furnished via a telecommunications system.''.

(c) PARAMETERS FOR NEW ORIGINATING SITES.—Section 1834(m)(4)(C) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)), as amended by section 8501, is amended by adding at the end the following new clause:

''(v) REQUIREMENTS FOR NEW SITES.—

''(I) IN GENERAL.—The Secretary may establish requirements for the furnishing of telehealth services at sites described in clause (ii)(XII) to provide for beneficiary and program integrity protections.

"(II) CLARIFICATION.—Nothing in this clause shall be construed to preclude the Secretary from establishing requirements for other originating sites described in clause (ii)".

(d) NO ORIGINATING SITE FACILITY FEE FOR NEW SITES.—Section 1834(m)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(2)(B)(ii)) is amended—

(1) in the heading, by striking "IF ORIGINATING SITE IS THE HOME" and inserting "FOR CERTAIN SITES"; and

(2) by striking "paragraph (4)(C)(ii)(X)" and inserting "subclause (X) or (XII) of paragraph (4)(C)".

TITLE IX—ACCOUNTABILITY AND EVALUATION

SEC. 9001. PROHIBITION ON DISCRIMINATION IN FEDERAL ASSISTED HEALTH CARE SERVICES AND RESEARCH ON THE BASIS OF SEX (INCLUDING SEXUAL ORIENTATION, GENDER IDENTITY, AND PREGNANCY, INCLUDING TERMINATION OF PREGNANCY), RACE, COLOR, NATIONAL ORIGIN, MARITAL STATUS, FAMILIAL STATUS, OR DISABILITY STATUS.

(a) IN GENERAL.—No person in the United States shall, on the basis of sex (including sexual orientation, gender identity, and pregnancy, including termination of pregnancy), race, color, national origin, marital status, familial status, sexual orientation, gender identity, or disability status, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under—

(1) any health program or activity, including any health research program or activity, receiving Federal financial assistance, including credits, subsidies, or contracts of insurance; or

(2) any health program or activity that is administered by an executive agency.

(b) DEFINITION.—In this section, the term ''familial status'' means, with respect to one or more individuals—

(1) being domiciled with any individual related by blood or affinity whose close association with the individual is the equivalent of a family relationship;

(2) being in the process of securing legal custody of any individual; or

(3) being pregnant.

SEC. 9002. TREATMENT OF MEDICARE PAYMENTS UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.

For the purposes of title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), a payment made under part A, B, C, or D of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to a provider of services, physician, or other supplier (including a payment made to a subcontractor of the provider of services, physician, or other supplier) shall be deemed a grant, not a contract of insurance or guaranty.

SEC. 9003. ACCOUNTABILITY AND TRANSPARENCY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Title XXXIV of the Public Health Service Act, as amended by titles I, II, III, and IV of this Act, is further amended by inserting after subtitle D the following:

"Subtitle E—Strengthening Accountability

"SEC. 3451. ELEVATION OF THE OFFICE FOR CIVIL RIGHTS AND HEALTH EQUITY.

''(a) IN GENERAL.—

''(1) NAME OF OFFICE.—Beginning on the date of enactment of this subtitle, the Office for Civil Rights of the Department of Health and Human Services shall be known as the 'Office for Civil Rights and Health Equity' of the Department of Health and Human Services. Any reference to the Office for Civil Rights of the Department of Health and Human Services in any law, regulation, map, document, record, or other paper of the United States shall be deemed to be a reference to the Office for Civil Rights and Health Equity.

''(2) HEAD OF OFFICE.—The head of the Office for Civil Rights and Health Equity shall be the Director for Civil Rights and Health Equity, to be appointed by the President. Any reference to the Director of the Office for Civil Rights of the Department of Health and Human Services in any law, regulation, map, document, record, or other paper of the United States shall be deemed to be a reference to the Director for Civil Rights and Health Equity.

''(b) PURPOSE.—The Director for Civil Rights and Health Equity shall ensure that the health programs, activities, policies, projects, procedures, and operations of health entities that receive Federal financial assistance are in compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), including through the following activities:

''(1) The development and implementation of an action plan to address racial and ethnic health care disparities. Such plan shall—

''(A) address concerns relating to the Office for Civil Rights and Health Equity as released by the United States Commission on Civil Rights in the report entitled 'Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity' (September 1999), in conjunction with existing and future reports of the National Academy of Medicine (formerly known as the Institute of Medicine) including the reports titled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', 'Crossing the Quality Chasm: A New Health System for the 21st Century', 'In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Work-

force', 'The National Partnership for Action to End Health Disparities', and 'The Health of Lesbian, Gay, Bisexual, and Transgender People', and other related reports of the National Academies of Sciences, Engineering, and Medicine;

"(B) be issued in proposed form for public review and comment; and

"(C) be finalized taking into consideration any comments or concerns that are received by the Office.

"(2) Investigative and enforcement actions against intentional or in effect discrimination and policies and practices that have a disparate impact on racial or ethnic minorities and communities of color pursuant to section 9007 of the Health Equity and Accountability Act of 2022.

"(3) The review of racial, ethnic, gender identity, sexual orientation, sex, disability status, socioeconomic status, and primary language health data collected by Federal health agencies to assess health care disparities related to intentional discrimination and policies and practices that have a disparate impact on minorities. Such review shall include an as-

sessment of health disparities in communities with a combination of these classes.

''(4) Outreach and education activities relating to compliance with title VI of the Civil Rights Act of 1964, including the process of filing a complaint in accordance with section 9007 of the Health Equity and Accountability Act of 2022.

''(5) The provision of technical assistance for health entities to facilitate compliance with title VI of the Civil Rights Act of 1964.

''(6) Coordination and oversight of activities of the civil rights compliance offices established under section 3452.

''(7) Ensuring—

''(A) at a minimum, compliance with the most recent version of the Office of Management and Budget statistical policy directive entitled 'Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity'; and

''(B) consideration of available data and language standards such as—

''(i) the standards for collecting, monitoring, and reporting data under section 3101; and

''(ii) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health.

''(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office for Civil Rights and Health Equity by ensuring that the Office is provided with—

''(1) adequate funding to enable the Office to carry out its duties under this section; and

''(2) staff with expertise in—

''(A) epidemiology;

''(B) statistics;

''(C) health quality assurance;

''(D) minority health and health disparities;

''(E) health equity;

''(F) cultural and linguistic competency;

''(G) civil rights; and

''(H) social, political, mental, behavioral, economic, and related determinants of health, including education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

''(d) ADVISORY BOARD.—

''(1) ESTABLISHMENT.—The Secretary, in collaboration with the Director Civil Rights and Health Equity and the Deputy Assistant Secretary for Minority Health, shall establish an advisory board (in this subsection referred to as the 'advisory board') to report in accordance with paragraph (2).

''(2) REPORTS TO CONGRESS.—Not later than December 31, 2023, and annually thereafter, the advisory board shall publish and submit to the Office, other Federal agencies, and the Congress a report that includes—

''(A) the number of complaints filed in accordance with section 9007 of the Health Equity and Accountability Act of 2022 during the reporting period under title VI of the Civil Rights Act of 1964, broken down by category;

''(B) the number of such complaints investigated and closed by the Office;

''(C) the outcomes of such complaints investigated;

''(D) the staffing levels of the Office, including staff credentials;

''(E) the number of such complaints that are pending (including backlogged complaints) in which civil rights inequities can be dem-

onstrated and an explanation of why such complaints remain pending; and

''(F) trends among filed complaints and other systemic patterns or themes, including an analysis from the Department of Justice about litigation concerning such complaints.

''(3) COMPOSITION.—The members of the advisory board shall include—

''(A) representatives of stakeholders; and

''(B) subject matter- and disciplinary-appropriate experts.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2023 through 2027.

''SEC. 3452. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN AGENCIES OF DEPARTMENT OF HEALTH AND HUMAN SERVICES.

''(a) IN GENERAL.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

''(b) PURPOSE OF OFFICES.—Each office established under subsection (a) shall ensure that recipients of Fed-

eral financial assistance under Federal health programs administer programs, and determine and implement policies, services, and activities, in a manner that—

''(1) does not discriminate, either intentionally or in effect, on the basis of race, color, national origin, language, ethnicity, sex, age, disability status, sexual orientation, or gender identity; and

''(2) promotes the reduction and elimination of disparities in health and health care based on race, color, national origin, language, ethnicity, sex, age, disability status, sexual orientation, or gender identity.

''(c) POWERS AND DUTIES.—The offices established in subsection (a) shall, with respect to the applicable agency, have the following powers and duties:

''(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program administered by the agency, including the establishment of disparity reduction standards to encompass disparities in health and health care related to race, color, national origin, language, ethnicity, sex, age, disability, sexual orientation, or gender identity.

''(2) The development and implementation of policies, procedures, and program-specific guidelines

that interpret and apply Department of Health and Human Services guidance under title VI of the Civil Rights Act of 1964 and section 1557 of the Patient Protection and Affordable Care Act to each Federal health program administered by the agency.

''(3) The development of a disparity-reduction impact analysis methodology that shall—

''(A) be applied to every rule issued by the agency and published as part of the formal rulemaking process under sections 555, 556, and 557 of title 5, United States Code; and

''(B) include an analysis of the intersecting forms of discrimination.

''(4) Oversight of data collection, reporting, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency, compliance with, at a minimum, the most recent version of the Office of Management and Budget statistical policy directive entitled 'Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity', and consideration of available data and language standards such as—

''(A) the standards for collecting and reporting data under section 3101;

"(B) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health; and

"(C) the disaggregation of all health and health care data by racial and ethnic minority population group.

"(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as disparity reduction initiatives by recipients of Federal financial assistance under Federal health programs.

"(6) Annual reports to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives on the progress in reducing disparities in health and health care through the Federal programs administered by the agency.

"(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF JUSTICE.—

"(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Office for Civil Rights of the Department of Health and Human Services shall provide standard-setting and compliance review inves-

tigation support services to each civil rights compliance office established under subsection (a), subject to paragraph (2).

''(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights of the Department of Justice may, as appropriate, institute formal proceedings when a civil rights compliance office established under subsection (a) determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the applicable agency.

''(e) DEFINITION.—In this section, the term 'Federal health programs' mean programs—

''(1) under the Social Security Act (42 U.S.C. 301 et seq.) that pay for health care and services; and

''(2) under this Act that—

''(A) provide Federal financial assistance for health care, biomedical research, or health services research; or

''(B) are designed to improve the public's health, including health service programs.''.

SEC. 9004. UNITED STATES COMMISSION ON CIVIL RIGHTS.

(a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARI-

TIES.—Section 3(a) of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a(a)) is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(3) shall, with respect to activities carried out in health care and correctional facilities, toward the goal of eliminating health disparities between the general population and members of minority groups based on race or color, promote coordination of such activities of—

''(A) the Office of Justice Programs of the Department of Justice, including the Office for Civil Rights within that Office;

''(B) the Office for Civil Rights within the Department of Health and Human Services; and

''(C) the Office of Minority Health within the Department of Health and Human Services.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 5 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975c) is amended by striking the first sentence and in-

serting the following: ''For the purpose of carrying out this Act, there are authorized to be appropriated $30,000,000 for fiscal year 2023, and such sums as may be necessary for each of the fiscal years 2024 through 2028.''.

SEC. 9005. SENSE OF CONGRESS CONCERNING FULL FUNDING OF ACTIVITIES TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES.

(a) FINDINGS.—Congress finds the following:

(1) The health status of the population of the United States is declining, and the United States currently ranks below most industrialized nations in health status measured by longevity, sickness, and mortality.

(2) Racial and ethnic minority populations tend to have the poorest health status and face substantial cultural, social, political, and economic barriers to obtaining high-quality health care.

(3) Racial and ethnic minority populations experience and suffer from the extreme and egregious health disparities and inequities that are caused by racism, discrimination, and implicit racial and ethnic bias in and throughout the health care system.

(4) Communities of color with intersecting identities and backgrounds, including children, older

adults, women, people with disabilities, people with limited English proficiency, immigrants, lesbian, gay, bisexual, transgender, queer, and questioning populations, and people with lower incomes experience significant personal and structural barriers to obtaining affordable, high-quality health care.

(5) Efforts to reduce and eliminate racial and ethnic health disparities and inequities, and improve minority health, have been limited by inadequate resources (such as funding, staffing, and stewardship), a lack of prioritization, and a lack of accountability from the Federal Government, particularly due to stagnant or declining appropriations that are not in line with the dire need faced by communities that are impacted.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that—

(1) health disparities negatively impact outcomes for health and human security of the Nation;

(2) reducing racial, ethnic, age, sexual, and gender disparities in prevention and treatment are unique civil and human rights challenges and, as such, Federal agencies and health care entities and systems receiving Federal funds should be account-

able for their role in causing disparities and inequity;

(3) funding for the National Institute on Minority Health and Health Disparities, the Office of Civil Rights in the Department of Health and Human Services, the National Institute of Nursing Research, and the Office of Minority Health should be doubled by fiscal year 2023, to effectively address racial and ethnic disparities elimination in health and health care as a matter of health and national security;

(4) adequate funding by fiscal year 2023, and subsequent funding increases, should be provided for health and human service professions training programs, the Racial and Ethnic Approaches to Community Health Initiative at the Centers for Disease Control and Prevention, the Minority HIV/AIDS Initiative, the Excellence Centers to Eliminate Ethnic/Racial Disparities Program at the Agency for Healthcare Research and Quality, and the National Health Service Corps Scholarship Program initiatives, programs, policies, projects, and activities that are the backbone of the Nation's agenda to eliminate racial and ethnic health disparities and inequities;

(5) adequate funding for fiscal year 2023 and increased funding for future years should be provided for the Racial and Ethnic Approaches to Community Health Initiative's United States Risk Factor Survey to ensure adequate data collection to track health disparities, and there should be appropriate avenues provided to disseminate findings to the general public;

(6) current and newly created health disparity elimination incentives, programs, agencies, and departments under this Act (and the amendments made by this Act) should receive adequate staffing and funding by fiscal year 2023; and

(7) stewardship and accountability should be provided to the Congress and the President for measurable and sustainable progress toward health disparity elimination under programs under this Act, including increased data collection and reporting, capacity building for impacted communities, technical assistance, training programs, and avenues to disseminate program details and successes to the public and to policymakers.

SEC. 9006. GAO AND NIH REPORTS.

(a) GAO REPORT ON NIH GRANT RACIAL AND ETHNIC DIVERSITY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the racial and ethnic diversity among the following groups:

(A) All applicants for grants, contracts, and cooperative agreements awarded by the National Institutes of Health during the period beginning on January 1, 2023, and ending December 31, 2032.

(B) All recipients of such grants, contracts, and cooperative agreements during such period.

(C) All members of the peer review panels of such applicants and recipients, respectively.

(2) REPORT.—Not later than 6 months after the date of enactment of this Act, the Comptroller General shall complete the study under paragraph (1) and submit to the Congress a report containing the results of such study.

(b) NIH REPORT ON CERTAIN AUTHORITY OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—Not later than 6 months after the date of enactment of this Act, and biennially thereafter, the Director of the National Institutes of Health, in collaboration with the Director of the National Institute on Minority

Health and Health Disparities, shall submit to the Congress a report that details and evaluates—

(1) the steps taken during the applicable report period by the Director of the National Institutes of Health to plan, coordinate, review, and evaluate all minority health and health disparity research that is conducted or supported by the institutes and centers at the National Institutes of Health; and

(2) the outcomes of such steps.

(c) GAO REPORT RELATED TO RECIPIENTS OF PPACA FUNDING.—Not later than one year after the date of enactment of this Act and biennially thereafter, the Comptroller General of the United States shall submit to the Congress a report that identifies—

(1) the racial and ethnic diversity of community-based organizations that applied for Federal enrollment funding provided pursuant to the Patient Protection and Affordable Care Act (Public Law 111–148) (including the amendments made by such Act);

(2) the percentage of such organizations that were awarded such funding; and

(3) the impact of such community-based organizations' enrollment efforts on the insurance status of their communities.

(d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—The Director of the National Institute on Minority Health and Health Disparities shall prepare an annual report on the activities carried out or to be carried out by such institute, and shall submit each such report to the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Energy and Commerce of the House of Representatives, the Secretary of Health and Human Services, and the Director of the National Institutes of Health. With respect to the fiscal year involved, the report shall—

(1) describe and evaluate the progress made in health disparities research conducted or supported by institutes and centers of the National Institutes of Health;

(2) summarize and analyze expenditures made for activities with respect to health disparities research conducted or supported by the National Institutes of Health;

(3) include a separate statement applying the requirements of paragraphs (1) and (2) specifically to minority health disparities research; and

(4) contain such recommendations as the Director of the Institute considers appropriate.

SEC. 9007. INVESTIGATIVE AND ENFORCEMENT ACTIONS.

(a) IN GENERAL.—In carrying out the investigative and enforcement actions of section 3451(b)(2) of the Public Health Service Act, as added by section 9003 of this Act, the Director for Civil Rights and Health Equity (referred to in this section as the ''Director'') shall pursue such investigative and enforcement actions pursuant to this section.

(b) ADMINISTRATIVE COMPLAINT AND CONCILIATION PROCESS.—

(1) COMPLAINTS AND ANSWERS.—

(A) IN GENERAL.—An aggrieved person may, not later than 1 year after an alleged violation of subsection (a) has occurred or concluded, file a complaint with the Director alleging inequitable provision of health care by a provider described in subsection (a).

(B) COMPLAINT.—A complaint submitted pursuant to subparagraph (A) shall be in writing and shall contain such information and be in such form as the Director requires.

(C) OATH OR AFFIRMATION.—The complaint and any answer made under this subsection shall be made under oath or affirmation, and may be reasonably and fairly modified at any time.

(2) RESPONSE TO COMPLAINTS.—

(A) IN GENERAL.—Upon the filing of a complaint under this subsection, the following procedures shall apply:

(i) COMPLAINANT NOTICE.—The Director shall serve notice upon the complainant acknowledging receipt of such filing and advising the complainant of the time limits and procedures provided under this section.

(ii) RESPONDENT NOTICE.—The Director shall, not later than 30 days after receipt of such filing—

(I) serve on the respondent a notice of the complaint, together with a copy of the original complaint; and

(II) advise the respondent of the procedural rights and obligations of respondents under this section.

(iii) ANSWER.—The respondent may file, not later than 60 days after receipt of the notice from the Director, an answer to such complaint.

(iv) INVESTIGATIVE DUTIES.—The Director shall—

(I) make an investigation of the alleged inequitable provision of health care; and

(II) complete such investigation within 180 days (unless it is impracticable to complete such investigation within 180 days) after the filing of the complaint.

(B) INVESTIGATIONS.—

(i) PATTERN OR PRACTICE.—In the course of investigating the complaint, the Director may seek records of care provided to patients other than the complainant if necessary to demonstrate or disprove an allegation of inequitable provision of health care or to determine whether there is a pattern or practice of such care.

(ii) ACCOUNTING FOR SOCIAL DETERMINANTS OF HEALTH.—In investigating the complaint and reaching a determination on the validity of the complaint, the Director shall account for social determinants of health and the effect of such social determinants on health care outcomes.

(iii) INABILITY TO COMPLETE INVESTIGATION.—If the Director is unable to complete (or finds it is impracticable to complete) the investigation within 180 days after the filing of the complaint (or, if the Secretary takes further action under paragraph (6)(B) with respect to a complaint, within 180 days after the commencement of such further action), the Director shall notify the complainant and respondent in writing of the reasons involved.

(C) REPORT.—

(i) FINAL REPORT.—On completing each investigation under this paragraph, the Director shall prepare a final investigative report.

(ii) MODIFICATION OF REPORT.—A final report under this subparagraph may be modified if additional evidence is later discovered.

(3) CONCILIATION.—

(A) IN GENERAL.—During the period beginning on the date on which a complaint is filed under this subsection and ending on the

date of final disposition of such complaint (including during an investigation under paragraph (2)(B)), the Director shall, to the extent feasible, engage in conciliation with respect to such complaint.

(B) CONCILIATION AGREEMENT.—A conciliation agreement arising out of such conciliation shall be an agreement between the respondent and the complainant, and shall be subject to approval by the Director.

(C) RIGHTS PROTECTED.—The Director shall approve a conciliation agreement only if the agreement protects the rights of the complainant and other persons similarly situated.

(D) PUBLICLY AVAILABLE AGREEMENT.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall make available to the public a copy of a conciliation agreement entered into pursuant to this subsection unless the complainant and respondent otherwise agree, and the Secretary determines, that disclosure is not required to further the purposes of this subsection.

(ii) LIMITATION.—A conciliation agreement that is made available to the public pursuant to clause (i) may not disclose individually identifiable health information.

(4) FAILURE TO COMPLY WITH CONCILIATION AGREEMENT.—Whenever the Director has reasonable cause to believe that a respondent has breached a conciliation agreement, the Director shall refer the matter to the Attorney General to consider filing a civil action to enforce such agreement.

(5) WRITTEN CONSENT FOR DISCLOSURE OF INFORMATION.—Nothing said or done in the course of conciliation under this subsection may be made public, or used as evidence in a subsequent proceeding under this subsection, without the written consent of the parties to the conciliation.

(6) PROMPT JUDICIAL ACTION.—

(A) IN GENERAL.—If the Director determines at any time following the filing of a complaint under this subsection that prompt judicial action is necessary to carry out the purposes of this subsection, the Director may recommend that the Attorney General promptly commence a civil action under subsection (d).

(B) IMMEDIATE SUIT.—If the Director determines at any time following the filing of a complaint under this subsection that the public interest would be served by allowing the complainant to bring a civil action under subsection (c) in a State or Federal court immediately, the Director shall certify that the administrative process has concluded and that the complainant may file such a suit immediately.

(7) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director shall make publicly available a report detailing the activities of the Office for Civil Rights and Health Equity under this subsection, including—

(A) the number of complaints filed and the basis on which the complaints were filed;

(B) the number of investigations undertaken as a result of such complaints; and

(C) the disposition of all such investigations.

(c) ENFORCEMENT BY PRIVATE PERSONS.—

(1) IN GENERAL.—

(A) CIVIL ACTION.—

(i) IN SUIT.—A complainant under subsection (b) may commence a civil action to obtain appropriate relief with respect to an alleged violation of subsection (a), or for breach of a conciliation agreement under subsection (b), in an appropriate district court of the United States or State court—

(I) not sooner than the earliest of—

(aa) the date a conciliation agreement is reached under subsection (b);

(bb) the date of a final disposition of a complaint under subsection (b); or

(cc) 180 days after the first day of the alleged violation; and

(II) not later than 2 years after the final day of the alleged violation.

(ii) STATUTE OF LIMITATIONS.—The computation of such 2-year period shall not include any time during which an administrative proceeding (including investigation or conciliation) under subsection

(b) was pending with respect to a complaint under such subsection.

(B) BARRING SUIT.—If the Director has obtained a conciliation agreement under subsection (b) regarding an alleged violation of subsection (a), no action may be filed under this paragraph by the complainant involved with respect to the alleged violation except for the purpose of enforcing the terms of such an agreement.

(2) RELIEF WHICH MAY BE GRANTED.—

(A) IN GENERAL.—In a civil action under paragraph (1), if the court finds that a violation of subsection (a) or breach of a conciliation agreement has occurred, the court may award to the plaintiff actual and punitive damages, and may grant as relief, as the court determines to be appropriate, any permanent or temporary injunction, temporary restraining order, or other order (including an order enjoining the defendant from engaging in a practice violating subsection (a) or ordering such affirmative action as may be appropriate).

(B) FEES AND COSTS.—In a civil action under paragraph (1), the court, in its discre-

tion, may allow the prevailing party, other than the United States, a reasonable attorney's fee and costs. The United States shall be liable for such fees and costs to the same extent as a private person.

(3) INTERVENTION BY ATTORNEY GENERAL.—Upon timely application, the Attorney General may intervene in a civil action under paragraph (1), if the Attorney General certifies that the case is of general public importance.

(d) ENFORCEMENT BY THE ATTORNEY GENERAL.—

(1) COMMENCEMENT OF ACTIONS.—

(A) PATTERN OR PRACTICE CASES.—The Attorney General may commence a civil action in any appropriate district court of the United States if the Attorney General has reasonable cause to believe that any health care provider covered by subsection (a)—

(i) is engaged in a pattern or practice that violates such subsection; or

(ii) is engaged in a violation of such subsection that raises an issue of significant public importance.

(B) CASES BY REFERRAL.—The Director may determine, based on a pattern of com-

plaints, a pattern of violations, a review of data reported by a health care provider covered by subsection (a), or any other means, that there is reasonable cause to believe a health care provider is engaged in a pattern or practice that violates subsection (a). If the Director makes such a determination, the Director shall refer the related findings to the Attorney General. If the Attorney General finds that such reasonable cause exists, the Attorney General may commence a civil action in any appropriate district court of the United States.

(2) ENFORCEMENT OF SUBPOENAS.—The Attorney General, on behalf of the Director, or another party at whose request a subpoena is issued under this subsection, may enforce such subpoena in appropriate proceedings in the district court of the United States for the district in which the person to whom the subpoena was addressed resides, was served, or transacts business.

(3) RELIEF WHICH MAY BE GRANTED IN CIVIL ACTIONS.—

(A) IN GENERAL.—In a civil action under 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

(II) in an amount not exceeding $1,000,000, for any subsequent violation.

(B) FEES AND COSTS.—In a civil action under this subsection, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee and costs. The United States shall be liable for

such fees and costs to the extent provided by section 2412 of title 28, United States Code.

(4) INTERVENTION IN CIVIL ACTIONS.—Upon timely application, any person may intervene in a civil action commenced by the Attorney General under paragraphs (1) and (2) if the action involves an alleged violation of subsection (a) with respect to which such person is an aggrieved person (including a person who is a complainant under subsection (b)) or a conciliation agreement to which such person is a party.

SEC. 9008. FEDERAL HEALTH EQUITY COMMISSION.

(a) ESTABLISHMENT OF COMMISSION.—

(1) IN GENERAL.—There is established the Federal Health Equity Commission (hereinafter in this section referred to as the ''Commission'').

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Commission shall be composed of—

(i) 8 voting members appointed under subparagraph (B); and

(ii) the nonvoting, ex officio members listed in subparagraph (C).

(B) VOTING MEMBERS.—Not more than 4 of the members described in subparagraph

(A)(i) shall at any one time be of the same political party. Such members shall have recognized expertise in and personal experience with racial and ethnic health inequities, health care needs of vulnerable and marginalized populations, and health equity as a vehicle for improving health status and health outcomes. Such members shall be appointed to the Commission as follows:

(i) Four members of the Commission shall be appointed by the President.

(ii) Two members of the Commission shall be appointed by the President pro tempore of the Senate, upon the recommendations of the majority leader and the minority leader of the Senate. Each member appointed to the Commission under this clause shall be appointed from a different political party.

(iii) Two members of the Commission shall be appointed by the Speaker of the House of Representatives upon the recommendations of the majority leader and the minority leader of the House of Representatives. Each member appointed to

the Commission under this clause shall be appointed from a different political party.

(C) EX OFFICIO MEMBER.—The Commission shall have the following nonvoting, ex officio members:

(i) The Director for Civil Rights and Health Equity of the Department of Health and Human Services.

(ii) The Deputy Assistant Secretary for Minority Health of the Department of Health and Human Services.

(iii) The Director of the National Institute on Minority Health and Health Disparities.

(iv) The Chairperson of the Advisory Committee on Minority Health established under section 1707(c) of the Public Health Service Act (42 U.S.C. 300u–6(c)).

(3) TERMS.—The term of office of each member appointed under paragraph (2)(B) of the Commission shall be 6 years.

(4) CHAIRPERSON; VICE CHAIRPERSON.—

(A) CHAIRPERSON.—The President shall, with the concurrence of a majority of the members of the Commission appointed under para-

graph (2)(B), designate a Chairperson from among the members of the Commission appointed under such paragraph.

(B) VICE CHAIRPERSON.—

(i) DESIGNATION.—The Speaker of the House of Representatives shall, in consultation with the majority leaders and the minority leaders of the Senate and the House of Representatives and with the concurrence of a majority of the members of the Commission appointed under paragraph (2)(B), designate a Vice Chairperson from among the members of the Commission appointed under such paragraph. The Vice Chairperson may not be a member of the same political party as the Chairperson.

(ii) DUTY.—The Vice Chairperson shall act in place of the Chairperson in the absence of the Chairperson.

(5) REMOVAL OF MEMBERS.—The President may remove a member of the Commission only for neglect of duty or malfeasance in office.

(6) QUORUM.—A majority of members of the Commission appointed under paragraph (2)(B) shall

constitute a quorum of the Commission, but a lesser number of members may hold hearings.

(b) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) monitor and report on the implementation of this Act; and

(B) investigate, monitor, and report on progress towards health equity and the elimination of health disparities.

(2) ANNUAL REPORT.—The Commission shall—

(A) submit to the President and Congress at least one report annually on health equity and health disparities; and

(B) include in such report—

(i) a description of actions taken by the Department of Health and Human Services and any other Federal agency related to health equity or health disparities; and

(ii) recommendations on ensuring equitable health care and eliminating health disparities.

(c) POWERS.—

(1) HEARINGS.—

(A) IN GENERAL.—The Commission or, at the direction of the Commission, any subcommittee or member of the Commission, may, for the purpose of carrying out this section, as the Commission or the subcommittee or member considers advisable—

(i) hold such hearings, meet and act at such times and places, take such testimony, receive such evidence, and administer such oaths; and

(ii) require, by subpoena or otherwise, the attendance and testimony of such witnesses and the production of such books, records, correspondence, memoranda, papers, documents, tapes, and materials.

(B) LIMITATION ON HEARINGS.—The Commission may hold a hearing under subparagraph (A)(i) only if the hearing is approved—

(i) by a majority of the members of the Commission appointed under subsection (a)(2)(B); or

(ii) by a majority of such members present at a meeting when a quorum is present.

(2) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

(A) ISSUANCE.—A subpoena issued under paragraph (1) shall—

(i) bear the signature of the Chairperson of the Commission; and

(ii) be served by any person or class of persons designated by the Chairperson for that purpose.

(B) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under paragraph (1), the United States district court for the district in which the subpoenaed person resides, is served, or may be found may issue an order requiring the person to appear at any designated place to testify or to produce documentary or other evidence.

(C) NONCOMPLIANCE.—Any failure to obey the order of the court may be punished by the court as a contempt of court.

(3) WITNESS ALLOWANCES AND FEES.—

(A) IN GENERAL.—Section 1821 of title 28, United States Code, shall apply to a witness requested or subpoenaed to appear at a hearing of the Commission.

(B) EXPENSES.—The per diem and mileage allowances for a witness shall be paid from funds available to pay the expenses of the Commission.

(4) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other agencies of the Federal Government.

(5) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(d) ADMINISTRATIVE PROVISIONS.—

(1) STAFF.—

(A) DIRECTOR.—There shall be a full-time staff director for the Commission who shall—

(i) serve as the administrative head of the Commission; and

(ii) be appointed by the Chairperson with the concurrence of the Vice Chairperson.

(B) OTHER PERSONNEL.—The Commission may—

(i) appoint such other personnel as it considers advisable, subject to the provisions 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.

(B) FEDERAL EMPLOYEES.—Each member of the Commission who is an officer or employee of the Federal Government shall serve without compensation in addition to the compensation received for the services of the member as an office or employee of the Federal Government.

(C) TRAVEL EXPENSES.—A member of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Commission.

(3) COOPERATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this Act. Upon request of the Chairman of the Commission, the head of such department or agency shall furnish such information to the Commission.

(e) PERMANENT COMMISSION.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal year 2023 and each fiscal year thereafter such sums as may be necessary to carry out the duties of the Commission.

TITLE X—ADDRESSING SOCIAL DETERMINANTS AND IMPROVING ENVIRONMENTAL JUSTICE

Subtitle A—In General

SEC. 10001. DEFINITIONS.

In this title:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Environmental Protection Agency.

(2) AGENCY.—The term ''Agency'' means the Environmental Protection Agency.

(3) BUILT ENVIRONMENT.—The term ''built environment'' means the components of the environment, and the location of those components in a geographically defined space, that are created or modified by individuals to form the physical and social characteristics of a community or enhance quality of human life, including—

(A) homes, schools, and places of work and worship;

(B) parks, recreation areas, and greenways;

(C) transportation systems;

(D) business, industry, and agriculture; and

(E) land-use plans, projects, and policies that impact the physical or social characteristics of a community, including access to services and amenities.

(4) DETERMINANTS OF HEALTH.—The term ''determinants of health''—

(A) means the range of nonclinical factors inclusive of personal, social, economic, and environmental factors that directly influence health status; and

(B) includes social determinants of health.

(5) ECONOMIC DETERMINANTS OF HEALTH.—The term ''economic determinants of health'' means income and social status.

(6) ENVIRONMENTAL DETERMINANTS OF HEALTH.—The term ''environmental determinants of health'' means the broad physical (including man-made and natural), psychological, social, spiritual, cultural, and aesthetic environment.

(7) PERSONAL DETERMINANTS OF HEALTH.—The term ''personal determinants of health'' means an individual's behavior, biology, and genetics.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(9) SOCIAL DETERMINANTS OF HEALTH.—The term ''social determinants of health''—

(A) means a subset of determinants of the health of individuals and environments (such as communities, neighborhoods, and societies) that describe an individual's or group of people's social identity, describe the social and economic resources to which such individual or group has access, and describe the conditions in which an individual or group of people works, lives, and plays; and

(B) are sometimes referred to as ''social and economic determinants of health'', ''socioeconomic determinants of health'', ''environmental determinants of health'', ''social drivers of inequality'', or ''personal determinants of health''.

SEC. 10002. FINDINGS.

Congress finds as follows:

(1) Social determinants of health are the greatest predictors of health outcomes.

(2) Social determinants of health, including health-related behaviors, social and economic factors, and physical environment factors account for 80 percent of health outcomes, whereas clinical care accounts for 20 percent of improved health outcomes. Yet, in 2017, public health spending represented only 2.5 percent of all health spending in the United States.

(3) There are more opportunities to improve health for everyone when we understand that health starts, not in a medical setting, but in our families, in our schools and workplaces, in our neighborhoods, in the air we breathe, and in the water we drink.

(4)(A) Healthy People 2030 identifies health and health care quality as a function of not only access to health care, but also the social determinants of health, categorized into the following: neighborhoods and the built environment; social and community context; education; and economic stability.

(B) The following examples illustrate the nexus between the unequal distribution of the social determinants of health and health inequities:

(i) The built environment influences residents' level of physical activity. Neighborhoods with high levels of poverty are significantly less likely to have places where children can be physically active, such as parks, green spaces, and bike paths and lanes. Neighborhoods and communities can provide opportunities for physical activity and support active lifestyles through accessible and safe parks and open spaces and through land use policy, zoning, and healthy community design.

(ii) Emotional and physical health and well-being are directly impacted by perceived levels of safety, such as unlit streets at night. Community members have expressed that safety is not only a barrier to accessing programs and services that increase quality of life, but also a barrier to accessing physical activity in their community through the built environment.

(iii) Historical and institutional racism in the United States has shaped the way in which social and economic resources and exposure to health promoting environments are distributed. Income, education, occupation, neighborhood conditions, schools, workplaces, the use of

health and social services, and experiences with the criminal justice system are all highly patterned by race, with people of color experiencing more that is health harming. Finding ways to uncouple the link between race and access to resources and healthy environments is a principal means of reducing health inequities. Additionally, the anticipation of racism itself causes higher psychological and cardiovascular stress levels that are linked to poor health outcomes. Remedying discriminatory practices at the individual and systemic levels will likely reduce health inequities caused by this unequal distribution of stress.

(iv) Poor health among Native Americans has largely been driven by post-colonial oppression and historical trauma. The expropriation of native lands and territories to the American state had severe consequences on Native American health. This resulted in the deprivation of traditional food sources—and nutrients—for Native Americans and also the destruction of traditional economies and community organization. Today, Native Americans have twice the rate of diabetes of non-Hispanic Whites. Rec-

ognition of the origins of diabetes as having a social and community context, rather than just individual responsibility and genetic predisposition, will shape better policy to provide food security.

(v) In the context of prisons, overcrowding has led to the deterioration of the physical and mental health of individuals after they leave prison. In particular, the mass incarceration of African-American males as a result of inequities within and treatment in the criminal justice system has contributed to an overburdening of certain infectious diseases within the African-American community. As a social institution, incarceration amplifies existing adverse health conditions by concentrating diseases and harmful health behaviors such as tobacco use, drug use, and violence.

(vi) Educational attainment is the strongest predictor of adult mortality. It is a basic component of socioeconomic status that shapes earning potential, and consequently, access to resources that promote health. People with more education are less likely to report that

they are in poor health, and are also less likely to have diabetes and other chronic diseases.

(vii) Individuals with lower levels of educational attainment are much more likely to report to be current smokers. In 2017, smoking prevalence was 36.8 percent among adults with a GED diploma, 23.1 percent with less than a high school diploma, and 18.7 percent with a high school diploma, while dropping significantly to 7.1 percent among adults with an undergraduate college degree and 4.1 percent with a postgraduate college degree.

(viii) Income inequality differences account for a large part of health inequities. For example, children living in poverty experience poorer housing conditions, increased exposure to indoor allergens and toxins (such as pesticides, lead, mercury, radon, air pollution, and carcinogens), increased food insecurity, and more psychological stress. These experiences culminate in worse adult health as compared with children with higher socioeconomic status. Specifically, children living in lower socioeconomic neighborhoods have higher rates of asthma due to higher rates of psychological stress resulting from

higher rates of violence. Food insecurity is associated with obesity, and racial and ethnic minorities have higher rates of food insecurity.

(ix) Lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied (referred to in this section as ''LGBTQIA+'') individuals face health inequities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQIA+ individuals has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBTQIA+ individuals, and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTQIA+ individuals.

(x) Individuals in older and cheaper housing are at higher risk to be exposed to lead, particularly in housing built prior to 1960. The threat of lead poisoning disproportionally affects vulnerable populations, with children living in poverty (5.6 percent) and Black children

(5.6) experiencing the highest rates. According to the Department of Housing and Urban Development, about 3,600,000 homes nationwide that house young children have lead hazards such as contaminated drinking water, peeling paint, contaminated dust, or toxic soil. The combined cost of medical treatment and special education for lead poisoned children averages about $5,600 per child per year, and lead poisoning costs the United States an estimated $50,000,000,000 annually.

(xi) According to the report Healthy People 2030, people with disabilities, as a group, experience health inequities in routine public health arenas such as health behaviors, clinical preventive services, and chronic conditions. Compared with people without disabilities, people with disabilities are—

(I) less likely to receive recommended preventive health care services, such as routine teeth cleanings and cancer screenings;

(II) at a high risk for poor health outcomes such as obesity, hypertension, falls-

related injuries, and mood disorders such as depression; and

(III) more likely to engage in unhealthy behaviors that put their health at risk, such as cigarette smoking and inadequate physical activity.

(5) Laws and regulations that improve opportunities to live in safe neighborhoods with more social cohesion, attain higher education, sustain stable employment, and bridge class differences help foster the health and safety of individuals.

(6) The global public health community has reached consensus through the Rio Political Declaration of Social Determinants of Health adopted by the World Health Organization in October 2011 that ''[c]ollaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, an initiative of the American Public Health Association, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors of health, as well as the promotion of health equity and more inclusive and productive societies.''.

SEC. 10003. HEALTH IMPACT ASSESSMENTS.

(a) FINDINGS.—Congress makes the following findings:

(1) Health impact assessment is a tool to help planners, health officials, decision makers, and the public make more informed decisions about the potential health effects of proposed plans, policies, programs, and projects in order to maximize health benefits and minimize harms.

(2) Health impact assessments foster community leadership, ownership, and participation in decision-making processes.

(3) Health impact assessments can build community support and reduce opposition to a project or policy, thereby facilitating economic growth by aiding the development of consensus regarding new development proposals.

(4) Health impact assessments facilitate collaboration across sectors.

(b) PURPOSES.—It is the purpose of this section to—

(1) provide more information about the potential human health effects of policy decisions and the distribution of those effects;

(2) improve how health is considered in planning and decision-making processes; and

(3) build stronger, healthier communities through the use of health impact assessments.

(c) HEALTH IMPACT ASSESSMENTS.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 7602(a), is further amended by adding at the end the following:

"SEC. 399V–14. HEALTH IMPACT ASSESSMENTS.

''(a) DEFINITIONS.—In this section:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Environmental Protection Agency.

''(2) DIRECTOR.—The term 'Director' means the Director of the Centers for Disease Control and Prevention.

''(3) HEALTH IMPACT ASSESSMENT.—The term 'health impact assessment' means a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. Such term includes identifying and recommending appropriate actions on monitoring and maximizing potential benefits and minimizing potential harms.

''(4) HEALTH INEQUITY.—The term 'health inequity' means a particular type of health difference that is closely linked with social, economic, or environmental disadvantage and that adversely affects groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; citizenship status; or other characteristics historically linked to discrimination or exclusion.

''(b) ESTABLISHMENT.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

''(1) in consultation with the Director of the National Center for Chronic Disease Prevention and Health Promotion and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture, establish a program at the National Center for Environmental Health at the Centers for Disease Control and Prevention focused on advancing the field of health impact assessment that includes—

"(A) collecting and disseminating best practices;

"(B) administering capacity building grants to States, Indian Tribes, and Tribal organizations to support subgrantees in initiating health impact assessments, in accordance with subsection (d);

"(C) providing technical assistance;

"(D) developing training tools and providing training on conducting health impact assessment and the implementation of built environment and health indicators;

"(E) making information available, as appropriate, regarding the existence of other community healthy living tools, checklists, and indices that help connect public health to other sectors, and tools to help examine the effect of the indoor built environment and building codes on population health;

"(F) conducting research and evaluations of health impact assessments; and

"(G) awarding competitive extramural research grants;

''(2) develop guidance and guidelines to conduct health impact assessments in accordance with subsection (c); and

''(3) establish a grant program to allow States, Indian Tribes, and Tribal organizations to award subgrants to eligible entities to conduct health impact assessments.

''(c) GUIDANCE.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Correcting Hurtful and Alienating Names in Government Expression Act, the Secretary, acting through the Director, shall issue final guidance for conducting health impact assessments. In developing such guidance the Secretary shall—

''(A) consult with the Director of the National Center for Environmental Health, the Director of the National Center for Chronic Disease Prevention and Health Promotion, and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture; and

''(B) consider available international health impact assessment guidance, North American

health impact assessment practice standards, and recommendations from the National Academy of Science.

''(2) CONTENT.—The guidance under this subsection shall include—

''(A) background on national and international efforts to bridge urban planning, climate forecasting, and public health institutions and disciplines, including a review of health impact assessment best practices internationally;

''(B) evidence-based direct and indirect pathways that link land-use planning, transportation, and housing policy and objectives to human health outcomes;

''(C) data resources and quantitative and qualitative forecasting methods to evaluate both the status of health determinants and health effects, including identification of existing programs that can disseminate these resources;

''(D) best practices for inclusive public involvement in conducting health impact assessments; and

''(E) technical assistance for other agencies seeking to develop their own guidelines and procedures for health impact assessment.

''(d) GRANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

''(A) award grants to States, Indian Tribes, and Tribal organizations to award subgrants to eligible entities for capacity building or to prepare health impact assessments; and

''(B) ensure that States, Indian Tribes, and Tribal organizations receiving a grant under this subsection further support training and technical assistance for subgrantees under subparagraph (A) by funding and overseeing appropriate experts on health impact assessments from local, State, and Tribal governments, the Federal Government, institutions of higher education, and nonprofit organizations to provide such training and technical assistance.

''(2) APPLICATIONS FOR SUBGRANTS.—

''(A) IN GENERAL.—To be eligible to receive a subgrant under this section, an eligible entity shall—

''(i) be a community-based organization serving individuals or populations the

health of which are, or will be, affected by an activity or a proposed activity; and

''(ii) submit to the grantee an application in accordance with this subsection, at such time, in such manner, and containing such additional information as the Secretary (acting through the Director and in collaboration with the Administrator) and the grantee may require.

''(B) INCLUSION.—An application for a subgrant under this subsection shall include—

''(i) a list of proposed activities that require or would benefit from conducting a health impact assessment within six months of receiving the subgrant;

''(ii) supporting documentation, including letters of support, from potential conductors of health impact assessments for the listed proposed activities;

''(iii) an assessment by the applicant of the health of the population to be served through the subgrant; and

''(iv) a description of potential adverse or positive effects on health that the proposed activities may create.

"(C) PREFERENCE.—In awarding subgrants under this subsection, States may give preference to eligible entities that demonstrate the potential to significantly improve population health or lower health care costs as a result of potential health impact assessment work.

"(3) USE OF FUNDS.—

"(A) IN GENERAL.—A State, Indian Tribe, or Tribal organization receiving a grant under this subsection shall use such grant to conduct health impact assessment capacity building in support of a subgrantee conducting a health impact assessment for a proposed activity in accordance with this subsection.

"(B) PURPOSES.—The purposes of a health impact assessment under this subsection are—

"(i) to facilitate the involvement of Tribal, State, and local public health officials in community planning, transportation, housing, and land use decisions and other decisions affecting the built environment to identify any potential health concern or health benefit relating to an activity or proposed activity;

''(ii) to provide for an investigation of any health-related issue of concern raised in a planning process, an environmental impact assessment process, or policy appraisal relating to a proposed activity;

''(iii) to describe and compare alternatives (including no-action alternatives) to a proposed activity to provide clarification with respect to the potential health outcomes associated with the proposed activity and, where appropriate, to the related benefit-cost or cost-effectiveness of the proposed activity and alternatives;

''(iv) to contribute, when applicable, to the findings of a planning process, policy appraisal, or an environmental impact statement with respect to the terms and conditions of implementing a proposed activity or related mitigation recommendations, as necessary;

''(v) to ensure that the disproportionate distribution of negative impacts among vulnerable populations is minimized as much as possible;

''(vi) to engage affected community members and ensure adequate opportunity for public comment on all stages of the health impact assessment;

''(vii) where appropriate, to consult with local and county health departments and appropriate organizations, including planning, transportation, and housing organizations, and provide them information and tools regarding how to conduct and integrate health impact assessment into their work; and

''(viii) to inspect homes, water systems, and other elements that pose risks to lead exposure, with an emphasis on areas that pose a higher risk to children.

''(4) ASSESSMENTS.—Health impact assessments carried out using funds under this section shall—

''(A) take appropriate health factors into consideration as early as practicable during the planning, review, or decision-making processes;

''(B) assess the effect on the health of individuals and populations of proposed policies,

projects, or plans that result in modifications to the built environment; and

''(C) assess the distribution of health effects across various factors, such as race, income, ethnicity, age, disability status, gender, and geography.

''(5) ELIGIBLE ACTIVITIES.—

''(A) IN GENERAL.—A State, Indian Tribe, or Tribal organization receiving a grant under this section shall conduct an evaluation of any activity proposed to be funded through the grant, including through a subgrant, to determine whether such activity will have a significant adverse or positive effect on the health of the affected population to be served, based on the criteria described in subparagraph (B).

''(B) CRITERIA.—The criteria described in this subparagraph include, as applicable to the proposed activity, the following:

''(i) Any substantial adverse effect or significant health benefit on health outcomes or factors known to influence health, including the following:

''(I) Physical activity.

''(II) Injury.

''(III) Mental health.

''(IV) Accessibility to health-promoting goods and services.

''(V) Respiratory health.

''(VI) Chronic disease.

''(VII) Nutrition.

''(VIII) Land use changes that promote local, sustainable food sources.

''(IX) Infectious disease.

''(X) Health inequities.

''(XI) Existing air quality, ground or surface water quality or quantity, or noise levels.

''(XII) Lead exposure.

''(XIII) Drinking water quality and accessibility.

''(ii) Other factors that may be considered, including—

''(I) the potential for a proposed activity to result in systems failure that leads to a public health emergency;

''(II) the probability that the proposed activity will result in a signifi-

cant increase in tourism, economic development, or employment in the population to be served;

''(III) any other significant potential hazard or enhancement to human health, as determined by the grantee; or

''(IV) whether the evaluation of a proposed activity would duplicate another analysis or study being undertaken in conjunction with the proposed activity.

''(C) FACTORS FOR CONSIDERATION.—In evaluating a proposed activity under subparagraph (A), a grantee may take into consideration any reasonable, direct, indirect, or cumulative effect that can be clearly related to potential health effects and that is related to the proposed activity, including the effect of any action that is—

''(i) included in the long-range plan relating to the proposed activity;

''(ii) likely to be carried out in coordination with the proposed activity;

"(iii) dependent on the occurrence of the proposed activity; or

"(iv) likely to have a disproportionate impact on high-risk or vulnerable populations.

"(6) REQUIREMENTS.—A health impact assessment prepared with funds awarded under this subsection shall incorporate the following, after conducting the screening phase (identifying projects or policies for which a health impact assessment would be valuable and feasible) through the application process:

"(A) SCOPING.—Identifying which health effects to consider and the research methods to be utilized.

"(B) ASSESSING RISKS AND BENEFITS.—Assessing the baseline health status and factors known to influence the health status in the affected community, which may include aggregating and synthesizing existing health assessment evidence and data from the community.

"(C) DEVELOPING RECOMMENDATIONS.—Suggesting changes to proposals to promote positive or mitigate adverse health effects.

"(D) REPORTING.—Synthesizing the assessment and recommendations and communicating the results to decision makers.

"(E) MONITORING AND EVALUATING.—Tracking the decision and implementation effect on health determinants and health status.

"(7) PLAN.—A subgrantee under this section shall develop and implement a plan, to be approved by the Secretary (acting through the Director and in collaboration with the Administrator) and the grantee, for meaningful and inclusive stakeholder involvement in all phases of the health impact assessment. Stakeholders may include community leaders, community-based organizations, youth-serving organizations, planners, public health experts, State and local public health departments and officials, health care experts or officials, housing experts or officials, and transportation experts or officials.

"(8) SUBMISSION OF FINDINGS.—A grantee under this section shall submit the findings of any funded health impact assessment activities to the Secretary and make these findings publicly available.

"(9) ASSESSMENT OF IMPACTS.—A subgrantee under this section shall ensure the assessment of the distribution of health impacts (related to the pro-

posed activity) across race, ethnicity, income, age, gender, disability status, and geography.

''(10) CONDUCT OF ASSESSMENT.—To the greatest extent feasible, a health impact assessment shall be conducted under this section in a manner that respects the needs and timing of the decision-making process such assessment evaluates.

''(11) METHODOLOGY.—In preparing a health impact assessment funded under this subsection, a subgrantee under this section shall follow the guidance published under subsection (c).

''(e) HEALTH IMPACT ASSESSMENT DATABASE.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish, maintain, and make publicly available a health impact assessment database, including—

''(1) a catalog of health impact assessments received under this section;

''(2) an inventory of tools used by subgrantees to conduct health impact assessments; and

''(3) guidance for subgrantees with respect to the selection of appropriate tools described in paragraph (2).

''(f) EVALUATION OF GRANTEE ACTIVITIES.—The Secretary shall award competitive grants to Prevention

Research Centers, or nonprofit organizations or academic institutions with expertise in health impact assessments to—

''(1) assist grantees and subgrantees with the provision of training and technical assistance in the conducting of health impact assessments;

''(2) evaluate the activities carried out with grants and subgrants under subsection (d); and

''(3) assist the Secretary in disseminating evidence, best practices, and lessons learned from grantees and subgrantees.

''(g) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of the Correcting Hurtful and Alienating Names in Government Expression Act, the Secretary shall submit to Congress a report concerning the evaluation of the programs under this section, including recommendations as to how lessons learned from such programs can be incorporated into future guidance documents developed and provided by the Secretary and other Federal agencies, as appropriate.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

"SEC. 399V–15. IMPLEMENTATION OF RESEARCH FINDINGS TO IMPROVE HEALTH OUTCOMES THROUGH THE BUILT ENVIRONMENT.

''(a) RESEARCH GRANT PROGRAM.—The Secretary, in collaboration with the Administrator of the Environmental Protection Agency (referred to in this section as the 'Administrator'), shall award grants to public agencies or private nonprofit institutions to implement evidence-based programming to improve human health through improvements to the built environment and subsequently human health, by addressing—

''(1) levels of physical activity;

''(2) consumption of nutritional foods;

''(3) rates of crime;

''(4) air, water, and soil quality;

''(5) risk or rate of injury;

''(6) accessibility to health-promoting goods and services;

''(7) chronic disease rates;

''(8) community design;

''(9) housing;

''(10) transportation options; and

''(11) other factors, as the Secretary determines appropriate.

''(b) APPLICATIONS.—A public agency or private nonprofit institution desiring a grant under this section

shall submit to the Secretary an application at such time, in such manner, and containing such agreements, assurances, and information as the Secretary, in consultation with the Administrator, may require.

''(c) RESEARCH.—The Secretary, in consultation with the Administrator, shall support, through grants awarded under this section, research that—

''(1) uses evidence-based research to improve the built environment and human health;

''(2) examines—

''(A) the scope and intensity of the impacts that the built environment (including the various characteristics of the built environment) has on human health; or

''(B) the distribution of such impacts by—

''(i) location; and

''(ii) population subgroup;

''(3) is used to develop—

''(A) measures and indicators to address health impacts and the connection of health to the built environment;

''(B) efforts to link the measures to transportation, land use, and health databases; and

''(C) efforts to enhance the collection of built environment surveillance data;

''(4) distinguishes carefully between personal attitudes and choices and external influences on behavior to determine how much the association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

''(5)(A) identifies or develops effective intervention strategies focusing on enhancements to the built environment that promote increased use physical activity, access to nutritious foods, or other health-promoting activities by residents; and

''(B) in developing the intervention strategies under subparagraph (A), ensures that the intervention strategies will reach out to high-risk or vulnerable populations, including low-income urban and rural communities and aging populations, in addition to the general population.

''(d) SURVEYS.—The Secretary may allow recipients of grants under this section to use such grant funds to support the expansion of national surveys and data tracking systems to provide more detailed information about the connection between the built environment and health.

''(e) PRIORITY.—In awarding grants under this section, the Secretary and the Administrator shall give priority to entities with programming that incorporates—

''(1) interdisciplinary approaches; or

''(2) the expertise of the public health, physical activity, urban planning, land use, and transportation research communities in the United States and abroad.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section. The Secretary may allocate not more than 20 percent of the amount so appropriated for a fiscal year for purposes of conducting research under subsection (c).''.

SEC. 10004. GRANT PROGRAM TO CONDUCT ENVIRONMENTAL HEALTH IMPROVEMENT ACTIVITIES AND TO IMPROVE SOCIAL DETERMINANTS OF HEALTH.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention, acting in collaboration with the Administrator and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State, Indian Tribe, Tribal organization, or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) bears a disproportionate burden of exposure to unhealthy living conditions, low standard housing conditions, low socioeconomic status, poor nutrition, less opportunity for educational attainment, disproportionately high unemployment rates, or lower literacy levels and access to information;

(C) has established a coalition—

(i) with not less than 1 community-based organization or demonstration program; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization;

(III) academic institution, including any minority-serving institution (including a Hispanic-serving institution, a historically Black college or

university, or a Tribal College or University);

(IV) child-serving institution; or

(V) landlord or housing provider working on lead remediation;

(D) ensures planned activities and funding streams are coordinated to improve community health; and

(E) submits an application in accordance with subsection (c).

(b) ESTABLISHMENT.—The Director shall establish a grant program under which eligible entities shall receive grants to conduct environmental health improvement activities and to improve social determinants of health.

(c) APPLICATION.—To receive a grant under this section, an eligible entity shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(d) USE OF GRANT FUNDS.—An eligible entity may use a grant under this section—

(1) to promote environmental health;

(2) to address environmental health inequities among all populations, including children; and

(3) to address racial and ethnic inequities in social determinants of health.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—The Director shall award grants to eligible entities at the following 3 funding levels:

(1) LEVEL 1 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify environmental health problems and solutions by—

(i) establishing a planning and prioritizing council in accordance with subparagraph (B); and

(ii) conducting an environmental health assessment in accordance with subparagraph (C).

(B) PLANNING AND PRIORITIZING COUNCIL.—

(i) IN GENERAL.—A planning and prioritizing council established under subparagraph (A)(i) (referred to in this paragraph as a ''PPC'') shall assist the environmental health assessment process and environmental health promotion activities of the eligible entity.

(ii) MEMBERSHIP.—Membership of a PPC shall consist of representatives from

various organizations within public health, planning, development, and environmental services and shall include stakeholders from vulnerable groups such as children, the elderly, disabled, and minority ethnic groups that are often not actively involved in democratic or decision-making processes.

(iii) DUTIES.—A PPC shall—

(I) identify key stakeholders and engage and coordinate potential partners in the planning process;

(II) establish a formal advisory group to plan for the establishment of services;

(III) conduct an in-depth review of the nature and extent of the need for an environmental health assessment, including a local epidemiological profile, an evaluation of the service provider capacity of the community, and a profile of any target populations; and

(IV) define the components of care and form essential programmatic

linkages with related providers in the community.

(C) ENVIRONMENTAL HEALTH ASSESSMENT.—

(i) IN GENERAL.—A PPC shall carry out an environmental health assessment to identify environmental health concerns.

(ii) ASSESSMENT PROCESS.—The PPC shall—

(I) define the goals of the assessment;

(II) generate the environmental health issue list;

(III) analyze issues with a systems framework;

(IV) develop appropriate community environmental health indicators;

(V) rank the environmental health issues;

(VI) set priorities for action;

(VII) develop an action plan;

(VIII) implement the plan; and

(IX) evaluate progress and planning for the future.

(D) EVALUATION.—Each eligible entity that receives a grant under this paragraph shall evaluate, report, and disseminate program findings and outcomes.

(E) TECHNICAL ASSISTANCE.—The Director may provide such technical and other non-financial assistance to eligible entities as the Director determines to be necessary.

(2) LEVEL 2 COOPERATIVE AGREEMENTS.—

(A) ELIGIBILITY.—

(i) IN GENERAL.—The Director shall award grants under this paragraph to eligible entities that have already—

(I) established broad-based collaborative partnerships; and

(II) completed environmental assessments.

(ii) NO LEVEL 1 REQUIREMENT.—To be eligible to receive a grant under this paragraph, an eligible entity is not required to have successfully completed a Level 1 Cooperative Agreement (as described in paragraph (1)).

(B) USE OF GRANT FUNDS.—An eligible entity awarded a grant under this paragraph

shall use the funds to further activities to carry out environmental health improvement activities, including—

(i) addressing community environmental health priorities in accordance with paragraph (1)(C)(ii), including—

(I) geography;

(II) the built environment;

(III) air quality;

(IV) water quality;

(V) land use;

(VI) solid waste;

(VII) housing;

(VIII) violence;

(IX) socioeconomic status;

(X) ethnicity, social construct, and language preference;

(XI) educational attainment;

(XII) employment;

(XIII) food safety, accessibility, and affordability;

(XIV) nutrition;

(XV) health care services; and

(XVI) injuries;

(ii) building partnerships between planning, public health, and other sectors, including child-serving institutions, to address how the built environment impacts food availability and access and physical activity to promote healthy behaviors and lifestyles and reduce overweight and obesity, musculoskeletal diseases, respiratory conditions, infectious diseases, dental, oral, and mental health conditions, poverty, and related co-morbidities;

(iii) establishing programs to address—

(I) how environmental and social conditions of work and living choices influence physical activity and dietary intake; or

(II) how the conditions described in subclause (I) influence the concerns and needs of people who have impaired mobility and use assistance devices, including wheelchairs, lower limb prostheses, and hip, knee, and other joint replacements; and

(iv) convening intervention and demonstration programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food;

(II) improving physical activity to reduce overweight, obesity, and comorbidities and increase quality of life; and

(III) location and access to medical facilities.

(3) LEVEL 3 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify and address racial and ethnic inequities in social determinants of health by creating demonstration programs that assess the feasibility of establishing a federally funded comprehensive program and describe key outcomes that address racial and ethnic inequities in social determinants of health.

(B) PROGRAM DESIGN.—

(i) EVALUATION.—No later than 1 year after enactment of this Act, the Director shall evaluate the best practices of existing programs from the private, public, community based, and academically supported initiatives focused on reducing inequities in the social determinants of health for racial and ethnic populations.

(ii) DEMONSTRATION PROJECTS.—Not later than 2 years after the date of enactment of this Act, the Director shall implement at least 12 demonstration projects, including at least one project for each major racial and ethnic minority group, each of which is unique to the cultural and linguistic needs of each of the following groups:

(I) Native Americans and Alaska Natives.

(II) Asian Americans.

(III) African Americans/Blacks.

(IV) Hispanic/Latino-Americans.

(V) Native Hawaiians and Pacific Islanders.

(VI) Middle Eastern and Northern African communities.

(iii) REPORT TO CONGRESS.—No later than 2 years after the implementation of the initial demonstration projects under this paragraph, the Director shall submit to Congress a report that includes—

(I) a description of each demonstration project and design;

(II) an evaluation of the cost-effectiveness of each project's prevention and treatment efforts;

(III) an evaluation of the cultural and linguistic appropriateness of each project by racial and ethnic group; and

(IV) an evaluation of the beneficiary's health status improvement under the demonstration project.

(iv) ANY OTHER INFORMATION DEEMED APPROPRIATE BY THE DIRECTOR.—The Director shall require eligible entities awarded a grant under this paragraph to report any other information the Director determines appropriate to be

shared by or developed by such entity, including the following:

(I) Developing models and evaluating methods that improve the cultural and linguistically appropriate services provided through the Centers for Disease Control and Prevention to target individuals impacted by health inequities based on their race, ethnicity, gender, or sexual orientation.

(II) Promoting the collaboration between primary and specialty care health care providers and patients, to ensure patients impacted by health inequities based on race, ethnicity, gender, or sexual orientation are receiving comprehensive and organized treatment and care.

(III) Educating health care professionals on the causes and effects of inequities in the social determinants of health in relation to minority and racial and ethnic communities and the need for culturally and linguistically

appropriate care in the prevention and treatment of high-impact diseases.

(IV) Encouraging collaboration among community- and patient-based organizations which work to address inequities in the social determinants of health in relation to high-impact diseases in minority and racial and ethnic populations.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $25,000,000 for fiscal year 2023; and

(2) such sums as may be necessary for fiscal years 2024 through 2026.

SEC. 10005. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND THE HEALTH OF COMMUNITY RESIDENTS.

(a) DEFINITION OF ELIGIBLE INSTITUTION.—In this section, the term ''eligible institution'' means a public or private nonprofit institution that submits to the Secretary and the Administrator an application for a grant under the grant program authorized under subsection (b)(2) at such time, in such manner, and containing such agree-

ments, assurances, and information as the Secretary and Administrator may require.

(b) RESEARCH GRANT PROGRAM.—

(1) DEFINITION OF HEALTH.—In this section, the term ''health'' includes—

(A) levels of physical activity;

(B) degree of mobility due to factors such as musculoskeletal diseases, arthritis, and obesity;

(C) consumption of nutritional foods;

(D) rates of crime;

(E) air, water, and soil quality;

(F) risk of injury;

(G) accessibility to health care services;

(H) levels of educational attainment; and

(I) other indicators as determined appropriate by the Secretary.

(2) GRANTS.—The Secretary, in collaboration with the Administrator, shall provide grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

(3) RESEARCH.—The Secretary shall support research that—

(A) investigates and defines the causal links between all aspects of the built environment and the health of residents;

(B) examines—

(i) the extent of the impact of the built environment (including the various characteristics of the built environment) on the health of residents;

(ii) the variation in the health of residents by—

(I) location (such as inner cities, inner suburbs, outer suburbs, reservations, and rural areas); and

(II) population subgroup (including children, young adults, the elderly, the disadvantaged); or

(iii) the importance of the built environment to the total health of residents, which is the primary variable of interest from a public health perspective;

(C) is used to develop—

(i) measures to address health and the connection of health to the built environment; and

(ii) efforts to link the measures to travel and health databases;

(D) distinguishes carefully between personal attitudes and choices and external influences on observed behavior to determine how much an observed association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

(E)(i) identifies or develops effective intervention strategies to promote better health among residents with a focus on behavioral interventions and enhancements of the built environment that promote increased use by residents; and

(ii) in developing the intervention strategies under clause (i), ensures that the intervention strategies will reach out to high-risk populations, including racial and ethnic minorities, low-income urban and rural communities, and children.

(4) PRIORITY.—In providing assistance under the grant program authorized under paragraph (2),

the Secretary and the Administrator shall give priority to research that incorporates—

(A) minority-serving institutions as grantees;

(B) interdisciplinary approaches; or

(C) the expertise of the public health, physical activity, nutrition and health care (including child health), urban planning, and transportation research communities in the United States and abroad.

SEC. 10006. ENVIRONMENT AND PUBLIC HEALTH RESTORATION.

(a) FINDINGS.—Congress finds that—

(1) humans share an environment with a wide variety of habitats and ecosystems that nurture and sustain a diversity of species;

(2) the abundance of natural resources in the environment forms the basis for the economy and has greatly contributed to human development throughout history;

(3) the accelerated pace of human development over the last several hundred years has significantly impacted—

(A) the natural environment and its resources;

(B) the health and diversity of plant and animal life;

(C) the availability of critical habitats;

(D) the quality of the air and water; and

(E) the global climate;

(4) the intervention of the Federal Government is necessary to minimize and mitigate human impact on the environment—

(A) for the benefit of public health;

(B) to maintain air quality and water quality;

(C) to sustain the diversity of plants and animals;

(D) to combat global climate change; and

(E) to protect the environment;

(5) laws and regulations in the United States have been enacted and promulgated to minimize and mitigate human impact on the environment for the benefit of public health, to maintain air quality and water quality, to sustain wildlife, and to protect the environment; and

(6) attempts to repeal or weaken key environmental safeguards pose dangers to the public health, air quality, water quality, wildlife, and the environment.

(b) STATEMENT OF POLICY.—It is the policy of the Federal Government to work in conjunction with States, territories, Tribal governments, international organizations, and foreign governments as a steward of the environment for the benefit of public health, to maintain air quality and water quality, to sustain the diversity of plant and animal species, to combat global climate change, and to protect the environment for future generations.

(c) STUDY AND REPORT ON PUBLIC HEALTH OR ENVIRONMENTAL IMPACT OF REVISED RULES, REGULATIONS, LAWS, OR OTHER AGENCY DECISIONS.—

(1) STUDY.—Not later than 30 days after the date of enactment of this Act, the President shall seek to enter into an arrangement under which the National Academy of Sciences shall conduct a study to determine the effects on public health, air quality, water quality, wildlife, and the environment of the following regulations, laws, and other agency decisions:

(A) CLEAN WATER.—

(i) The final rule of the Environmental Protection Agency and the Corps of Engineers entitled ''Final Revisions to the Clean Water Act Regulatory Definitions of 'Fill Material' and 'Discharge of Fill Mate-

rial'' and published in the Federal Register on May 9, 2002 (67 Fed. Reg. 31129).

(ii) The final rule of the Environmental Protection Agency entitled ''National Pollutant Discharge Elimination System Permit Regulation for Concentrated Animal Feeding Operations: Removal of Vacated Elements in Response to 2011 Court Decision'' and published in the Federal Register on July 30, 2012 (77 Fed. Reg. 44494).

(iii) The final rule entitled ''Withdrawal of Revisions to the Water Quality Planning and Management Regulation and Revisions to the National Pollutant Discharge Elimination System Program in Support of Revisions to the Water Quality Planning and Management Regulation'' and published in the Federal Register on March 19, 2003 (68 Fed. Reg. 13608).

(iv) The final rule of the Environmental Protection Agency entitled ''Consolidated Permit Regulations: RCRA Hazardous 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.).

(ii) The application of section 553(e) of title 5, United States Code, such that a State may petition for a special rule for the National Forest System inventoried roadless areas within the State.

(iii) The final rules entitled ''National Forest System Land Management Planning'' (77 Fed. Reg. 21162) and ''National Forest System Land Management Planning'' (81 Fed. Reg. 90723), published on April 19, 2013, and December 15, 2016, respectively.

(iv) The final rule entitled ''Oil Shale Management—General'' and published on January 15, 2009 (73 Fed. Reg. 69414).

(v) The record of decision described in the notice of availability entitled ''Notice of Availability of Approved Land Use Plan Amendments/Record of Decision for Allocation of Oil Shale and Tar Sands Resources on Lands Administered by the Bureau of Land Management in Colorado, Utah, and Wyoming and Final Programmatic Environmental Impact State-

ment'' and published on April 1, 2013 (78 Fed. Reg. 19518).

(C) SCIENTIFIC REVIEW.—The final rule entitled ''Interagency Cooperation Under the Endangered Species Act'' (December 16, 2008) (73 Fed. Reg. 76272), as amended by the final rule entitled ''Endangered and Threatened Wildlife and Plants; Regulations for Interagency Cooperation'' (August 27, 2019) (84 Fed. Reg. 44976).

(2) METHOD.—In conducting the study under paragraph (1), the National Academy of Sciences may use and compare existing scientific studies regarding the regulations, laws, and other agency decisions described in paragraph (1).

(3) REPORT.—Not later than 270 days after the date on which the President enters into the arrangement under paragraph (1), the National Academy of Sciences shall make publicly available and shall submit to Congress and to the head of each department and agency of the Federal Government that issued, implements, or would implement a regulation, law, or other agency decision described in paragraph (1), a report that includes—

(A) a description of the effects of each regulation, law, or other agency decision described in paragraph (1) on public health, air quality, water quality, wildlife, and the environment, compared to the impact of preexisting regulations, laws, or other agency decisions in effect, as applicable, including—

(i) any negative impacts to air quality or water quality;

(ii) any negative impacts to wildlife;

(iii) any delays in hazardous waste cleanup that are projected to be hazardous to public health; and

(iv) any other negative impact on public health or the environment; and

(B) any recommendations that the National Academy of Sciences considers appropriate to maintain, restore, or improve in whole or in part protections for public health, air quality, water quality, wildlife, and the environment for each of the regulations, laws, and other agency decisions described in paragraph (1), which may include recommendations for the adoption of any regulation or law in place or proposed prior to January 1, 2001.

(d) DEPARTMENT AND AGENCY REVISION OF EXISTING RULES, REGULATIONS, OR LAWS.—Not later than 180 days after the date on which the report is submitted pursuant to subsection (c)(3), the head of each department or agency that has issued or implemented a regulation, law, or other agency decision described in subsection (c)(1) shall submit to Congress a plan describing the steps the department or agency will take, or has taken, to restore or improve protections for public health and the environment in whole or in part that were in existence prior to the issuance of the applicable regulation, law, or other agency decision.

SEC. 10007. GAO REPORT ON HEALTH EFFECTS OF DEEPWATER HORIZON OIL RIG EXPLOSION IN THE GULF COAST.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the type and scope of health care services administered through the Department of Health and Human Services addressing the provision of health care to racial and ethnic minorities, including residents, cleanup workers, and volunteers, affected by the blowout and explosion of the mobile offshore drilling unit Deepwater Horizon that occurred on April 20, 2010, and resulting hydrocarbon releases into the environment.

(b) SPECIFIC COMPONENTS.—In carrying out subsection (a), the Comptroller General of the United States shall—

(1) assess the type, size, and scope of programs administered by the Secretary that focus on the provision of health care to communities on the Gulf Coast;

(2) identify the merits and disadvantages associated with each of the programs;

(3) perform an analysis of the costs and benefits of the programs; and

(4) determine whether there is any duplication of programs.

(c) REPORT.—Not later than 180 days after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that includes—

(1) the findings of the study conducted under subsection (a); and

(2) recommendations for improving access to health care for racial and ethnic minorities.

SEC. 10008. ESTABLISH AN INTERAGENCY COUNSEL AND GRANT PROGRAMS ON SOCIAL DETERMINANTS OF HEALTH.

(a) FINDINGS; PURPOSES.—

(1) FINDINGS.—Congress finds as follows:

(A) There is a significant body of evidence showing that economic and social conditions have a powerful impact on individual and population health outcomes and well-being, as well as medical costs.

(B) State, local, and Tribal governments and the service delivery partners of such governments face significant challenges in coordinating benefits and services delivered through the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and other social services programs because of the fragmented and complex nature of Federal and State funding and administrative requirements.

(C) The Federal Government should prioritize and proactively assist State and local governments to strengthen the capacity of State and local governments to improve health and social outcomes for individuals, thereby improving cost-effectiveness and return on investment.

(2) PURPOSES.—The purposes of this section are as follows:

(A) To establish effective, coordinated Federal technical assistance to help State and local governments to improve outcomes and cost-effectiveness of, and return on investment from, health and social services programs.

(B) To build a pipeline of State and locally designed, cross-sector interventions and strategies that generate rigorous evidence about how to improve health and social outcomes, and increase the cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal health and social services programs.

(C) To enlist State and local governments and the service providers of such governments as partners in identifying Federal statutory, regulatory, and administrative challenges in improving the health and social outcomes of, cost-effectiveness of, and return on investment from, Federal spending on individuals enrolled in Medicaid.

(D) To develop strategies to improve health and social outcomes without denying services to, or restricting the eligibility of, vulnerable populations.

(b) SOCIAL DETERMINANTS ACCELERATOR COUNCIL.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in coordination with the Administrator of the Centers for Medicare & Medicaid Services (referred to in this section as the ''Administrator''), shall establish an interagency council, to be known as the Social Determinants Accelerator Interagency Council (referred to in this section as the ''Council'') to achieve the purposes listed in subsection (b)(2).

(2) MEMBERSHIP.—

(A) FEDERAL COMPOSITION.—The Council shall be composed of at least one designee from each of the following Federal agencies:

(i) The Office of Management and Budget.

(ii) The Department of Agriculture.

(iii) The Department of Education.

(iv) The Indian Health Service.

(v) The Department of Housing and Urban Development.

(vi) The Department of Labor.

(vii) The Department of Transportation.

(viii) Any other Federal agency the Chair of the Council determines necessary.

(B) DESIGNATION.—

(i) IN GENERAL.—The head of each agency specified in subparagraph (A) shall designate at least one employee described in clause (ii) to serve as a member of the Council.

(ii) RESPONSIBILITIES.—An employee described in this clause shall be a senior employee of the agency—

(I) whose responsibilities relate to authorities, policies, and procedures with respect to the health and well-being of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

(II) who has authority to implement and evaluate transformative initiatives that harness data or conduct rigorous evaluation to improve the im-

pact and cost-effectiveness of federally funded services and benefits.

(C) HHS REPRESENTATION.—In addition to the designees under subparagraph (A), the Council shall include designees from at least 3 agencies within the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, at least one of whom shall meet the criteria under subparagraph (B)(ii).

(D) OMB ROLE.—The Director of the Office of Management and Budget shall facilitate the timely resolution of Federal Government-wide and multiagency issues to help the Council achieve consensus recommendations described under this section.

(E) NON-FEDERAL COMPOSITION.—The Comptroller General of the United States may designate up to 6 Council designees—

(i) who have relevant subject matter expertise, including expertise implementing and evaluating transformative initiatives that harness data and conduct evaluations to improve the impact and cost-effectiveness of Federal Government services; and

(ii) that each represent—

(I) State, local, and Tribal health and human services agencies;

(II) public housing authorities or State housing finance agencies;

(III) State and local government budget offices;

(IV) State Medicaid agencies; or

(V) national consumer advocacy organizations.

(F) CHAIR.—

(i) IN GENERAL.—The Secretary shall select the Chair of the Council from among the members of the Council.

(ii) INITIATING GUIDANCE.—The Chair, on behalf of the Council, shall identify and invite individuals from diverse entities to provide the Council with advice and information pertaining to addressing social determinants of health, including—

(I) individuals from State and local government health and human services agencies;

(II) individuals from State Medicaid agencies;

(III) individuals from State and local government budget offices;

(IV) individuals from public housing authorities or State housing finance agencies;

(V) individuals from nonprofit organizations, small businesses, and philanthropic organizations;

(VI) advocates;

(VII) researchers; and

(VIII) any other individuals the Chair determines to be appropriate.

(3) DUTIES.—The duties of the Council are—

(A) to make recommendations to the Secretary and the Administrator regarding the criteria for making awards under this section;

(B) to identify Federal authorities and opportunities for use by States or local governments to improve coordination of funding and administration of Federal programs, the beneficiaries of whom include individuals, and which may be unknown or underutilized, and to make information on such authorities and opportunities publicly available;

(C) to provide targeted technical assistance to States developing a social determinants accelerator plan under this section, including identifying potential statutory or regulatory pathways for implementation of the plan and assisting in identifying potential sources of funding to implement the plan;

(D) to report to Congress annually on the subjects set forth in this section;

(E) to develop and disseminate evaluation guidelines and standards that can be used to reliably assess the impact of an intervention or approach that may be implemented pursuant to this section on outcomes, cost-effectiveness of, and return on investment from Federal, State, local, and Tribal governments, and to facilitate technical assistance, where needed, to help to improve State and local evaluation designs and implementation;

(F) to seek feedback from State, local, and Tribal governments, including through an annual survey by an independent third party, on how to improve the technical assistance the Council provides to better equip State, local,

and Tribal governments to coordinate health and social service programs;

(G) to solicit applications for grants under subsection (c); and

(H) to coordinate with other cross-agency initiatives focused on improving the health and well-being of low-income and at-risk populations in order to prevent unnecessary duplication between agency initiatives.

(4) SCHEDULE.—Not later than 60 days after the date of enactment of this Act, the Council shall convene to develop a schedule and plan for carrying out the duties described in this section, including solicitation of applications for the grants under this section.

(5) REPORT TO CONGRESS.—The Council shall submit an annual report to Congress, which shall include—

(A) a list of the Council members;

(B) activities and expenditures of the Council;

(C) summaries of the interventions and approaches that will be supported by State, local, and Tribal governments that received a grant under this section, including—

(i) the best practices and evidence-based approaches such governments plan to employ to achieve the purposes listed in this section; and

(ii) a description of how the practices and approaches will impact the outcomes, cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal governments with respect to such purposes;

(D) the feedback received from State and local governments on ways to improve the technical assistance of the Council, including findings from a third-party survey and actions the Council plans to take in response to such feedback; and

(E) the major statutory, regulatory, and administrative challenges identified by State, local, and Tribal governments that received a grant under subsection (c), and the actions that Federal agencies are taking to address such challenges.

(6) FACA APPLICABILITY.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(7) COUNCIL PROCEDURES.—The Secretary, in consultation with the Comptroller General of the United States and the Director of the Office of Management and Budget, shall establish procedures for the Council to—

(A) ensure that adequate resources are available to effectively execute the responsibilities of the Council;

(B) effectively coordinate with other relevant advisory bodies and working groups to avoid unnecessary duplication;

(C) create transparency to the public and Congress with regard to Council membership, costs, and activities, including through use of modern technology and social media to disseminate information; and

(D) avoid conflicts of interest that would jeopardize the ability of the Council to make decisions and provide recommendations.

(c) SOCIAL DETERMINANTS ACCELERATOR GRANTS TO STATES OR LOCAL GOVERNMENTS.—

(1) GRANTS TO STATES, LOCAL GOVERNMENTS, AND TRIBES.—Not later than 180 days after the date of enactment of this Act, the Administrator, in consultation with the Secretary and the Council,

shall award on a competitive basis not more than 25 grants to eligible applicants described in this subsection, for the development of social determinants accelerator plans, as described in this subsection.

(2) ELIGIBLE APPLICANT.—An eligible applicant described in this subsection is a State, local, or Tribal health or human services agency that—

(A) demonstrates the support of relevant parties across relevant State, local, or Tribal jurisdictions; and

(B) in the case of an applicant that is a local government agency, provides to the Secretary a letter of support from the lead State health or human services agency for the State in which the local government is located.

(3) AMOUNT OF GRANT.—The Administrator, in coordination with the Council, shall determine the total amount that the Administrator will make available to each grantee under this subsection.

(4) APPLICATION.—An eligible applicant seeking a grant under this subsection shall include in the application the following information:

(A) The target population (or populations) that would benefit from implementation of the

social determinants accelerator plan proposed to be developed by the applicant.

(B) A description of the objective or objectives and outcome goals of such proposed plan, which shall include at least one health outcome and at least one other important social outcome.

(C) The sources and scope of inefficiencies that, if addressed by the plan, could result in improved cost-effectiveness of or return on investment from Federal, State, local, and Tribal governments.

(D) A description of potential interventions that could be designed or enabled using such proposed plan.

(E) The State, local, and Tribal governments, academic institutions, nonprofit organizations, community-based organizations, and other public and private sector partners that would participate in the development of the proposed plan and subsequent implementation of programs or initiatives included in such proposed plan.

(F) Such other information as the Administrator, in consultation with the Secretary and

the Council, determines necessary to achieve the purposes of this section.

(5) USE OF FUNDS.—A recipient of a grant under this subsection may use funds received through the grant for the following purposes:

(A) To convene and coordinate with relevant government entities and other stakeholders across sectors to assist in the development of a social determinant accelerator plan.

(B) To identify populations of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) who may benefit from the proposed approaches to improving the health and well-being of such individuals through the implementation of the proposed social determinants accelerator plan.

(C) To engage qualified research experts to advise on relevant research and to design a proposed evaluation plan, in accordance with the standards and guidelines issued by the Administrator.

(D) To collaborate with the Council to support the development of social determinants accelerator plans.

(E) To prepare and submit a final social determinants accelerator plan to the Council.

(6) CONTENTS OF PLANS.—A social determinant accelerator plan developed under this subsection shall include the following:

(A) A description of the target population (or populations) that would benefit from implementation of the social determinants accelerator plan, including an analysis describing the projected impact on the well-being of individuals described in paragraph (5)(B).

(B) A description of the interventions or approaches designed under the social determinants accelerator plan and the evidence for selecting such interventions or approaches.

(C) The objectives and outcome goals of such interventions or approaches, including at least one health outcome and at least one other important social outcome.

(D) A plan for accessing and linking relevant data to enable coordinated benefits and services for the jurisdictions described in this

section and an evaluation of the proposed interventions and approaches.

(E) A description of the State, local, and Tribal governments, academic institutions, nonprofit organizations, or any other public or private sector organizations that would participate in implementing the proposed interventions or approaches, and the role each would play to contribute to the success of the proposed interventions or approaches.

(F) The identification of the funding sources that would be used to finance the proposed interventions or approaches.

(G) A description of any financial incentives that may be provided, including outcome-focused contracting approaches to encourage service providers and other partners to improve outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, or Tribal government spending.

(H) The identification of the applicable Federal, State, local, or Tribal statutory and regulatory authorities, including waiver authorities, to be leveraged to implement the proposed interventions or approaches.

(I) A description of potential considerations that would enhance the impact, scalability, or sustainability of the proposed interventions or approaches and the actions the grant awardee would take to address such considerations.

(J) A proposed evaluation plan, to be carried out by an independent evaluator, to measure the impact of the proposed interventions or approaches on the outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal governments.

(K) Precautions for ensuring that vulnerable populations will not be denied access to Medicaid or other essential services as a result of implementing the proposed plan.

(d) FUNDING.—

(1) IN GENERAL.—Out of any money in the Treasury not otherwise appropriated, there is appropriated to carry out this section $25,000,000 to remain available for obligation until the date that is 5 years after the date of enactment of this section.

(2) RESERVATION OF FUNDS.—

(A) IN GENERAL.—Of the funds made available under paragraph (1), the Secretary

shall reserve not less than 20 percent to award grants to eligible applicants for the development of social determinants accelerator plans under this section intended to serve rural populations.

(B) EXCEPTION.—In the case of a fiscal year for which the Secretary determines that there are not sufficient eligible applicants to award up to 25 grants under subsection (d) that are intended to serve rural populations and the Secretary cannot satisfy the 20-percent requirement, the Secretary may reserve an amount that is less than 20 percent of amounts made available under paragraph (1) to award grants for such purpose.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall prevent Federal agencies represented on the Council from contributing additional funding from other sources to support activities to improve the effectiveness of the Council.

SEC. 10009. CORRECTING HURTFUL AND ALIENATING NAMES IN GOVERNMENT EXPRESSION (CHANGE).

(a) SHORT TITLE.—This section may be cited as the ''Correcting Hurtful and Alienating Names in Government Expression Act'' or the ''CHANGE Act''.

(b) DEFINITIONS.—In this section:

(1) EMPLOYEE.—The term ''employee'' has the meaning given the term in section 2105 of title 5, United States Code.

(2) EXECUTIVE AGENCY.—The term ''Executive agency'' has the meaning given the term in section 105 of title 5, United States Code.

(3) OFFICER.—The term ''officer'' has the meaning given the term in section 2104 of title 5, United States Code.

(4) PROHIBITED TERM.—The term ''prohibited term'' means—

(A) the term ''alien'', when used to refer to an individual who is not a citizen or national of the United States; and

(B) the term ''illegal alien'', when used to refer to an individual who—

(i) is unlawfully present in the United States; or

(ii) lacks a lawful immigration status in the United States.

(c) MODERNIZATION OF LANGUAGE REFERRING TO INDIVIDUALS WHO ARE NOT CITIZENS OR NATIONALS OF THE UNITED STATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), on and after the date of enactment of this Act, an Executive agency may not use a prohibited term in any proposed or final rule, regulation, interpretation, publication, other document, display, or sign issued by the Executive agency.

(2) EXCEPTION.—An Executive agency may use a prohibited term under paragraph (1) if the Executive agency uses the prohibited term while quoting or reproducing text written by a source that is not an officer or employee of the Executive agency.

(d) UNIFORM DEFINITION.—

(1) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

"§ 9. Definition of 'foreign national'

''In determining the meaning of any Act of Congress or any ruling, regulation, or interpretation of an administrative bureau or agency of the United States, the term 'foreign national' means any individual that is not an individual who—

''(1) is a citizen of the United States; or

''(2) though not a citizen of the United States, owes permanent allegiance to the United States.''.

(2) TECHNICAL AMENDMENT.—The table of sections for chapter 1 of title 1, United States Code, is amended by adding at the end the following:

"9. Definition of 'foreign national'.".

(e) REFERENCES.—Any reference in any Federal statute, rule, regulation, Executive order, publication, or other document of the United States—

(1) to the term ''alien'', when used to refer to an individual who is not a citizen or national of the United States, is deemed to refer to the term ''foreign national''; and

(2) to the term ''illegal alien'' is deemed to refer to the term ''undocumented foreign national'', when used to refer to an individual who—

(A) is unlawfully present in the United States; or

(B) lacks a lawful immigration status in the United States.

SEC. 10010. ANDREW KEARSE ACCOUNTABILITY FOR DENIAL OF MEDICAL CARE.

(a) IN GENERAL.—Chapter 13 of title 18, United States Code, is amended by adding at the end the following:

"§ 250. Medical attention for individuals in Federal custody displaying medical distress

''(a) DEFINITIONS.—In this section—

''(1) the term 'appropriate Inspector General', with respect to a covered official, means—

''(A) the Inspector General of the Federal agency that employs the covered official; or

''(B) in the case of a covered official employed by a Federal agency that does not have an Inspector General, the Inspector General of the Department of Justice;

''(2) the term 'covered official' means—

''(A) a Federal law enforcement officer (as defined in section 115);

''(B) an officer or employee of the Bureau of Prisons; or

''(C) an officer or employee of the United States Marshals Service; and

''(3) the term 'medical distress' includes breathing difficulties.

''(b) REQUIREMENT.—

''(1) OFFENSE.—It shall be unlawful for a covered official to negligently fail to obtain or provide immediate medical attention to an individual in Federal custody who displays medical distress in the presence of the covered official if the individual suffers unnecessary pain, injury, or death as a result of that failure.

''(2) PENALTY.—A covered official who violates paragraph (1) shall be fined under this title, imprisoned for not more than 1 year, or both.

''(3) STATE CIVIL ENFORCEMENT.—Whenever an attorney general of a State has reasonable cause to believe that a resident of the State has been aggrieved by a violation of paragraph (1) by a covered official, the attorney general, or another official, agency, or entity designated by the State, may bring a civil action in any appropriate district court of the United States to obtain appropriate equitable and declaratory relief.

''(c) INSPECTOR GENERAL INVESTIGATION.—

''(1) IN GENERAL.—The appropriate Inspector General shall investigate any instance in which—

''(A) a covered official fails to obtain or provide immediate medical attention to an individual in Federal custody who displays medical distress in the presence of the covered official; and

''(B) the individual suffers unnecessary pain, injury, or death as a result of the failure to obtain or provide immediate medical attention.

"(2) REFERRAL FOR PROSECUTION.—If an appropriate Inspector General, in conducting an investigation under paragraph (1), concludes that the covered official acted negligently in failing to obtain or provide immediate medical attention to the individual in Federal custody, the appropriate Inspector General shall refer the case to the Attorney General for prosecution under this section.

"(3) CONFIDENTIAL COMPLAINT PROCESS.—The Inspector General of a Federal agency that employs covered officials shall establish a process under which an individual may confidentially submit a complaint to the Inspector General regarding an incident described in paragraph (1) involving a covered official employed by the Federal agency (or, in the case of the Inspector General of the Department of Justice, involving a covered official employed by a Federal agency that does not have an Inspector General).

"(d) TRAINING.—The head of an agency that employs covered officials shall provide training to each such covered official on obtaining or providing medical assistance to individuals in medical distress.".

(b) TECHNICAL AND CONFORMING AMENDMENT.—The table of sections for chapter 13 of title 18, United

States Code, is amended by adding at the end the following:

"250. Medical attention for individuals in Federal custody displaying medical distress.".

SEC. 10011. INVESTING IN COMMUNITY HEALING.

(a) FINDINGS.—Congress finds as follows:

(1) According to the Bureau of Justice Statistics, African Americans are more likely to have face-to-face contact with law enforcement and are 2.5 times more likely to experience a threat or use of nonfatal force by police.

(2) Research shows that young men who have experienced these law enforcement practices display higher levels of stress, anxiety, and trauma associated with the interaction.

(3) Witnessing or experiencing invasive encounters with law enforcement can also be an everyday stressor for racial and ethnic minorities, leading to physiological and psychological strain.

(4) Racial and ethnic minorities face inequities in accessing mental health services.

(5) Addressing the stigma in some communities of color associated with receiving mental health services and informing individuals about available treatment can encourage better utilization of these services.

(b) SENSE OF CONGRESS.—It is the sense of Congress that it is imperative that a comprehensive public health approach to addressing trauma and mental health care be focused on care delivery that is culturally sensitive and competent.

(c) RESEARCH ON ADVERSE HEALTH EFFECTS ASSOCIATED WITH INTERACTIONS WITH LAW ENFORCEMENT.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Office of Minority Health of the Centers for Disease Control and Prevention (established pursuant to section 1707A of the Public Health Service Act (42 U.S.C. 300u–6a)), shall conduct research on the adverse health effects associated with interactions with law enforcement.

(2) EFFECTS AMONG RACIAL AND ETHNIC MINORITIES.—The research under paragraph (1) shall include research on—

(A) the health consequences, both individual and community-wide, of trauma related to violence committed by law enforcement among racial and ethnic minorities; and

(B) the disproportionate burden of morbidity and mortality associated with such trauma.

(3) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall—

(A) complete the research under this subsection; and

(B) submit to Congress a report on the findings, conclusions, and recommendations resulting from such research.

(d) GRANTS FOR INCREASING RACIAL AND ETHNIC MINORITY ACCESS TO HIGH-QUALITY TRAUMA SUPPORT SERVICES AND MENTAL HEALTH CARE.—

(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall award grants to eligible entities to establish or expand programs for the purpose of increasing racial and ethnic minority access to high-quality trauma support services and mental health care.

(2) ELIGIBLE ENTITIES.—To seek a grant under this subsection, an entity shall be a community-based program or organization that—

(A) provides culturally competent programs and resources that are aligned with evi-

dence-based practices for trauma-informed care; and

(B) has demonstrated expertise in serving communities of color or can partner with a program that has such demonstrated expertise.

(3) USE OF FUNDS.—As a condition on receipt of a grant under this subsection, a grantee shall agree to use the grant to increase racial and ethnic minority access to high-quality trauma support services and mental health care, such as by—

(A) establishing and maintaining community-based programs providing evidence-based services in trauma-informed care and culturally specific services and other resources;

(B) developing innovative culturally specific strategies and projects to enhance access to trauma-informed care and resources for racial and ethnic minorities who face obstacles to using more traditional services and resources (such as obstacles in geographic access to providers, insurance coverage, and access to audio and video technologies);

(C) working with State and local governments and social service agencies to develop and

enhance effective strategies to provide culturally specific services to racial and ethnic minorities;

(D) increasing communities' capacity to provide culturally specific resources and support for communities of color;

(E) working in cooperation with the community to develop education and prevention strategies highlighting culturally specific issues and resources regarding racial and ethnic minorities;

(F) providing culturally specific programs for racial and ethnic minorities exposed to law enforcement violence; and

(G) examining the dynamics of culture and its impact on victimization and healing.

(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall give priority to eligible entities proposing to serve communities that have faced high rates of community trauma, including from exposure to law enforcement violence, intergenerational poverty, civil unrest, discrimination, or oppression.

(5) GRANT PERIOD.—The period of a grant under this subsection shall be 4 years.

(6) EVALUATION.—Not later than 6 months after the end of the period of all grants under this subsection, the Secretary shall—

(A) conduct an evaluation of the programs funded by a grant under this subsection;

(B) include in such evaluation an assessment of the outcomes of each such program; and

(C) submit a report on the results of such evaluation to Congress.

(7) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there is authorized to be appropriated $20,000,000 for each of fiscal years 2023 through 2027.

(e) BEHAVIORAL AND MENTAL HEALTH OUTREACH EDUCATION STRATEGY.—

(1) IN GENERAL.—The Secretary, in coordination with advocacy and behavioral and mental health organizations serving racial and ethnic minority groups, shall develop and implement an outreach and education strategy to promote behavioral and mental health, and reduce stigma associated with mental health conditions, among racial and ethnic minorities.

(2) DESIGN.—The strategy under this subsection shall be designed to—

(A) meet the diverse cultural and language needs of racial and ethnic minority groups;

(B) provide information on evidence-based, culturally and linguistically appropriate and adapted interventions and treatments;

(C) increase awareness of symptoms of mental illness among racial and ethnic minority groups; and

(D) ensure full participation of, and engage, both consumers and community members in the development and implementation of materials.

(3) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress, and make publicly available, a report detailing the outreach and education strategy that is developed and implemented under this subsection and the results of such implementation.

SEC. 10012. ENVIRONMENTAL JUSTICE MAPPING AND DATA COLLECTION.

(a) FINDINGS.—Congress finds that—

(1) environmental hazards causing adverse health outcomes have disproportionately affected en-

vironmental justice communities as a result of systemic injustices relating to factors that include race and income;

(2) environmental justice communities have increased vulnerability to the adverse effects of climate change and need significant investment to face current and future environmental hazards;

(3) the Federal Government has lacked a cohesive and consistent strategy to carry out the responsibilities of Federal agencies described in Executive Order 12898 (42 U.S.C. 4321 note; relating to Federal actions to address environmental justice in minority populations and low-income populations);

(4) it is necessary that the Federal Government meaningfully engage environmental justice communities in the process of developing a robust strategy to address environmental justice, including high levels of review, input, and consent;

(5) there is a lack of nationwide high-quality data relating to environmental justice concerns, such as socioeconomic factors, air pollution, water pollution, soil pollution, and public health, and a failure to update the existing data with adequate frequency;

(6) there is no nationally consistent method to identify environmental justice communities based on

the cumulative effects of socioeconomic factors, pollution burden, and public health;

(7) a method described in paragraph (6) is needed to correct for racist and unjust practices leading to historical and current environmental injustices through the targeted investment in environmental justice communities of at least 40 percent of the funds provided for a clean energy transition and other related investments, including transportation infrastructure, housing infrastructure, and water quality infrastructure;

(8) funds targeted for environmental justice communities should include set-asides for technical assistance and capacity building for environmental justice communities to access the funds;

(9) particular oversight and care are necessary when investing in environmental justice communities to ensure that existing issues are not exacerbated and new issues are not created, particularly issues relating to pollution burden and the displacement of residents;

(10) several States, academic institutions, and nonprofit organizations have engaged in cumulative impact environmental justice mapping efforts that can serve as references for a Federal mapping effort;

(11) many environmental justice communities, such as communities in ''Cancer Alley'' in the State of Louisiana, have been clearly affected by extreme environmental hazards such that the communities—

(A) are identifiable before the establishment of the tool under paragraph (2) of subsection (d) and the completion of the data gap audit under paragraph (4) of that subsection; and

(B) should be eligible for programs targeted toward environmental justice communities that have faced extreme environmental hazards before the establishment of that tool and the completion of that audit;

(12) in addition to investment in environmental justice communities, pollution reduction is essential to achieving equitable access to a healthy and clean environment and an equitable energy system; and

(13) specific policy and permitting decisions and investments may rely on different combinations of data sets and indicators relating to environmental justice, and race alone may be considered a criterion when assessing the susceptibility of a community to environmental injustice.

(b) DEFINITIONS.—In this section:

(1) ADVISORY COUNCIL.—The term ''advisory council'' means the advisory council established under subsection (c)(4)(B)(i).

(2) COMMITTEE.—The term ''Committee'' means the Environmental Justice Mapping Committee established by subsection (c)(1).

(3) ENVIRONMENTAL JUSTICE.—The term ''environmental justice'' means the fair treatment and meaningful involvement of all people regardless of race, color, culture, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies to ensure that each person enjoys—

(A) the same degree of protection from environmental and health hazards; and

(B) equal access to any Federal agency action relating to the development, implementation, and enforcement of environmental laws, regulations, and policies for the purpose of having a healthy environment in which to live, learn, work, and recreate.

(4) ENVIRONMENTAL JUSTICE COMMUNITY.—The term ''environmental justice community'' means a community with significant representation of communities of color, low-income communities, or Tribal

and indigenous communities, that experiences, or is at risk of experiencing, higher or more adverse human health or environmental effects, as compared to other communities.

(5) GROUND-TRUTHING.—The term ''ground-truthing'' means a community fact-finding process by which residents of a community supplement technical information with local knowledge for the purpose of better informing policy and project decisions.

(6) RELEVANT STAKEHOLDER.—The term ''relevant stakeholder'' means—

(A) a representative of a regional, State, Tribal, or local government agency;

(B) a representative of a nongovernmental organization with experience in areas that may include Tribal relations, environmental conservation, city and regional planning, and public health;

(C) a representative of a labor union;

(D) a representative or member of—

(i) an environmental justice community; or

(ii) a community-based organization for an environmental justice community;

(E) an individual with expertise in cumulative impacts, geospatial data, and environmental justice, particularly such an individual from an academic or research institution; and

(F) an advocate with experience in environmental justice who represents an environmental justice community.

(c) ESTABLISHMENT OF COMMITTEE.—

(1) IN GENERAL.—There is established a committee, to be known as the ''Environmental Justice Mapping Committee''.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Committee shall be composed of not fewer than 1 representative of each of the following:

(i) Of the Environmental Protection Agency—

(I) the Office of Air and Radiation;

(II) the Office of Chemical Safety and Pollution Prevention;

(III) the Office of International and Tribal Affairs;

(IV) the Office of Land and Emergency Management;

(V) the Office of Water;

(VI) the Office of Environmental Justice;

(VII) the Office of Research and Development; and

(VIII) the Office of Public Engagement and Environmental Education.

(ii) The Council on Environmental Quality.

(iii) Of the Department of Commerce—

(I) the Office of Oceanic and Atmospheric Research, including not fewer than 1 representative of the Climate Program Office;

(II) the Economics and Statistics Administration, including not fewer than 1 representative of the Bureau of Economic Analysis; and

(III) the National Institute of Standards and Technology.

(iv) Of the Department of Health and Human Services—

(I) the Centers for Disease Control and Prevention, not including the Agency for Toxic Substances and Disease Registry;

(II) the Agency for Toxic Substances and Disease Registry;

(III) the Administration for Children and Families;

(IV) of the National Institutes of Health—

(aa) the National Institute of Environmental Health Sciences;

(bb) the National Institute of Mental Health; and

(cc) the National Institute on Minority Health and Health Disparities; and

(V) the Office for Civil Rights.

(v) Of the Department of the Interior—

(I) the Bureau of Indian Affairs;

(II) the Office of Civil Rights; and

(III) the United States Geological Survey.

(vi) The Forest Service.

(vii) The Department of Housing and Urban Development.

(viii) The Department of Energy.

(ix) The Department of Transportation.

(x) The Department of Justice.

(xi) The Federal Energy Regulatory Commission.

(xii) The Department of the Treasury.

(xiii) Such other Federal departments, agencies, and offices as the Administrator determines to be appropriate, particularly offices relating to public engagement.

(B) SELECTION OF REPRESENTATIVES.—The head of a department or agency described in subparagraph (A) shall, in appointing to the Committee a representative of the department or agency, select a representative—

(i) of a component of the department or agency that is among the components that are the most relevant to the responsibilities of the Committee; or

(ii) who has expertise in areas relevant to those responsibilities, such as demographic indicators relating to socioeconomic hardship, environmental justice, public engagement, public health, exposure to pollution, future climate and extreme weather mapping, affordable energy, sustainable transportation, and access to water, food, and green space.

(C) CO-CHAIRS.—

(i) IN GENERAL.—The members of the Committee shall select 3 members to serve as co-chairs of the Committee—

(I) 1 of whom shall be a representative of the Environmental Protection Agency;

(II) 1 of whom shall be a representative of the Council on Environmental Quality; and

(III) 1 of whom shall have substantial experience in public engagement.

(ii) TERMS.—Each co-chair shall serve for a term of not more than 3 years.

(iii) RESPONSIBILITIES OF CO-CHAIRS.—The co-chairs of the Committee shall—

(I) determine the agenda of the Committee, in consultation with other members of the Committee;

(II) direct the work of the Committee, including the oversight of a meaningful public engagement process; and

(III) convene meetings of the Committee not less frequently than once each fiscal quarter.

(3) ADMINISTRATIVE SUPPORT.—

(A) IN GENERAL.—The Administrator shall provide technical and administrative support to the Committee.

(B) FUNDING.—The Administrator may carry out subparagraph (A) using, in addition to any amounts made available under subsection (f), amounts authorized to be appropriated to the Administrator before the date of enactment of this Act and available for obligation as of that date of enactment.

(4) CONSULTATION.—

(A) IN GENERAL.—In carrying out the duties of the Committee, the Committee shall consult with relevant stakeholders.

(B) ADVISORY COUNCIL.—

(i) IN GENERAL.—The Committee shall establish an advisory council composed of a balanced proportion of relevant stakeholders, at least ½ of whom shall represent environmental justice communities.

(ii) CHAIR.—The advisory council shall be chaired by an environmental justice advocate or other relevant stakeholder with substantial experience in environmental justice.

(iii) REQUIREMENTS.—Consultation described in subparagraph (A) shall include—

(I) early and regular engagement with the advisory council, including in carrying out public engagement under subparagraph (C); and

(II) consideration of the recommendations of the advisory council.

(iv) RECOMMENDATIONS NOT USED.—If the Committee does not use a recommendation of the advisory council, not later than 60 days after the date on which the Committee receives notice of the recommendation, the Committee shall—

(I) make available to the public on an internet website of the Environmental Protection Agency a written report describing the rationale of the Committee for not using the recommendation; and

(II) submit the report described in subclause (I) to the Committee on Environment and Public Works of the Senate and the Committee on Energy and Commerce of the House of Representatives.

(v) OUTREACH.—The advisory council may carry out public outreach activities using amounts made available under subsection (f) to supplement public engagement carried out by the Committee under subparagraph (C).

(C) PUBLIC ENGAGEMENT.—

(i) IN GENERAL.—The Committee shall, throughout the process of carrying out the duties of the Committee described in subsection (d)—

(I) meaningfully engage with relevant stakeholders, particularly—

(aa) members and representatives of environmental justice communities;

(bb) environmental justice advocates; and

(cc) individuals with expertise in cumulative impacts and geospatial data; and

(II) ensure that the input of the stakeholders described in subclause (I) is central to the activities of the Committee.

(ii) PLAN.—

(I) IN GENERAL.—In carrying out clause (i), the Committee shall develop a plan, in consultation with the advisory council, for comprehensive public engagement with, and incorporation of feedback from, environ-

mental justice advocates and members of environmental justice communities.

(II) STRATEGIES TO OVERCOME BARRIERS TO PUBLIC ENGAGEMENT.—The plan developed under subclause (I) shall include strategies to overcome barriers to public engagement, including—

(aa) language barriers;

(bb) transportation barriers;

(cc) economic barriers; and

(dd) lack of internet access.

(III) CONSIDERATION.—In developing the plan under subclause (I), the Committee shall consider the diverse and varied experiences of environmental justice communities relating to the scope and types of environmental hazards and socioeconomic injustices.

(iii) CONSULTATION AND SOLICITATION OF PUBLIC COMMENT.—

(I) IN GENERAL.—In carrying out clause (i), not less frequently than once each fiscal quarter, the Com-

mittee shall consult with the advisory council and solicit meaningful public comment, particularly from relevant stakeholders, on the activities of the Committee.

(II) REQUIREMENTS.—The Committee shall carry out subclause (I) through means including—

(aa) public notice of a meeting of the Committee occurring during the applicable fiscal quarter, which shall include—

(AA) notice in publications relevant to environmental justice communities;

(BB) notification to environmental justice communities through direct means, such as community centers and schools; and

(CC) direct outreach to known environmental justice groups;

(bb) public broadcast of that meeting, including soliciting and

receiving comments by virtual means; and

(cc) public availability of a transcript of that meeting through publication on an accessible website.

(III) LANGUAGES.—The Committee shall provide each notice, notification, direct outreach, broadcast, and transcript described in subclause (II) in each language commonly used in the applicable environmental justice community, including through oral interpretation, if applicable.

(iv) FUNDING.—Of amounts made available under subsection (f), the Administrator shall make available to the Committee such sums as are necessary for participation by relevant stakeholders in public engagement under this paragraph, as determined by the Administrator, in consultation with the advisory council.

(d) DUTIES OF COMMITTEE.—

(1) IN GENERAL.—The Committee shall—

(A) establish a tool described in paragraph (2) to identify environmental justice communities, including the identification of—

(i) criteria to be used in the tool; and

(ii) a methodology to determine the cumulative impacts of those criteria;

(B) assess and address data gaps in accordance with paragraph (4); and

(C) collect data for the environmental justice data repository established under subsection (e).

(2) ESTABLISHMENT OF TOOL.—

(A) IN GENERAL.—The Committee, in consultation with relevant stakeholders and the advisory council, shall establish an interactive, transparent, integrated, and Federal Government-wide tool for assessing and mapping environmental justice communities based on the cumulative impacts of all indicators selected by the Committee to be integrated into the tool.

(B) REQUIREMENTS.—In establishing the tool under subparagraph (A), the Committee shall—

(i) integrate into the tool multiple data layers of indicators that fall into categories including—

(I) demographics, particularly relating to socioeconomic hardship and social stressors, such as—

(aa) race and ethnicity;

(bb) low income;

(cc) high unemployment;

(dd) low levels of home ownership;

(ee) high rent burden;

(ff) high transportation burden;

(gg) low levels of educational attainment;

(hh) linguistic isolation;

(ii) energy insecurity or high utility rate burden;

(jj) food insecurity;

(kk) health insurance status and access to health care; and

(ll) membership in an Indian Tribe;

(II) public health, particularly data that are indicative of sensitive populations, such as—

(aa) rates of asthma;

(bb) rates of cardiovascular disease;

(cc) childhood leukemia or other cancers that correlate with environmental hazards;

(dd) low birth weight;

(ee) maternal mortality;

(ff) rates of lead poisoning; and

(gg) rates of diabetes;

(III) pollution burdens, such as pollution burdens created by—

(aa) toxic chemicals;

(bb) air pollutants;

(cc) water pollutants;

(dd) soil contaminants; and

(ee) perfluoroalkyl and polyfluoroalkyl substances; and

(IV) environmental effects, such as effects created by proximity to—

(aa) risk management plan sites;

(bb) hazardous waste facilities;

(cc) sites on the National Priorities List developed by the President in accordance with section 105(a)(8)(B) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9605(a)(8)(B)); and

(dd) fossil fuel infrastructure;

(ii) investigate how further indicators of vulnerability to the impacts of climate change (including proximity and exposure to sea level rise, wildfire smoke, flooding, drought, rising average temperatures, extreme storms, and extreme heat, and financial burdens from flood and fire insurance) should be incorporated into the tool as an additional set of layers;

(iii) identify and consider the effects of other indicators relating to environ-

mental justice for integration into the tool as layers, including—

(I) safe, sufficient, and affordable drinking water, sanitation, and stormwater services;

(II) access to and the quality of—

(aa) green space and tree canopy cover;

(bb) healthy food;

(cc) affordable energy and water;

(dd) transportation;

(ee) reliable communication systems, such as broadband internet;

(ff) child care;

(gg) high-quality public schools, early childhood education, and child care; and

(hh) heath care facilities;

(III) length of commute;

(IV) indoor air quality in multi-unit dwellings;

(V) mental health;

(VI) labor market categories, particularly relating to essential workers; and

(VII) each type of utility expense;

(iv) consider the implementation of specific regional indicators, with the potential—

(I) to create regionally and locally downscaled maps in addition to a national map;

(II) to provide incentives for States to collect data and conduct additional analyses to capture conditions specific to their localities;

(III) to provide resources for and engage in ground-truthing to identify and verify important data with community members; and

(IV) to develop companion resources for, and provide technical support to, regional, State, local, or Tribal governments to create their own maps and environmental justice scores with relevant regional, State, local, and Tribal data;

(v) identify a methodology to account for the cumulative impacts of all indicators selected by the Committee under clause (i), in addition to other indicators as the Committee determines to be necessary, to provide relative environmental justice scores for regions that are—

(I) as small as practicable to identify communities; and

(II) not larger than a census tract;

(vi) ensure that the tool is capable of providing maps of environmental justice communities based on environmental justice scores described in clause (v);

(vii) ensure that users of the tool are able to map available layers together or independently as desired;

(viii) implement a method for users of the tool to generate a map and environmental justice score based on a subset of indicators, particularly for the purpose of using the tool in addressing various policy needs, permitting processes, and investment goals;

(ix) make the tool customizable to address specific policy needs, permitting processes, and investment goals;

(x) account for conditions that are not captured by the quantitative data used to develop the 1 or more maps and environmental justice scores comprising the tool, by—

(I) developing and executing a plan to perform outreach to relevant communities; and

(II) establishing a mechanism by which communities can self-identify as environmental justice communities to be included in the tool, which may include citing qualitative data on conditions for which quantitative data are lacking, such as cultural loss in Tribal communities;

(xi) consider that the tool—

(I) will be used across the Federal Government in screening Federal policies, permitting processes, and investments for environmental and climate justice impacts; and

(II) may be used to assess communities for pollution reduction programs; and

(xii) carry out such other activities as the Committee determines to be appropriate.

(3) TRANSPARENCY AND UPDATES.—

(A) IN GENERAL.—

(i) NOTICE AND COMMENT.—The Committee shall establish the tool described in paragraph (2) after providing notice and an opportunity for public comment.

(ii) HEARINGS.—In carrying out clause (i), the Committee shall hold hearings, which shall be time- and language-appropriate, in communities affected by environmental justice issues in geographically disparate States and Tribal areas.

(B) UPDATES.—

(i) ANNUAL UPDATES.—The Committee shall update the tool described in paragraph (2) not less frequently than annually to account for data sets that are updated annually.

(ii) OTHER UPDATES.—Not less frequently than once every 3 years, the Committee shall—

(I) update the indicators, methodology, or both for the tool described in paragraph (2); and

(II) reevaluate data submitted by Federal departments and agencies that is used for the tool.

(iii) REPORTS.—After the initial establishment of the tool described in paragraph (2) and each update under clause (i) or (ii), the Committee shall publish a report describing—

(I) the process for identifying indicators relating to environmental justice in the development of the tool;

(II) the methodology described in paragraph (2)(B)(v); and

(III) the use of public input and community engagement in that process.

(C) TRAINING TUTORIALS AND SESSIONS.—

(i) IN GENERAL.—The Committee shall—

(I) develop virtual training tutorials and sessions for environmental justice communities for the use of the tool described in paragraph (2); and

(II) where practicable, provide in-person training sessions for environmental justice communities for the use of that tool.

(ii) LANGUAGES.—The tutorials and sessions under clause (i) shall be made available in each language commonly used in the applicable environmental justice community.

(D) PUBLIC AVAILABILITY.—

(i) IN GENERAL.—The Committee shall make available to the public on an internet website of the Environmental Protection Agency—

(I) the tool described in paragraph (2);

(II) each update under clauses (i) and (ii) of subparagraph (B);

(III) each report under subparagraph (B)(iii); and

(IV) the training tutorials and sessions developed under subparagraph (C)(i)(I).

(ii) ACCESSIBILITY.—The Committee shall make the tool, updates, and reports described in clause (i) accessible to the public by publication in relevant languages and with accessibility functions, as appropriate.

(iii) REQUIREMENT.—In carrying out clause (i)(I), the Committee shall take measures to prevent the tool from being misused to discriminate against environmental justice communities, such as by providing safeguards against the use of downscaled data that may enable the identification of individuals.

(4) DATA GAP AUDIT.—

(A) IN GENERAL.—In establishing the tool described in paragraph (2), the Committee shall direct relevant Federal departments and agencies to conduct an audit of data collected by the department or agency to identify any data that

are relevant to environmental justice concerns, including data relating to—

(i) public health metrics;

(ii) toxic chemicals;

(iii) socioeconomic demographics;

(iv) air quality;

(v) water quality; and

(vi) killings of individuals by law enforcement officers.

(B) REQUIREMENTS.—An audit described in subparagraph (A) shall—

(i) examine the granularity and accessibility of the data;

(ii) address the need for improved air quality monitoring; and

(iii) include recommendations to other Federal departments and agencies on means to improve the quality, granularity, and transparency of, and public involvement in, data collection and dissemination.

(C) IMPROVEMENTS.—The Committee shall direct a Federal department or agency, in conducting an audit under subparagraph (A), to address gaps in existing data collection that will assist the Committee in establishing and oper-

ating the tool described in paragraph (2), including by providing to the department or agency—

(i) benchmarks to meet in addressing the gaps;

(ii) instructions for consistency in data formatting that will allow for inclusion of data in the environmental justice data repository described in subsection (e); and

(iii) best practices for collecting data in collaboration with local organizations and partners, such as engaging in ground-truthing.

(D) REPORTS.—Not later than 180 days after a Federal department or agency has conducted an audit under subparagraph (A), the Committee shall—

(i) make available to the public on an internet website of the Environmental Protection Agency a report describing the findings and conclusions of the audit, including the progress made by the Federal department or agency in addressing environmental justice data gaps; and

(ii) submit the report described in clause (i) to—

(I) the Committee on Environment and Public Works of the Senate;

(II) the Committee on Health, Education, Labor, and Pensions of the Senate;

(III) the Committee on Energy and Commerce of the House of Representatives; and

(IV) the Committee on Education and Labor of the House of Representatives.

(e) ENVIRONMENTAL JUSTICE DATA REPOSITORY.—

(1) IN GENERAL.—The Administrator shall establish an environmental justice data repository to maintain—

(A) the data collected by the Committee through the establishment of the tool described in subsection (d)(2) and the audits conducted under subsection (d)(4)(A); and

(B) any subnational data collected under paragraph (3)(B).

(2) UPDATES.—The Administrator shall update the data in the data repository described in para-

graph (1) as frequently as practicable, including every year if practicable, but not less frequently than once every 3 years.

(3) AVAILABILITY; INCLUSION OF SUBNATIONAL DATA.—The Administrator—

(A) shall make the data repository described in paragraph (1) available to regional, State, local, and Tribal governments; and

(B) may collaborate with the governments described in subparagraph (A) to include within that data repository subnational data in existence before the establishment of the tool described in subsection (d)(2) and the completion of the audits under subsection (d)(4)(A).

(4) REQUIREMENT.—The Administrator shall take measures to prevent the data in the data repository described in paragraph (1) from being misused to discriminate against environmental justice communities, such as by providing safeguards against the use of downscaled data that may enable the identification of individuals.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Administrator to carry out this section, including any necessary administrative costs of the Committee—

(1) $20,000,000 for each of fiscal years 2023 and 2024; and

(2) $18,000,000 for each of fiscal years 2025 through 2027.

(g) EFFECT.—Nothing in any provision of this section relating to the tool described in subsection (d)(2) prohibits a State from developing a map relating to environmental justice or pollution burden that relies on different data, or analyzes data differently, than that tool.

SEC. 10013. ANTI-RACISM IN PUBLIC HEALTH.

(a) FINDINGS.—Congress finds as follows:

(1) For centuries, structural racism, defined by the National Museum of African American History and Culture as an ''overarching system of racial bias across institutions and society'', in the United States has negatively affected communities of color, especially Black, Latinx, Asian American, Pacific Islander, and American Indian and Alaska Native people, to expand and reinforce White supremacy.

(2) Structural racism determines the conditions in which people are born, grow, work, live, and age and determine people's access to quality housing, education, food, transportation, and political power, and other social determinants of health.

(3) Structural racism serves as a major barrier to achieving health equity and eliminating racial and ethnic inequities in health outcomes that exist at alarming rates and are determined by a wider set of forces and systems.

(4) Due to structural racism in the United States, people of color are more likely to suffer from chronic health conditions (such as heart disease, diabetes, asthma, hepatitis, and hypertension) and infectious diseases (such as HIV/AIDS, and COVID–19) compared to their White counterparts.

(5) Due to structural racism in maternal health care in the United States, Black and American Indian and Alaska Native infants are more than twice as likely to die than White infants, Black women are 3 to 4 times more likely to die from pregnancy-related causes than White women, and American Indian and Alaska Native women are 5 times more likely to die from pregnancy-related causes than White women. This trend persists even when adjusting for income and education.

(6) Due to structural racism in the United States, Non-Hispanic Black women have the highest rates for 22 of 25 severe morbidity indicators used by the Center for Disease Control and Prevention.

(7) Due to structural racism in the United States, people of color comprise a disproportionate percentage of persons with disabilities in the United States.

(8) Due to structural racism in the United States, Black men are up to 3½ times as likely to be killed by police as White men, and 1 in every 1,000 Black men will die as a result of police violence. Policing has adverse effects on mental health in Black communities.

(9) Due to the confluence of structural racism and factors such as gender, class, and sexual orientation or gender identity, commonly referred to as intersectionality, Black and Latinx transgender women are more likely to die due to violence and homicide than their White counterparts.

(10) Due to structural racism, inequitable access to quality health care and longterm services and supports also disproportionately burdens communities of color; people of color and immigrants are less likely to be insured and are more likely to live in medically underserved areas.

(11) Due to structural racism, older adults of color are also more likely to be admitted to nursing homes and assisted living facilities and to reside in

those of poor quality, and when older adults of color do receive home and community based services, Medicaid spends less money on their services and they are more likely to be hospitalized than older White adults.

(12) In addition, the Federal Government's failure to honor the unique political status of American Indian and Alaska Native people, to respect the inherent sovereignty of Tribal Nations, and to uphold its trust and treaty obligations to Tribal Nations and American Indian and Alaska Native people, is an ongoing and unjust manifestation of centuries of oppression, with the consequence of adverse health outcomes for Native peoples.

(13) The COVID–19 pandemic has exposed the devastating impact of structural racism on the United States ability to ensure equitable health outcomes for people of color, and made these communities more likely to suffer from severe outcomes due to the coronavirus infection.

(14) Racial and ethnic inequity in public health is a result of systematic, personally mediated, and internalized racism and racist public and private policies and practices, and dismantling structural racism is integral to addressing public health.

(b) PUBLIC HEALTH RESEARCH AND INVESTMENT IN DISMANTLING STRUCTURAL RACISM.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

"SEC. 320C. NATIONAL CENTER ON ANTIRACISM AND HEALTH.

''(a) IN GENERAL.—

''(1) NATIONAL CENTER.—There is established within the Centers for Disease Control and Prevention a center to be known as the 'National Center on Antiracism and Health' (referred to in this section as the 'Center'). The Director of the Centers for Disease Control and Prevention shall appoint a director to head the Center who has experience living in and working with racial and ethnic minority communities. The Center shall promote public health by—

''(A) declaring racism a public health crisis and naming racism as an historical and present threat to the physical and mental health and well-being of the United States and world;

''(B) aiming to develop new knowledge in the science and practice of antiracism, including by identifying the mechanisms by which racism

operates in the provision of health care and in systems that impact health and well-being;

"(C) transferring that knowledge into practice, including by developing interventions that dismantle the mechanisms of racism and replace such mechanisms with equitable structures, policies, practices, norms, and values so that a healthy society can be realized; and

"(D) contributing to a national and global conversation regarding the impacts of racism on the health and well-being of the United States and world.

"(2) GENERAL DUTIES.—The Secretary, acting through the Center, shall undertake activities to carry out the mission of the Center as described in paragraph (1), such as the following:

"(A) Conduct research into, collect, analyze and make publicly available data on, and provide leadership and coordination for the science and practice of antiracism, the public health impacts of structural racism, and the effectiveness of intervention strategies to address these impacts. Topics of research and data collection under this subparagraph may include identifying and understanding—

''(i) policies and practices that have a disparate impact on the health and well-being of communities of color;

''(ii) the public health impacts of implicit racial bias, White supremacy, weathering, xenophobia, discrimination, and prejudice;

''(iii) the social determinants of health resulting from structural racism, including poverty, housing, employment, political participation, and environmental factors; and

''(iv) the intersection of racism and other systems of oppression, including as related to age, sexual orientation, gender identity, and disability status.

''(B) Award noncompetitive grants and cooperative agreements to eligible public and nonprofit private entities, including State, local, territorial, and Tribal health agencies and organizations, for the research and collection, analysis, and reporting of data on the topics described in subparagraph (A).

''(C) Establish, through grants or cooperative agreements, at least 3 regional centers of

excellence, located in racial and ethnic minority communities, in antiracism for the purpose of developing new knowledge in the science and practice of antiracism in health by researching, understanding, and identifying the mechanisms by which racism operates in the health space, racial and ethnic inequities in health care access and outcomes, the history of successful antiracist movements in health, and other antiracist public health work.

''(D) Establish a clearinghouse within the Centers for Disease Control and Prevention for the collection and storage of data generated under the programs implemented under this section for which there is not an otherwise existing surveillance system at the Centers for Disease Control and Prevention. Such data shall—

''(i) be comprehensive and disaggregated, to the extent practicable, by including racial, ethnic, primary language, sex, gender identity, sexual orientation, age, socioeconomic status, and disability disparities;

''(ii) be made publicly available;

"(iii) protect the privacy of individuals whose information is included in such data; and

"(iv) comply with privacy protections under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(E) Provide information and education to the public on the public health impacts of structural racism and on antiracist public health interventions.

"(F) Consult with other Centers and National Institutes within the Centers for Disease Control and Prevention, including the Office of Minority Health and Health Equity and the Center for State, Tribal, Local, and Territorial Support, to ensure that scientific and programmatic activities initiated by the agency consider structural racism in their designs, conceptualizations, and executions, which shall include—

"(i) putting measures of racism in population-based surveys;

"(ii) establishing a Federal Advisory Committee on racism and health for the

Centers for Disease Control and Prevention;

''(iii) developing training programs, curricula, and seminars for the purposes of training public health professionals and researchers around issues of race, racism, and antiracism;

''(iv) providing standards and best practices for programming and grant recipient compliance with Federal data collection standards, including section 3101 of the Public Health Service Act; and

''(v) establishing leadership and stakeholder councils with experts and leaders in racism and public health disparities.

''(G) Coordinate with the Indian Health Service and with the Centers for Disease Control and Prevention's Tribal Advisory Committee to ensure meaningful Tribal consultation, the gathering of information from Tribal authorities, and respect for Tribal data sovereignty.

''(H) Engage in government to government consultation with Indian Tribes and Tribal organizations.

''(I) At least every 2 years, produce and publicly post on the Centers for Disease Control and Prevention's website a report on antiracist activities completed by the Center, which may include newly identified antiracist public health practices.

''(b) DEFINITIONS.—In this section:

''(1) ANTIRACISM.—The term 'antiracism' is a collection of antiracist policies that lead to racial equity, and are substantiated by antiracist ideas.

''(2) ANTIRACIST.—The term 'antiracist' is any measure that produces or sustains racial equity between racial groups.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.''.

(c) PUBLIC HEALTH RESEARCH AND INVESTMENT IN POLICE VIOLENCE.—

(1) IN GENERAL.—The Secretary shall establish within the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (referred to in this subsection as the ''Center'') a law enforcement violence prevention program.

(2) GENERAL DUTIES.—In implementing the program under paragraph (1), the Center shall conduct research into, and provide leadership and coordination for—

(A) the understanding and promotion of knowledge about the public health impacts of uses of force by law enforcement, including police brutality and violence;

(B) developing public health interventions and perspectives for eliminating deaths, injury, trauma, and negative mental health effects from police presence and interactions, including police brutality and violence; and

(C) ensuring comprehensive data collection, analysis, and reporting regarding police violence and misconduct, in consultation with the Department of Justice and independent researchers.

(3) FUNCTIONS.—Under the program under paragraph (1), the Center shall—

(A) summarize and enhance the knowledge of the distribution, status, and characteristics of law enforcement-related death, trauma, and injury;

(B) conduct research and prepare, with the assistance of State public health departments—

(i) statistics on law enforcement-related death, injury, and brutality;

(ii) studies of the factors, including legal, socioeconomic, discrimination, and other factors that correlate with or influence police brutality;

(iii) public information about uses of force by law enforcement, including police brutality and violence, for the practical use of the public health community, including publications that synthesize information relevant to the national goal of understanding police violence and methods for its control;

(iv) information to identify socioeconomic groups, communities, and geographic areas in need of study, and a strategic plan for research necessary to comprehend the extent and nature of police uses of force by law enforcement, including police brutality and violence, and determine what options exist to reduce or eradicate death and injury that result; and

(v) best practices in police violence prevention in other countries;

(C) award grants, contracts, and cooperative agreements to provide for the conduct of epidemiologic research on uses of force by law enforcement, including police brutality and violence, by Federal, State, local, and private agencies, institutions, organizations, and individuals;

(D) award grants, contracts, and cooperative agreements to community groups, independent research organizations, academic institutions, and other entities to support, execute, or conduct research on interventions to reduce or eliminate uses of force by law enforcement, including police brutality and violence;

(E) coordinate with the Department of Justice, and other Federal, State, and local agencies on the standardization of data collection, storage, and retrieval necessary to collect, evaluate, analyze, and disseminate information about the extent and nature of uses of force by law enforcement, including police brutality and violence, as well as options for the eradication of such practices;

(F) submit an annual report to Congress on research findings with recommendations to improve data collection and standardization and to disrupt processes in policing that preserve and reinforce racism and racial disparities in public health;

(G) conduct primary research and explore uses of force by law enforcement, including police brutality and violence, and options for its control; and

(H) study alternatives to law enforcement response as a method of reducing police violence.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary to carry out this subsection.

SEC. 10014. LGBTQ ESSENTIAL DATA.

(a) IMPROVING DATA COLLECTION ON THE SEXUAL ORIENTATION AND GENDER IDENTITY OF DECEASED INDIVIDUALS THROUGH THE NATIONAL VIOLENT DEATH REPORTING SYSTEM.—

(1) COLLECTION OF SEXUAL ORIENTATION AND GENDER IDENTITY DATA.—

(A) IN GENERAL.—Not later than 120 days after the date of enactment of this Act,

the Director of the Centers for Disease Control and Prevention shall take measures to improve the incidence of the collection of information on the sexual orientation and gender identity of deceased individuals through the National Violent Death Reporting System or any successor programs.

(B) CONFIDENTIALITY.—Any information collected relating to the sexual orientation or gender identity of a decedent shall be maintained in accordance with the confidentiality and privacy standards and policies for the protection of individuals applicable to all other data collected for purposes of the National Violent Death Reporting System.

(2) DEFINITIONS.—In this subsection:

(A) GENDER IDENTITY.—The term ''gender identity'' means an individual's sense of being male, female, transgender, or another gender, as distinct from the individual's sex assigned at birth.

(B) SEXUAL ORIENTATION.—The term ''sexual orientation'' means how a person identifies in terms of their emotional, romantic, or sexual attractions, and includes identification as

straight, heterosexual, gay, lesbian, or bisexual, among other terms.

(3) AUTHORIZATION.—There is authorized to be appropriated $25,000,000 for fiscal year 2023 to carry out this subsection.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the Centers for Disease Control and Prevention has made significant efforts to encourage States and other jurisdictions to collect data on sexual orientation and gender identity through the National Violent Death Reporting System; and

(2) jurisdictions that participate in the collection of such data through the National Violent Death Reporting System should be commended for their participation.

SEC. 10015. SOCIAL DETERMINANTS ACCELERATOR.

(a) FINDINGS; PURPOSES.—

(1) FINDINGS.—Congress finds as follows:

(A) There is a significant body of evidence showing that economic and social conditions have a powerful impact on individual and population health outcomes and well-being, as well as medical costs.

(B) State, local, and Tribal governments and the service delivery partners of such governments face significant challenges in coordinating benefits and services delivered through the Medicaid program and other social services programs because of the fragmented and complex nature of Federal and State funding and administrative requirements.

(C) The Federal Government should prioritize and proactively assist State and local governments to strengthen the capacity of State and local governments to improve health and social outcomes for individuals, thereby improving cost-effectiveness and return on investment.

(2) PURPOSES.—The purposes of this section are as follows:

(A) To establish effective, coordinated Federal technical assistance to help State and local governments to improve outcomes and cost-effectiveness of, and return on investment from, health and social services programs.

(B) To build a pipeline of State and locally designed, cross-sector interventions and strategies that generate rigorous evidence about how to improve health and social outcomes, and in-

crease the cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal health and social services programs.

(C) To enlist State and local governments and the service providers of such governments as partners in identifying Federal statutory, regulatory, and administrative challenges in improving the health and social outcomes of, cost-effectiveness of, and return on investment from, Federal spending on individuals enrolled in Medicaid.

(D) To develop strategies to improve health and social outcomes without denying services to, or restricting the eligibility of, vulnerable populations.

(b) SOCIAL DETERMINANTS ACCELERATOR COUNCIL.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in coordination with the Administrator of the Centers for Medicare & Medicaid Services (referred to in this section as the ''Administrator''), shall establish an interagency council, to be known as the Social Determinants Accelerator Interagency Council (referred to in this section as the

''Council'') to achieve the purposes listed in subsection (a)(2).

(2) MEMBERSHIP.—

(A) FEDERAL COMPOSITION.—The Council shall be composed of at least one designee from each of the following Federal agencies:

(i) The Office of Management and Budget.

(ii) The Department of Agriculture.

(iii) The Department of Education.

(iv) The Indian Health Service.

(v) The Department of Housing and Urban Development.

(vi) The Department of Labor.

(vii) The Department of Transportation.

(viii) Any other Federal agency the Chair of the Council determines necessary.

(B) DESIGNATION.—

(i) IN GENERAL.—The head of each agency specified in subparagraph (A) shall designate at least one employee described in clause (ii) to serve as a member of the Council.

(ii) RESPONSIBILITIES.—An employee described in this subparagraph shall be a senior employee of the agency—

(I) whose responsibilities relate to authorities, policies, and procedures with respect to the health and well-being of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

(II) who has authority to implement and evaluate transformative initiatives that harness data or conducts rigorous evaluation to improve the impact and cost-effectiveness of federally funded services and benefits.

(C) HHS REPRESENTATION.—In addition to the designees under subparagraph (A), the Council shall include designees from at least three agencies within the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, at least one of whom shall meet the criteria under subparagraph (B)(ii).

(D) OMB ROLE.—The Director of the Office of Management and Budget shall facilitate the timely resolution of Governmentwide and multiagency issues to help the Council achieve consensus recommendations described under paragraph (3)(A).

(E) NON-FEDERAL COMPOSITION.—The Comptroller General of the United States may designate up to 6 Council designees—

(i) who have relevant subject matter expertise, including expertise implementing and evaluating transformative initiatives that harness data and conduct evaluations to improve the impact and cost-effectiveness of Federal Government services; and

(ii) that each represent—

(I) State, local, and Tribal health and human services agencies;

(II) public housing authorities or State housing finance agencies;

(III) State and local government budget offices;

(IV) State Medicaid agencies; or

(V) national consumer advocacy organizations.

(F) CHAIR.—

(i) IN GENERAL.—The Secretary shall select the Chair of the Council from among the members of the Council.

(ii) INITIATING GUIDANCE.—The Chair, on behalf of the Council, shall identify and invite individuals from diverse entities to provide the Council with advice and information pertaining to addressing social determinants of health, including—

(I) individuals from State and local government health and human services agencies;

(II) individuals from State Medicaid agencies;

(III) individuals from State and local government budget offices;

(IV) individuals from public housing authorities or State housing finance agencies;

(V) individuals from nonprofit organizations, small businesses, and philanthropic organizations;

(VI) advocates;

(VII) researchers; and

(VIII) any other individuals the Chair determines to be appropriate.

(3) DUTIES.—The duties of the Council are—

(A) to make recommendations to the Secretary and the Administrator regarding the criteria for making awards under subsection (c);

(B) to identify Federal authorities and opportunities for use by States or local governments to improve coordination of funding and administration of Federal programs, the beneficiaries of whom include individuals described in subsection (a), and which may be unknown or underutilized and to make information on such authorities and opportunities publicly available;

(C) to provide targeted technical assistance to States developing a social determinants accelerator plan under subsection (c), including identifying potential statutory or regulatory pathways for implementation of the plan and assisting in identifying potential sources of funding to implement the plan;

(D) to report to Congress annually on the subjects set forth in paragraph (4);

(E) to develop and disseminate evaluation guidelines and standards that can be used to reliably assess the impact of an intervention or approach that may be implemented pursuant to this section on outcomes, cost-effectiveness of, and return on investment from Federal, State, local, and Tribal governments, and to facilitate technical assistance, where needed, to help to improve State and local evaluation designs and implementation;

(F) to seek feedback from State, local, and Tribal governments, including through an annual survey by an independent third party, on how to improve the technical assistance the Council provides to better equip State, local, and Tribal governments to coordinate health and social service programs;

(G) to solicit applications for grants under subsection (c); and

(H) to coordinate with other cross-agency initiatives focused on improving the health and well-being of low-income and at-risk populations in order to prevent unnecessary duplication between agency initiatives.

(4) SCHEDULE.—Not later than 60 days after the date of enactment of this Act, the Council shall convene to develop a schedule and plan for carrying out the duties described in paragraph (3), including solicitation of applications for the grants under subsection (c).

(5) REPORT TO CONGRESS.—The Council shall submit an annual report to Congress, which shall include—

(A) a list of the Council members;

(B) activities and expenditures of the Council;

(C) summaries of the interventions and approaches that will be supported by State, local, and Tribal governments that received a grant under subsection (c), including—

(i) the best practices and evidence-based approaches such governments plan to employ to achieve the purposes listed in subsection (a)(2); and

(ii) a description of how the practices and approaches will impact the outcomes, cost-effectiveness of, and return on investment from, Federal, State, local, and Trib-

al governments with respect to such purposes;

(D) the feedback received from State and local governments on ways to improve the technical assistance of the Council, including findings from a third-party survey and actions the Council plans to take in response to such feedback; and

(E) the major statutory, regulatory, and administrative challenges identified by State, local, and Tribal governments that received a grant under subsection (c), and the actions that Federal agencies are taking to address such challenges.

(6) FACA APPLICABILITY.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(7) COUNCIL PROCEDURES.—The Secretary, in consultation with the Comptroller General of the United States and the Director of the Office of Management and Budget, shall establish procedures for the Council to—

(A) ensure that adequate resources are available to effectively execute the responsibilities of the Council;

(B) effectively coordinate with other relevant advisory bodies and working groups to avoid unnecessary duplication;

(C) create transparency to the public and Congress with regard to Council membership, costs, and activities, including through use of modern technology and social media to disseminate information; and

(D) avoid conflicts of interest that would jeopardize the ability of the Council to make decisions and provide recommendations.

(c) SOCIAL DETERMINANTS ACCELERATOR GRANTS TO STATES OR LOCAL GOVERNMENTS.—

(1) GRANTS TO STATES, LOCAL GOVERNMENTS, AND TRIBES.—Not later than 180 days after the date of enactment of this Act, the Administrator, in consultation with the Secretary and the Council, shall award on a competitive basis not more than 25 grants to eligible applicants described in paragraph (2), for the development of social determinants accelerator plans, as described in paragraph (6).

(2) ELIGIBLE APPLICANT.—An eligible applicant described in this subsection is a State, local, or Tribal health or human services agency that—

(A) demonstrates the support of relevant parties across relevant State, local, or Tribal jurisdictions; and

(B) in the case of an applicant that is a local government agency, provides to the Secretary a letter of support from the lead State health or human services agency for the State in which the local government is located.

(3) AMOUNT OF GRANT.—The Administrator, in coordination with the Council, shall determine the total amount that the Administrator will make available to each grantee under this subsection.

(4) APPLICATION.—An eligible applicant seeking a grant under this subsection shall include in the application the following information:

(A) The target population (or populations) that would benefit from implementation of the social determinants accelerator plan proposed to be developed by the applicant.

(B) A description of the objective or objectives and outcome goals of such proposed plan, which shall include at least one health outcome and at least one other important social outcome.

(C) The sources and scope of inefficiencies that, if addressed by the plan, could result in improved cost-effectiveness of or return on investment from Federal, State, local, and Tribal governments.

(D) A description of potential interventions that could be designed or enabled using such proposed plan.

(E) The State, local, Tribal, academic, nonprofit, community-based organizations, and other private sector partners that would participate in the development of the proposed plan and subsequent implementation of programs or initiatives included in such proposed plan.

(F) Such other information as the Administrator, in consultation with the Secretary and the Council, determines necessary to achieve the purposes of this section.

(5) USE OF FUNDS.—A recipient of a grant under this subsection may use funds received through the grant for the following purposes:

(A) To convene and coordinate with relevant government entities and other stakeholders across sectors to assist in the development of a social determinant accelerator plan.

(B) To identify populations of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) who may benefit from the proposed approaches to improving the health and well-being of such individuals through the implementation of the proposed social determinants accelerator plan.

(C) To engage qualified research experts to advise on relevant research and to design a proposed evaluation plan, in accordance with the standards and guidelines issued by the Administrator.

(D) To collaborate with the Council to support the development of social determinants accelerator plans.

(E) To prepare and submit a final social determinants accelerator plan to the Council.

(6) CONTENTS OF PLANS.—A social determinant accelerator plan developed under this subsection shall include the following:

(A) A description of the target population (or populations) that would benefit from implementation of the social determinants accelerator

plan, including an analysis describing the projected impact on the well-being of individuals described in paragraph (5)(B).

(B) A description of the interventions or approaches designed under the social determinants accelerator plan and the evidence for selecting such interventions or approaches.

(C) The objectives and outcome goals of such interventions or approaches, including at least one health outcome and at least one other important social outcome.

(D) A plan for accessing and linking relevant data to enable coordinated benefits and services for the jurisdictions described in paragraph (2)(A) and an evaluation of the proposed interventions and approaches.

(E) A description of the State, local, Tribal, academic, nonprofit, or community-based organizations, or any other private sector organizations that would participate in implementing the proposed interventions or approaches, and the role each would play to contribute to the success of the proposed interventions or approaches.

(F) The identification of the funding sources that would be used to finance the proposed interventions or approaches.

(G) A description of any financial incentives that may be provided, including outcome-focused contracting approaches to encourage service providers and other partners to improve outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, or Tribal government spending.

(H) The identification of the applicable Federal, State, local, or Tribal statutory and regulatory authorities, including waiver authorities, to be leveraged to implement the proposed interventions or approaches.

(I) A description of potential considerations that would enhance the impact, scalability, or sustainability of the proposed interventions or approaches and the actions the grant awardee would take to address such considerations.

(J) A proposed evaluation plan, to be carried out by an independent evaluator, to measure the impact of the proposed interventions or approaches on the outcomes of, cost-effective-

ness of, and return on investment from, Federal, State, local, and Tribal governments.

(K) Precautions for ensuring that vulnerable populations will not be denied access to Medicaid or other essential services as a result of implementing the proposed plan.

(d) FUNDING.—

(1) IN GENERAL.—Out of any money in the Treasury not otherwise appropriated, there is appropriated to carry out this section $25,000,000, of which up to $5,000,000 may be used to carry out this section, to remain available for obligation until the date that is 5 years after the date of enactment of this Act.

(2) RESERVATION OF FUNDS.—

(A) IN GENERAL.—Of the funds made available under paragraph (1), the Secretary shall reserve not less than 20 percent to award grants to eligible applicants for the development of social determinants accelerator plans under subsection (c) intended to serve rural populations.

(B) EXCEPTION.—In the case of a fiscal year for which the Secretary determines that there are not sufficient eligible applicants to

award up to 25 grants under subsection (c) that are intended to serve rural populations and the Secretary cannot satisfy the 20-percent requirement, the Secretary may reserve an amount that is less than 20 percent of amounts made available under paragraph (1) to award grants for such purpose.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall prevent Federal agencies represented on the Council from contributing additional funding from other sources to support activities to improve the effectiveness of the Council.

SEC. 10016. IMPROVING SOCIAL DETERMINANTS OF HEALTH.

(a) FINDINGS.—Congress finds as follows:

(1) Healthy People 2030 defines social determinants of health as conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

(2) One of the overarching goals of Healthy People 2030 is to ''create social, physical, and economic environments that promote attaining the full potential for health and well-being for all''.

(3) Healthy People 2030 developed a ''place-based'' organizing framework, reflecting five key areas of social determinants of health namely—

(A) economic stability;

(B) education access and quality;

(C) social and community context;

(D) health care access and quality; and

(E) neighborhood and built environment.

(4) It is estimated that medical care accounts for only 10 to 20 percent of the modifiable contributors to healthy outcomes for a population.

(5) The Centers for Medicare & Medicaid Services has indicated the importance of the social determinants in its work stating that, ''As we seek to foster innovation, rethink rural health, find solutions to the opioid epidemic, and continue to put patients first, we need to take into account social determinants of health and recognize their importance.''.

(6) The Department of Health and Human Services' Public Health 3.0 initiative recognizes the role of public health in working across sectors on social determinants of health, as well as the role of public health as chief health strategist in communities.

(7) Through its Health Impact in 5 Years initiative, the Centers for Disease Control and Prevention has highlighted nonclinical, community-wide approaches that show positive health impacts, results within 5 years, and cost-effectiveness or cost-savings over the lifetime of the population or earlier.

(8) Health departments and the Centers for Disease Control and Prevention are not funded for such cross-cutting work.

(b) SOCIAL DETERMINANTS OF HEALTH PROGRAM.—

(1) PROGRAM.—To the extent and in the amounts made available in advance in appropriations Acts, the Director of the Centers for Disease Control and Prevention (in this section referred to as the ''Director'') shall carry out a program, to be known as the Social Determinants of Health Program (in this section referred to as the ''Program''), to achieve the following goals:

(A) Improve health outcomes and reduce health inequities by coordinating social determinants of health activities across the Centers for Disease Control and Prevention.

(B) Improve the capacity of public health agencies and community organizations to ad-

dress social determinants of health in communities.

(2) ACTIVITIES.—To achieve the goals listed in paragraph (1), the Director shall carry out activities including the following:

(A) Coordinating across the Centers for Disease Control and Prevention to ensure that relevant programs consider and incorporate social determinants of health in grant awards and other activities.

(B) Awarding grants under subsection (c) to State, local, territorial, and Tribal health agencies and organizations, and to other eligible entities, to address social determinants of health in target communities.

(C) Awarding grants under subsection (d) to nonprofit organizations and public or other nonprofit institutions of higher education—

(i) to conduct research on best practices to improve social determinants of health;

(ii) to provide technical assistance, training, and evaluation assistance to grantees under subsection (c); and

(iii) to disseminate best practices to grantees under subsection (c).

(D) Coordinating, supporting, and aligning activities of the Centers for Disease Control and Prevention related to social determinants of health with activities of other Federal agencies related to social determinants of health, including such activities of agencies in the Department of Health and Human Services such as the Centers for Medicare & Medicaid Services.

(E) Collecting and analyzing data related to the social determinants of health.

(c) GRANTS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH.—

(1) IN GENERAL.—The Director, as part of the Program, shall award grants to eligible entities to address social determinants of health in their communities.

(2) ELIGIBILITY.—To be eligible to apply for a grant under this subsection, an entity shall be—

(A) a State, local, territorial, or Tribal health agency or organization;

(B) a qualified nongovernmental entity, as defined by the Director; or

(C) a consortium of entities that includes a State, local, territorial, or Tribal health agency or organization.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A grant under this subsection shall be used to address social determinants of health in a target community by designing and implementing innovative, evidence-based, cross-sector strategies.

(B) TARGET COMMUNITY.—For purposes of this subsection, a target community shall be a State, county, city, or other municipality.

(4) PRIORITY.—In awarding grants under this subsection, the Director shall prioritize applicants proposing to serve target communities with significant unmet health and social needs, as defined by the Director.

(5) APPLICATION.—To seek a grant under this subsection, an eligible entity shall—

(A) submit an application at such time, in such manner, and containing such information as the Director may require;

(B) propose a set of activities to address social determinants of health through evidence-

based, cross-sector strategies, which activities may include—

(i) collecting quantifiable data from health care, social services, and other entities regarding the most significant gaps in health-promoting social, economic, and environmental needs;

(ii) identifying evidence-based approaches to meeting the nonmedical, social needs of populations identified by data collection described in clause (i), such as unstable housing or food insecurity;

(iii) developing scalable methods to meet patients' social needs identified in clinical settings or other sites;

(iv) convening entities such as local and State governmental and nongovernmental organizations, health systems, payors, and community-based organizations to review, plan, and implement community-wide interventions and strategies to advance health-promoting social conditions;

(v) monitoring and evaluating the impact of activities funded through the grant on the health and well-being of the resi-

dents of the target community and on the cost of health care; and

(vi) such other activities as may be specified by the Director;

(C) demonstrate how the eligible entity will collaborate with—

(i) health systems;

(ii) payors, including, as appropriate, medicaid managed care organizations (as defined in section 1903(m)(1)(A) of the Social Security Act (42 U.S.C. 1396b(m)(1)(A))), Medicare Advantage plans under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.), and health insurance issuers and group health plans (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91));

(iii) other relevant stakeholders and initiatives in areas of need, such as the Accountable Health Communities Model of the Centers for Medicare & Medicaid Services, health homes under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), commu-

nity-based organizations, and human services organizations;

(iv) other non-health care sector organizations, including organizations focusing on transportation, housing, or food access; and

(v) local employers; and

(D) identify key health inequities in the target community and demonstrate how the proposed efforts of the eligible entity would address such inequities.

(6) MONITORING AND EVALUATION.—As a condition of receipt of a grant under this subsection, a grantee shall agree to submit an annual report to the Director describing the activities carried out through the grant and the outcomes of such activities.

(7) INDEPENDENT NATIONAL EVALUATION.—

(A) IN GENERAL.—Not later than 5 years after the first grants are awarded under this subsection, the Director shall provide for the commencement of an independent national evaluation of the program under this subsection.

(B) REPORT TO CONGRESS.—Not later than 60 days after receiving the results of such

independent national evaluation, the Director shall report such results to Congress.

(d) RESEARCH AND TRAINING.—The Director, as part of the Program—

(1) shall award grants to nonprofit organizations and public or other nonprofit institutions of higher education—

(A) to conduct research on best practices to improve social determinants of health;

(B) to provide technical assistance, training, and evaluation assistance to grantees under subsection (c); and

(C) to disseminate best practices to grantees under subsection (c); and

(2) may require a grantee under paragraph (1) to provide technical assistance and capacity building to entities that are eligible entities under subsection (c) but not receiving funds through such section.

(e) FUNDING.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2023 through 2028.

(2) ALLOCATION.—Of the amount made available to carry out this section for a fiscal year, not

less than 75 percent shall be used for grants under subsections (c) and (d).

Subtitle B—Gun Violence

SEC. 10101. REAFFIRMING RESEARCH AUTHORITY OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) IN GENERAL.—Section 391 of the Public Health Service Act (42 U.S.C. 280b) is amended—

(1) in subsection (a)(1), by striking ''research relating to the causes, mechanisms, prevention, diagnosis, treatment of injuries, and rehabilitation from injuries;'' and inserting the following: ''research, including data collection, relating to—

''(A) the causes, mechanisms, prevention, diagnosis, and treatment of injuries, including with respect to gun violence; and

''(B) rehabilitation from such injuries;''; and

(2) by adding at the end the following new subsection:

''(c) NO ADVOCACY OR PROMOTION OF GUN CONTROL.—Nothing in this section shall be construed to—

''(1) authorize the Secretary to give assistance, make grants, or enter into cooperative agreements or

contracts for the purpose of advocating or promoting gun control; or

''(2) permit a recipient of any assistance, grant, cooperative agreement, or contract under this section to use such assistance, grant, agreement, or contract for the purpose of advocating or promoting gun control.''.

SEC. 10102. NATIONAL VIOLENT DEATH REPORTING SYSTEM.

The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall improve the National Violent Death Reporting System (as authorized by sections 301(a) and 391(a) of the Public Service Health Act (42 U.S.C. 241(a), 280b(a)), particularly through the inclusion of additional States and activities to increase the quality, type, and timeliness of reported data. Participation in the System by the States shall be voluntary.

SEC. 10103. REPORT ON EFFECTS OF GUN VIOLENCE ON PUBLIC HEALTH.

Not later than one year after the date of enactment of this Act, and annually thereafter, the Surgeon General shall submit to Congress a report on the effects on public health, including mental health, of gun violence in the

United States during the preceding year, and the status of actions taken to address such effects.

SEC. 10104. REPORT ON EFFECTS OF GUN VIOLENCE ON MENTAL HEALTH IN MINORITY COMMUNITIES.

Not later than one year after the date of enactment of this Act, the Deputy Assistant Secretary for Minority Health in the Office of the Secretary of Health and Human Services shall submit to Congress a report on the effects of gun violence on public health, including mental health, in minority communities in the United States, and the status of actions taken to address such effects.