H. R. 3459

To improve the health of minority individuals.

IN THE HOUSE OF REPRESENTATIVES

November 6, 2003

Mr. Cummings (for himself, Mr. Rodriguez, Mr. Kildee, Mr. Wu, Mrs. Christensen, Ms. Solis, Mr. Pallone, Mr. Honda, Ms. Bordallo, Ms. Pelosi, Mr. Hoyer, Mr. Menendez, Mr. Clyburn, Mr. Dingell, Mr. Rangel, Mr. Stark, Mr. Rahall, Mr. Brown of Ohio, Ms. Roybal-Allard, and Mr. Case) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce, Resources, the Judiciary, Ways and Means, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve the health of minority individuals.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Healthcare Equality and Accountability Act”.

(b) Table of Contents.—The table of contents of this Act is as follows:

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SEC. 2. FINDINGS AND PURPOSE.

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

(1) Despite significant advances in public health and health care, the health status of racial and ethnic minority populations continues to lag behind that of the white population.

(2) The United States is becoming increasingly diverse. According to the 2000 United States Census, African Americans, American Indians and Alaska Natives, Asians, Hispanics, and Native Hawaiians and other Pacific Islanders comprise 30 percent...
of the United States population. Racial and ethnic minorities are expected to comprise 40 percent of the United States population by 2030.

(3) To improve the health care of racial and ethnic minorities and to reduce and eliminate disparities in health care and health outcomes, the following issues must be addressed:

(A) **Need for Insurance Coverage.** —

(i) Disparities in health status can be attributed largely to underlying differences in socioeconomic status and insurance coverage. Minorities are at a greater risk of being uninsured than their white counterparts. Lack of health insurance has consistently been associated with worse health outcomes.

(ii) Even after adjusting for differences in socioeconomic and insurance status, however, racial and ethnic health and health care disparities remain.

(iii) Through treaties and Federal statutes, the Federal Government has established a trust responsibility to provide health care to American Indians and Alaskan Natives. In the Indian Health Amend-
ments of 1992, Congress specifically pledged to “assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” Despite those commitments, the unmet health needs of American Indians and Alaska Natives remain alarmingly severe and their health status is far below the health status of the general population of the United States. The critical shortfall of funding for the Indian Health Service is a major source of this problem.

(B) NEED FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE.—

(i) Limited English proficiency adversely affects the care of many racial and ethnic minority patients. The lack of available interpretation and translation services or bilingual providers contributes to racial and ethnic disparities in health and health care. The Federal Government provides and funds an array of services that should be made accessible to eligible persons who are not proficient in the English language.
(ii) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving Federal financial assistance. Discrimination on the basis of primary language has consistently been interpreted as discrimination on the basis of national origin.

(iii) The provision of effective language services has been shown to improve care for limited English proficient (referred to in this section as “LEP”) patients by increasing patient satisfaction, access to care, compliance with recommended medical advice, and appropriate utilization.

(iv) A 2002 study by the Office of Management and Budget found that language assistance services can substantially improve the health and quality of life of LEP individuals and their families, increase the efficiency of distribution of government services to LEP individuals, and
measurably increase the effectiveness of public health and safety programs.

(v) The same study estimated that language translation services would only increase the cost of the average health care visit by less than one percent.

(C) NEED FOR HEALTH WORKFORCE DIVERSITY.—

(i) Research has demonstrated that minority health professionals dramatically increase access to care for minority patients and improve the quality of care that they receive. African Americans, American Indians and Alaska Natives, Hispanics, Native Hawaiians and other Pacific Islanders, and Southeast Asians are significantly underrepresented in the health professions, exacerbating health disparities.

(ii) Minority physicians are more likely than white physicians to serve minority populations. Nearly 40 percent of all minority medical school graduates will practice medicine in underserved areas, compared to 10 percent of their white colleagues.
(iii) Minorities often report experiences with discrimination when seeking health care.

(iv) There is substantial evidence to demonstrate that race concordance between physicians and patients increases patient satisfaction and participation in health decisionmaking.

(v) Minority health care providers can bridge linguistic, cultural, and other barriers that hamper access to care.

(vi) African Americans, Hispanics, and American Indians remain severely underrepresented in health professions schools. African Americans and Hispanics constitute 20 percent and 16 percent, respectively, of the students in public health and baccalaureate nursing programs, and less than 15 percent of students in all other health professions.

(vi) The number of minorities enrolling in health professional schools has remained stagnant. For example, in 1994, 1,307 African American and 1,090 Hispanic students enrolled in American med-
ical colleges. In 2000, the figures were essentially unchanged at 1,307 African American and 1,033 Hispanic students.

(D) NEED FOR REDUCTION OF DISEASE OCCURRENCE AND DISEASE-RELATED COMPLICATIONS AMONG MINORITIES.—

(i) Despite notable progress in the overall health of the Nation, there are continuing disparities in the burden of illness and death experienced by minorities compared to the United States population as a whole. Minority populations are disproportionately impacted by acute and chronic diseases.

(ii) Despite suffering a greater burden of acute and chronic disease, minorities are less likely to receive needed health care. Numerous studies have documented that minorities receive less preventive care, medical therapy, and surgical interventions.

(E) NEED FOR MINORITY HEALTH DATA COLLECTION AND REPORTING.—

(i) Efforts to study disparities in health and health care for minorities have
been hampered by the lack of available data on race, ethnicity, and primary language.

(ii) Data collection, analysis, and reporting by race, ethnicity, and primary language is permissible under the law and necessary to assure equity and non-discrimination in the quality of health care services. Collection, analysis, and reporting of such data is authorized under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.). Such collection, analysis, and reporting should be conducted with appropriate privacy protections in place.

(F) NEED FOR GREATER ACCOUNTABILITY IN GOVERNMENT INSTITUTIONS.—A number of studies have shown that differences in health care quality contribute to health disparities among minority populations. These differences may result from bias, stereotyping, and discrimination. Government institutions must be held accountable for the quality of healthcare delivered to all patient populations and resultant health outcomes.
(G) NEED FOR STRENGTHENING HEALTH INSTITUTIONS THAT PROVIDE CARE TO MINORITY POPULATIONS.—

(i) A small segment of health care institutions provide a disproportionate amount of health care to minority populations.

(ii) Safety net institutions, including public hospitals, community health centers and community clinics, provide a disproportionate share of health care to minority and underserved populations.

(iii) Financial stress, negative operating margins, and the overall burden of caring for the uninsured and delivering high-cost specialty care to the entire community place undue pressure on core safety net providers. These providers are increasingly challenged in their ability to meet the day-to-day needs of their patients.

(b) PURPOSES.—It is the purpose of this Act to improve the health and healthcare of minority populations and to eliminate racial and ethnic disparities in health and healthcare by—
(1) increasing access to health care for all populations;

(2) expanding culturally and linguistically appropriate health services for all populations;

(3) promoting health workforce diversity;

(4) supporting and expanding programs and activities that will improve the prevention, diagnosis, and management of disease in minority populations;

(5) enhancing racial, ethnic, and primary language health data collection at the local, State, and Federal level;

(6) ensuring accountability for the quality of health care and health outcomes for minority populations; and

(7) strengthening the technical and financial resources of the safety net institutions of the United States.

**TITLE I—COVERAGE OF THE UNINSURED**

**Subtitle A—FamilyCare**

**SEC 101. SHORT TITLE.**

This subtitle may be cited as the “FamilyCare Act of 2003”.
SEC. 102. RENAMING OF TITLE XXI PROGRAM.

(a) In General.—The heading of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended to read as follows:

“TITLE XXI—FAMILYCARE PROGRAM”.

(b) Program References.—Any reference in any provision of Federal law or regulation to “SCHIP” or “State children’s health insurance program” under title XXI of the Social Security Act shall be deemed a reference to the FamilyCare program under such title.

SEC. 103. FAMILYCARE COVERAGE OF PARENTS UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) Incentives To Implement FamilyCare Coverage.—

(1) Under Medicaid.—


(i) by striking “or” at the end of subclause (XVII);

(ii) by adding “or” at the end of subclause (XVIII); and

(iii) by adding at the end the following:
“(XIX) who are individuals described in subsection (k)(1) (relating to parents of categorically eligible children);”.

(B) PARENTS DESCRIBED.—Section 1902 of the Social Security Act is further amended by inserting after subsection (j) the following:

“(k)(1)(A) Individuals described in this paragraph are individuals—

“(i) who are the parents of an individual who is under 19 years of age (or such higher age as the State may have elected under section 1902(l)(1)(D)) and who is eligible for medical assistance under subsection (a)(10)(A);

“(ii) who are not otherwise eligible for medical assistance under such subsection or under a waiver approved under section 1115 or otherwise (except under section 1931 or under subsection (a)(10)(A)(ii)(XIX)); and

“(iii) whose family income or resources exceeds the effective income level or resource level applicable under the State plan under part A of title IV as in effect as of July 16, 1996, but does not exceed the highest effective income or resource level (if any) applicable to a child in the family under this title.
“(B) In establishing an income eligibility level for individuals described in this paragraph, a State may vary such level consistent with the various income levels established under subsection (l)(2) in order to ensure, to the maximum extent possible, that such individuals shall be enrolled in the same program as their children.

“(C) An individual may not be treated as being described in this paragraph unless, at the time of the individual’s enrollment under this title, the child referred to in subparagraph (A)(i) of the individual is also enrolled under this title or otherwise insured.

“(D) In this subsection, the term ‘parent’ includes an individual treated as a caretaker for purposes of carrying out section 1931.

“(E) In this subsection, the term ‘effective income level’ means the income level expressed as a percent of the poverty line and considering applicable income disregards.

“(2) The State shall provide for coverage of a parent described in paragraph (1) or section 2111 of a child who is covered under this title or title XXI under the same title as the title as such child is covered. In the case of a parent described in paragraph (1) who is also the parent of a child who is eligible for child health assistance under title XXI, the State may elect (on a uniform basis) to
cover all such parents under section 2111 or under this title.”.

(C) ENHANCED MATCHING FUNDS AVAILABLE IF CERTAIN CONDITIONS MET.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(i) in the fourth sentence of subsection (b), by striking “or subsection (u)(3)” and inserting “, (u)(3), or (u)(4)”;

and

(ii) in subsection (u)—

(I) by redesignating paragraph (4) as paragraph (6), and

(II) by inserting after paragraph (3) the following:

“(4) For purposes of subsection (b) and section 2105(a)(1):

“(A) FAMILYCARE PARENTS.—The expenditures described in this subparagraph are the expenditures described in the following clauses (i) and (ii):

“(i) PARENTS.—If the conditions described in clauses (iii) and (iv) are met, expenditures for medical assistance for parents described in section 1902(k)(1) and for parents who would be described in such section but for the fact
that they are eligible for medical assistance under section 1931 or under a waiver approved under section 1115.

“(ii) CERTAIN PREGNANT WOMEN.—If the conditions described in clause (v) are met, expenditures for medical assistance for pregnant women described in subsection (n) or under section 1902(l)(1)(A) in a family the income of which exceeds the effective income level applicable under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 to a family of the size involved as of January 1, 2004.

“(iii) CONDITIONS RELATING TO ENSURING CHILDREN’S COVERAGE FOR ENHANCED MATCH FOR PARENTS.—The conditions described in this clause are the following:

“(I) The State has a State child health plan under title XXI which (whether implemented under such title or under this title) has an effective income level for children that is at least 200 percent of the poverty line.

“(II) Such State child health plan does not limit the acceptance of applications, does not use a waiting list for chil-
dren who meet eligibility standards to qualify for assistance, and provides benefits to all children in the State who apply for and meet eligibility standards.

“(III) Effective for determinations of eligibility made on or after the date that is 1 year after the date of the enactment of this clause, the application and renewal procedures for individuals under 19 years of age (or such higher age as the State has elected under section 1902(l)(1)(D)) for medical assistance under section 1902(a)(10)(A) are not be more restrictive or burdensome than such procedures used for children with higher income under the State child health plan under title XXI.

“(iv) CONDITIONS RELATING TO MINIMUM COVERAGE FOR PARENTS FOR ENHANCED MATCH FOR PARENTS.—The conditions described in this clause are the following:

“(I) The State does not apply an income level for parents that is lower than the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title
XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of January 1, 2004, to be eligible for medical assistance as a parent under this title.

“(II) The State plans under this title and title XXI do not provide coverage for parents with higher family income without covering parents with a lower family income.

“(v) CONDITIONS FOR ENHANCED MATCH FOR CERTAIN PREGNANT WOMEN.—The conditions described in this clause are the following:

“(I) The State has established an effective income eligibility level for pregnant women under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902 that is at least 185 percent of the poverty line.

“(II) The State plans under this title and title XXI do not provide coverage for pregnant women described in subparagraph (A)(ii) with higher family income without covering such pregnant women with a lower family income.
“(III) The State does not apply an income level for pregnant women that is lower than the effective income level that has been specified under the State plan under subsection (a)(10)(A)(i)(III) or (l)(2)(A) of section 1902, as of January 1, 2004, to be eligible for medical assistance as a pregnant woman.

“(IV) The State satisfies the conditions described in subclauses (I) and (II) of clause (iii).

“(vi) DEFINITIONS.—For purposes of this subsection:

“(I) The term ‘parent’ has the meaning given such term for purposes of section 1902(k)(1).

“(II) The term ‘poverty line’ has the meaning given such term in section 2110(e)(5).”.

(D) APPROPRIATION FROM TITLE XXI ALLOTMENT FOR CERTAIN MEDICAID EXPANSION COSTS.—Section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)) is amended—

(i) in paragraph (1), by redesignating subparagraphs (B) through (D) as sub-
paragraphs (C) through (E), respectively, and by inserting after subparagraph (A) the following new subparagraph:

“(B) for medical assistance that is attributable to expenditures described in section 1905(u)(4)(A);”;

(ii) in paragraph (2), by adding at the end the following new subparagraph:

“(E) Fifth, for expenditures for items described in paragraph (1)(E).”.

(2) UNDER TITLE XXI.—

(A) FAMILYCARE COVERAGE.—Title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

“SEC. 2111. OPTIONAL FAMILYCARE COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN.

“(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of parent health assistance for targeted low-income parents, health care assistance for targeted low-income pregnant women, or both, in accordance with this section, but only if—
“(1) with respect to the provision of parent
health assistance, the State meets the conditions de-
scribed in clause (iii) of section 1905(u)(4)(A);

“(2) with respect to the provision of health care
assistance for pregnant women, the State meets the
conditions described in clause (iv) of section
1905(u)(4)(A); and

“(3) in the case of parent health assistance for
targeted low-income parents, the State elects to pro-
vide medical assistance under section
1902(a)(10)(A)(ii)(XIX), under section 1931, or
under a waiver under section 1115 to individuals de-
scribed in section 1902(k)(1)(A)(i) and elects an ef-
effective income level that, consistent with paragraphs
(1)(B) and (2) of section 1902(k), ensures to the
maximum extent possible, that such individuals shall
be enrolled in the same program as their children if
their children are eligible for coverage under title
XIX (including under a waiver authorized by the
Secretary or under section 1902(r)(2)).

“(b) DEFINITIONS.—For purposes of this title:

“(1) PARENT HEALTH ASSISTANCE.—The term
‘parent health assistance’ has the meaning given the
term child health assistance in section 2110(a) as if
any reference to targeted low-income children were
a reference to targeted low-income parents.

“(2) PARENT.—The term ‘parent’ has the
meaning given the term ‘caretaker relative’ for pur-
poses of carrying out section 1931.

“(3) HEALTH CARE ASSISTANCE FOR PREG-
NANT WOMEN.—The term ‘health care assistance for
pregnant women’ has the meaning given the term
child health assistance in section 2110(a) as if any
reference to targeted low-income children were a ref-
ence to targeted low-income pregnant women.

“(4) TARGETED LOW-INCOME PARENT.—The
term ‘targeted low-income parent’ has the meaning
given the term targeted low-income child in section
2110(b) as if the reference to a child were deemed
a reference to a parent (as defined in paragraph (3))
of the child; except that in applying such section—

“(A) there shall be substituted for the in-
come level described in paragraph (1)(B)(ii)(I)
the applicable income level in effect for a tar-
geted low-income child;

“(B) in paragraph (3), January 1, 2004,
shall be substituted for July 1, 1997; and

“(C) in paragraph (4), January 1, 2004,
shall be substituted for March 31, 1997.
“(5) Targeted low-income pregnant woman.—The term ‘targeted low-income pregnant woman’ has the meaning given the term targeted low-income child in section 2110(b) as if any reference to a child were a reference to a woman during pregnancy and through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends; except that in applying such section—

“(A) there shall be substituted for the income level described in paragraph (1)(B)(ii)(I) the applicable income level in effect for a targeted low-income child;

“(B) in paragraph (3), January 1, 2004, shall be substituted for July 1, 1997; and

“(C) in paragraph (4), January 1, 2004, shall be substituted for March 31, 1997.

“(c) References to terms and special rules.—In the case of, and with respect to, a State providing for coverage of parent health assistance to targeted low-income parents or health care assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

“(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is
deemed to include a reference to a targeted low-income parent or a targeted low-income pregnant woman (as applicable).

“(2) Any such reference to child health assistance—

“(A) with respect to such parents is deemed a reference to parent health assistance; and

“(B) with respect to such pregnant women, is deemed a reference to health care assistance for pregnant women.

“(3) In applying section 2103(e)(3)(B) in the case of a family (consisting of a parent and one or more children) provided coverage under this section or a pregnant woman provided coverage under this section without covering other family members, the limitation on total annual aggregate cost-sharing shall be applied to such entire family or such pregnant woman, respectively.

“(4) In applying section 2110(b)(4), any reference to ‘section 1902(l)(2) or 1905(n)(2) (as selected by a State)’ is deemed a reference to the effective income level applicable to parents under section 1931 or under a waiver approved under section
1115, or, in the case of a pregnant woman, the income level established under section 1902(l)(2)(A).

“(5) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to parents and pregnant women.”.

(B) ADDITIONAL ALLOTMENT FOR STATES PROVIDING FAMILYCARE.—

(i) In general.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by inserting after subsection (c) the following:

“(d) ADDITIONAL ALLOTMENTS FOR STATE PROVIDING FAMILYCARE.—

“(1) Appropriation; total allotment.—For the purpose of providing additional allotments to States to provide FamilyCare coverage under section 2111, there is appropriated, out of any money in the Treasury not otherwise appropriated—

“(A) for fiscal year 2004, $2,000,000,000;
“(B) for fiscal year 2005, $2,000,000,000;
“(C) for fiscal year 2006, $3,000,000,000;

and

“(D) for fiscal year 2007, $3,000,000,000.
“(2) State and territorial allotments.—

“(A) In general.—In addition to the allotments provided under subsections (b) and (e), subject to paragraphs (3) and (4), of the amount available for the additional allotments under paragraph (1) for a fiscal year, the Secretary shall allot to each State with a State child health plan approved under this title—

“(i) in the case of such a State other than a commonwealth or territory described in clause (ii), the same proportion as the proportion of the State’s allotment under subsection (b) (determined without regard to subsection (f)) to 98.95 percent of the total amount of the allotments under such section for such States eligible for an allotment under this subparagraph for such fiscal year; and

“(ii) in the case of a commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth’s or territory’s allotment under subsection (e) (determined without regard to subsection (f)) to 1.05 percent of the total amount of the allotments under
such section for commonwealths and territories eligible for an allotment under this subparagraph for such fiscal year.

“(B) AVAILABILITY AND REDISTRIBUTION OF UNUSED ALLOTMENTS.—In applying subsections (e) and (f) with respect to additional allotments made available under this subsection, the procedures established under such subsections shall ensure such additional allotments are only made available to States which have elected to provide coverage under section 2111.

“(3) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are not available for amounts expended before October 1, 2003. Such amounts are available for amounts expended on or after such date for child health assistance for targeted low-income children, as well as for parent health assistance for targeted low-income parents, and health care assistance for targeted low-income pregnant women.

“(4) REQUIRING ELECTION TO PROVIDE COVERAGE.—No payments may be made to a State under this title from an allotment provided under this subsection unless the State has made an election to provide parent health assistance for targeted
low-income parents, or health care assistance for targeted low-income pregnant women.”.

(ii) CONFORMING AMENDMENTS.—

Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(I) in subsection (a), by inserting “subject to subsection (d),” after “under this section,”;

(II) in subsection (b)(1), by inserting “and subsection (d)” after “Subject to paragraph (4);” and

(III) in subsection (c)(1), by inserting “subject to subsection (d),” after “for a fiscal year,”.

(C) NO COST-SHARING FOR PREGNANCY-RELATED BENEFITS.—Section 2103(e)(2) of the Social Security Act (42 U.S.C. 1397cc(e)(2)) is amended—

(i) in the heading, by inserting “AND PREGNANCY-RELATED SERVICES” after “PREVENTIVE SERVICES”; and

(ii) by inserting before the period at the end the following: “and for pregnancy-related services”.

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(3) EFFECTIVE DATE.—The amendments made by this subsection apply to items and services furnished on or after October 1, 2003, whether or not regulations implementing such amendments have been issued.

(b) RULES FOR IMPLEMENTATION BEGINNING WITH FISCAL YEAR 2005.—

(1) EXPANSION OF AVAILABILITY OF ENHANCED MATCH UNDER MEDICAID FOR PRE-CHIP EXPANSIONS.—Paragraph (4) of section 1905(u) of the Social Security Act (42 U.S.C. 1396d(u)), as inserted by subsection (a)(1)(C), is amended—

(A) by amending clause (ii) of subparagraph (A) to read as follows:

“(ii) CERTAIN PREGNANT WOMEN.—Expenditures for medical assistance for pregnant women under section 1902(l)(1)(A) in a family the income of which exceeds the 133 percent of the income official poverty line, but only if the income level established under section 1902(l)(2) (or under a Statewide waiver under section 1115) for pregnant women is 185 percent of the income official poverty line.”; and

(B) by adding at the end the following:
“(B) Children in families with income above Medicaid mandatory level not previously described.—The expenditures described in this subparagraph are expenditures (other than expenditures described in paragraph (2) or (3)) for medical assistance made available to any child who is eligible for assistance under section 1902(a)(10)(A) (other than under clause (i)) and the income of whose family exceeds the minimum income level required under subsection 1902(l)(2) (or, if higher, the minimum level required under section 1931 for that State) for a child of the age involved (treating any child who is 19 or 20 years of age as being 18 years of age).”.

(2) Offset of additional expenditures for enhanced match for Pre-Chip expansion.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in the fourth sentence of subsection (b), by inserting “(except in the case of expenditures described in subsection (u)(5))” after “do not exceed”;

(B) in subsection (u), by inserting after paragraph (4) (as inserted by subparagraph (C)), the following:
“(5) For purposes of the fourth sentence of subsection (b) and section 2105(a), the following payments under this title do not count against a State’s allotment under section 2104:

“(A) **Regular FMAP for expenditures for pregnant women with income above 133 percent of poverty.**—The portion of the payments made for expenditures described in paragraph (4)(A)(ii) that represents the amount that would have been paid if the enhanced FMAP had not been substituted for the Federal medical assistance percentage.

“(B) **FamilyCare Parents.**—Payments for expenditures described in paragraph (4)(A)(i).

“(C) **Regular FMAP for expenditures for certain children in families with income above Medicaid mandatory level.**—The portion of the payments made for expenditures described in paragraph (4)(B) that represents the amount that would have been paid if the enhanced FMAP had not been substituted for the Federal medical assistance percentage.”.

(B) **Conforming Amendments.**—Subparagraph (B) of section 2105(a)(1) of the So-
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...
(2) REPORT.—Not later than July 1, 2005, the
Comptroller General shall submit a report on the
study conducted under paragraph (1). Such report
shall include recommendations regarding a better
mechanism for determining State allotments and re-
distribution of unspent funds under such title in
order to ensure all eligible families in need can ac-
cess coverage through such title.

(d) CONFORMING AMENDMENTS.—

(1) ELIGIBILITY CATEGORIES.—Section
1905(a) of the Social Security Act (42 U.S.C.
1396d(a)) is amended, in the matter before para-
graph (1)—

(A) by striking “or” at the end of clause
(xii);

(B) by inserting “or” at the end of clause
(xiii); and

(C) by inserting after clause (xiii) the fol-
lowing:

“(xiv) who are parents described (or treated as
if described) in section 1902(k)(1),”.

(2) INCOME LIMITATIONS.—Section 1903(f)(4)
of the Social Security Act (42 U.S.C. 1396b(f)(4))
is amended by inserting “1902(a)(10)(A)(ii)(XIX),”
after “1902(a)(10)(A)(ii)(XVIII),”.
(3) Conforming Amendment relating to no waiting period for pregnant women.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) by striking ‘‘, and’’ at the end of clause (i) and inserting a semicolon;

(B) by striking the period at the end of clause (ii) and inserting ‘‘; and’’; and

(C) by adding at the end the following:

‘‘(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income parent who is pregnant.’’.

SEC. 104. AUTOMATIC ENROLLMENT OF CHILDREN BORN TO TITLE XXI PARENTS.

Section 2102(b)(1) of the Social Security Act (42 U.S.C. 1397bb(b)(1)) is amended by adding at the end the following:

‘‘(C) Automatic eligibility of children born to a parent being provided familycare.—Such eligibility standards shall provide for automatic coverage of a child born to an individual who is provided assistance under this title in the same manner as medical assistance would be provided under section
1902(e)(4) to a child described in such section.”.

SEC. 105. OPTIONAL COVERAGE OF CHILDREN THROUGH AGE 20 UNDER THE MEDICAID PROGRAM AND TITLE XXI.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1902(l)(1)(D) of the Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting “(or, at the election of a State, 20 or 21 years of age)” after “19 years of age”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(e)(3)(A) of the Social Security Act (42 U.S.C. 1396a(e)(3)(A)) is amended by inserting “(or 1 year less than the age the State has elected under subsection (l)(1)(D))” after “18 years of age”.

(B) Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended by inserting “or such higher age as the State has elected under subsection (l)(1)(D)” after “19 years of age”.

(C) Section 1920A(b)(1) of the Social Security Act (42 U.S.C. 1396r–1a(b)(1)) is amended by inserting “or such higher age as
the State has elected under section 1902(l)(1)(D)” after “19 years of age”.

(D) Section 1928(h)(1) of the Social Security Act (42 U.S.C. 1396s(h)(1)) is amended by inserting “or 1 year less than the age the State has elected under section 1902(l)(1)(D)” before the period at the end.

(E) Section 1932(a)(2)(A) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting “(or such higher age as the State has elected under section 1902(l)(1)(D))” after “19 years of age”.

(b) Title XXI.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by inserting “(or such higher age as the State has elected under section 1902(l)(1)(D))”.

(c) Effective Date.—The amendments made by this section take effect on January 1, 2004, and apply to medical assistance and child health assistance provided on or after such date, whether or not regulations implementing such amendments have been issued.

SEC. 106. ALLOWING STATES TO SIMPLIFY RULES FOR FAMILIES.

(a) Presumptive Eligibility.—
(1) Application to presumptive eligibility for pregnant women under Medicaid.—Section 1920(b) of the Social Security Act (42 U.S.C. 1396r–1(b)) is amended by adding at the end after and below paragraph (2) the following flush sentence:

“The term ‘qualified provider’ includes a qualified entity as defined in section 1920A(b)(3).”.

(2) Optional application of presumptive eligibility provisions to parents.—Section 1920A of the Social Security Act (42 U.S.C. 1396r–1a) is amended by adding at the end the following:

“(e) A State may elect to apply the previous provisions of this section to provide for a period of presumptive eligibility for medical assistance for a parent of a child with respect to whom such a period is provided under this section.”.

(3) Application under title xxl.—Section 2107(e)(1)(D) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

“(D) Sections 1920 and 1920A (relating to presumptive eligibility).”.

(b) 12-Months continuous eligibility.—
(1) **MEDICAID.**—Section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)) is amended—

(A) by striking “At the option of the State, the plan may” and inserting “The plan shall”;

(B) by striking “an age specified by the State (not to exceed 19 years of age)” and inserting “19 years of age (or such higher age as the State has elected under subsection (l)(1)(D)) or, at the option of the State, who is eligible for medical assistance as the parent of such a child”; and

(C) in subparagraph (A), by striking “a period (not to exceed 12 months)” and inserting “the 12-month period beginning on the date”.

(2) **TITLE XXI.**—Section 2102(b)(2) of such Act (42 U.S.C. 1397bb(b)(2)) is amended by adding at the end the following: “Such methods shall provide continuous eligibility for children under this title in a manner that is no less generous than the 12-months continuous eligibility provided under section 1902(e)(12) for children described in such section under title XIX. If a State has elected to apply section 1902(e)(12) to parents, such methods may
provide continuous eligibility for parents under this
title in a manner that is no less generous than the
12-months continuous eligibility provided under such
section for parents described in such section under
title XIX.”.

(3) EFFECTIVE DATE.—The amendments made
by this subsection shall take effect on July 1, 2004
(or, if later, 60 days after the date of the enactment
of this Act), whether or not regulations imple-
menting such amendments have been issued.

(c) PROVISION OF MEDICAID AND CHIP APPLICA-
TIONS AND INFORMATION UNDER THE SCHOOL LUNCH
PROGRAM.—Section 9(b)(2)(B) of the Richard B. Russell
National School Lunch Act (42 U.S.C. 1758(b)(2)(B)) is
amended—

(1) by striking “(B) Applications” and inserting
“(B)(i) Applications”; and

(2) by adding at the end the following:
“(ii)(I) Applications for free and reduced price
lunches that are distributed pursuant to clause (i) to par-
ents or guardians of children in attendance at schools par-
ticipating in the school lunch program under this Act shall
also contain information on the availability of medical as-
sistance under title XIX of the Social Security Act (42
U.S.C. 1396 et seq.) and of child health and FamilyCare
assistance under title XXI of such Act, including informa-
tion on how to obtain an application for assistance under
such programs.

“(II) Information on the programs referred to in sub-
clause (I) shall be provided on a form separate from the
application form for free and reduced price lunches under
clause (i).”.

SEC. 107. DEMONSTRATION PROGRAMS TO IMPROVE MED-
ICAID AND CHIP OUTREACH TO HOMELESS
INDIVIDUALS AND FAMILIES.

(a) AUTHORITY.—The Secretary of Health and
Human Services may award demonstration grants to not
more than 7 States (or other qualified entities) to conduct
innovative programs that are designed to improve out-
reach to homeless individuals and families under the pro-
grams described in subsection (b) with respect to enroll-
ment of such individuals and families under such pro-
grams and the provision of services (and coordinating the
provision of such services) under such programs.

(b) PROGRAMS FOR HOMELESS DESCRIBED.—The
programs described in this subsection are as follows:

(1) MEDICAID.—The program under title XIX
of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) CHIP.—The program under title XXI of
the Social Security Act (42 U.S.C. 1397aa et seq.).
(3) TANF.—The program under part of A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(4) SAMHSA BLOCK GRANTS.—The program of grants under part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–1 et seq.).

(5) FOOD STAMP PROGRAM.—The program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(6) WORKFORCE INVESTMENT ACT.—The program under the Workforce Investment Act of 1999 (29 U.S.C. 2801 et seq.).

(7) WELFARE-TO-WORK.—The welfare-to-work program under section 403(a)(5) of the Social Security Act (42 U.S.C. 603(a)(5)).

(8) OTHER PROGRAMS.—Other public and private benefit programs that serve low-income individuals.

(c) APPROPRIATIONS.—For the purposes of carrying out this section, there is appropriated for fiscal year 2004, out of any funds in the Treasury not otherwise appropriated, $10,000,000, to remain available until expended.

SEC. 108. ADDITIONAL CHIP REVISIONS.

(a) LIMITING COST-SHARING TO 2.5 PERCENT FOR FAMILIES WITH INCOME BELOW 150 PERCENT OF POV-
ERTY.—Section 2103(e)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(e)(3)(A)) is amended—

(1) by striking “and” at the end of clause (i);
(2) by striking the period at the end of clause (ii) and inserting “; and”;
(3) by adding at the end the following new clause:

“(iii) total annual aggregate cost-sharing described in clauses (i) and (ii) with respect to all such targeted low-income children in a family under this title that exceeds 2.5 percent of such family’s income for the year involved.”.

(b) EMPLOYER COVERAGE WAIVER CHANGES.—Section 2105(c)(3) of such Act (42 U.S.C. 1397ee(c)(3)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii) and indenting appropriately;
(2) by designating the matter beginning with “Payment may be made” as a subparagraph (A) with the heading “IN GENERAL” and indenting appropriately; and
(3) by adding at the end the following new subparagraph:
“(B) APPLICATION OF REQUIREMENTS.—

In carrying out subparagraph (A)—

“(i) in determining cost-effectiveness, the Secretary shall measure against family coverage costs to the extent that a State has expanded coverage to parents pursuant to section 2111;

“(ii) subject to clause (iii), the State shall provide satisfactory assurances that the minimum benefits and cost-sharing protections established under this title are provided, either through the coverage under subparagraph (A) or as a supplement to such coverage; and

“(iii) coverage under such subparagraph shall not be considered to violate clause (ii) because it does not comply with requirements relating to reviews of health service decisions if the enrollee involved is provided the option of being provided benefits directly under this title.”.

(c) EFFECTIVE DATE.—The amendments made by this section apply as of January 1, 2004, whether or not regulations implementing such amendments have been issued.
SEC. 109. COORDINATION OF TITLE XXI WITH THE MATERIAL AND CHILD HEALTH PROGRAM.

(a) In General.—Section 2102(b)(3) of the Social Security Act (42 U.S.C. 1397bb(b)(3)) is amended—

(1) in subparagraph (D), by striking “and” at the end;

(2) in subparagraph (E), by striking the period and inserting “; and”; and

(3) by adding at the end the following new sub-

paragraph:

“(F) that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting.”.

(b) Conforming Medicaid Amendment.—Section 1902(a)(11) of such Act (42 U.S.C. 1396a(a)(11)) is amended—

(1) by striking “and” before “(C)”; and

(2) by inserting before the semicolon at the end the following: “, and (D) provide that operations and activities under this title are developed and implemented in consultation and coordination with the
program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2004.

Subtitle B—State Option To Provide Coverage for All Residents With Income At or Below the Poverty Line

SEC. 121. STATE OPTION TO PROVIDE COVERAGE FOR ALL RESIDENTS WITH INCOME AT OR BELOW THE POVERTY LINE.

(a) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by striking “or” at the end of subclause (XVII);

(2) by adding “or” at the end of subclause (XVIII); and

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

“(XIX) any individual whose family income does not exceed 100
percent of the income 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 who is not otherwise eligible for medical assistance under this title;”.

(b) CONFORMING AMENDMENTS.—

(1) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter before paragraph (1)—

(A) by striking “or” at the end of clause (xii);

(B) by adding “or” at the end of clause (xiii); and

(C) by inserting after clause (xiii) the following new clause:

“(xii) individuals described in section 1902(a)(10)(A)(ii)(XIX),”.

(c) **Effective Date.**—The amendments made by this section shall take effect on October 1, 2004.

### Subtitle C—Optional Coverage of Legal Immigrants under the Medicaid Program and Title XXI

#### SEC. 131. EQUAL ACCESS TO HEALTH COVERAGE FOR LEGAL IMMIGRANTS.

(a) **In General.**—Section 401(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)(1)) is amended—

- (1) by striking subparagraph (A) and inserting the following:
  
  “(A) Medical assistance under title XIX of the Social Security Act.”; and

- (2) by adding at the end the following:
  
  “(F) Child health assistance under title XXI of the Social Security Act.”.

(b) **Conforming Amendments.**—

- (1) Section 402(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)) is amended—

  - (A) in paragraph (2)—
    - (i) in subparagraph (A)—
      - (I) by striking clause (i);
(II) by redesignating clause (ii)
as subparagraph (A) and realigning
the margins accordingly; and

(III) by redesignating subclauses
(I) through (V) of subparagraph (A),
as so redesignated, as clauses (i)
through (v), respectively and realign-
ing the margins accordingly; and

(ii) by striking subparagraphs (E) and

(F); and

(B) in paragraph (3), by striking subpara-
graph (C).

(2) Section 403 of the Personal Responsibility
and Work Opportunity Reconciliation Act of 1996 (8
U.S.C. 1613)) is amended—

(A) in subsection (e), by adding at the end
the following:

“(M) Child health assistance provided
under title XXI of the Social Security Act.”;
and

(B) in subsection (d)(1), by striking “pro-
grams specified in subsections (a)(3) and
(b)(3)(C)” and inserting “program specified in
subsection (a)(3)”.

(3) Section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631) is amended by adding at the end the following:

“(g) EXCEPTIONS.—This section shall not apply to—

“(1) medical assistance provided under a State plan approved under title XIX of the Social Security Act; and

“(2) child health assistance provided under title XXI of the Social Security Act.”.

(4) Section 423(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding at the end the following:

“(12) Child health assistance provided under title XXI of the Social Security Act.”.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on the date of enactment of this Act and apply to medical assistance provided under title XIX of the Social Security Act and child health assistance provided under title XXI of the Social Security Act on or after that date.

(2) REQUIREMENTS FOR SPONSOR’S AFFIDAVIT OF SUPPORT.—Section 423(d) of the Personal Re-
responsibility and Work Opportunity Reconciliation
Act of 1996 shall be applied as if the amendments
made by this Act were enacted on December 1,
2002.

Subtitle D—Indian Healthcare
Funding

CHAPTER 1—GUARANTEED FUNDING

SEC. 141. GUARANTEED ADEQUATE FUNDING FOR INDIAN
HEALTHCARE.

Section 825 of the Indian Health Care Improvement
Act (25 U.S.C. 1680o) is amended to read as follows:

“SEC. 825. FUNDING.

“(a) IN GENERAL.—Notwithstanding any other pro-
vision of law, not later than 30 days after the date of en-
actment of this section, on October 1, 2003, and on each
October 1 thereafter, out of any funds in the Treasury
not otherwise appropriated, the Secretary of the Treasury
shall transfer to the Secretary to carry out this title the
amount determined under subsection (d).

“(b) USE AND AVAILABILITY.—

“(1) IN GENERAL.—An amount transferred
under subsection (a)—

“(A) shall remain available until expended;

and
“(B) shall be used to carry out any programs, functions, and activities relating to clinical services (as defined in paragraph (2)) of the Service and Service units.

“(2) CLINICAL SERVICES DEFINED.—For purposes of paragraph (1)(B), the term ‘clinical services’ includes all programs of the Indian Health Service which are funded directly or under the authority of the Indian Self-Determination and Education Assistance Act, for the purposes of—

“(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

“(B) preventive health, including mammography and other cancer screening;

“(C) dental care;

“(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers;

“(E) emergency medical services;

“(F) treatment and control of, and rehabilitative care related to, alcoholism and drug
abuse (including fetal alcohol syndrome) among
Indians;
“(G) accident prevention programs;
“(H) home healthcare;
“(I) community health representatives;
“(J) maintenance and repair; and
“(K) traditional healthcare practices and
training of traditional healthcare practitioners.
“(c) RECEIPT AND ACCEPTANCE.—The Secretary
shall be entitled to receive, shall accept, and shall use to
carry out this title the funds transferred under subsection
(a), without further appropriation.
“(d) AMOUNT.—The amount referred to in sub-
section (a) is—
“(1) for fiscal year 2004, the amount equal to
390 percent of the amount obligated by the Service
during fiscal year 2002 for the purposes described in
subsection (b)(2); and
“(2) for fiscal year 2005 and each fiscal year
thereafter, the amount equal to the product obtained
by multiplying—
“(A) the number of Indians served by the
Service as of September 30 of the preceding the
fiscal year; and
“(B) the per capita baseline amount, as determined under subsection (e).

“(e) PER CAPITA BASELINE AMOUNT.—

“(1) IN GENERAL.—For the purpose of subsection (d)(2)(B), the per capita baseline amount shall be equal to the sum of—

“(A) the quotient obtained by dividing—

“(i) the amount specified in subsection (d)(1); by

“(ii) the number of Indians served by the Service as of September 30, 2002; and

“(B) any applicable increase under paragraph (2).

“(2) INCREASE.—For each fiscal year, the Secretary shall provide a percentage increase (rounded to the nearest dollar) in the per capita baseline amount equal to the percentage by which—

“(A) the Consumer Price Index for all Urban Consumers published by the Department of Labor (relating to the United States city average for medical care and not seasonally adjusted) for the 1-year period ending on the June 30 of the fiscal year preceding the fiscal year for which the increase is made; exceeds
“(B) that Consumer Price Index for the 1-year period preceding the 1-year period described in subparagraph (A).”.

CHAPTER 2—INDIAN HEALTHCARE PROGRAMS

SEC. 145. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

The Service shall provide funds for healthcare programs and facilities operated by Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act on the same basis as such funds are provided to programs and facilities operated directly by the Service.

SEC. 146. LICENSING.

Healthcare professionals employed by Indian tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

SEC. 147. AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES.

With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services...
from a non-Service provider or in a non-Service facility
under the authority of the Indian Health Care Improve-
ment Act, the time limitation (as a condition of payment)
for notifying the Service of such treatment or admission
shall be 30 days.

SEC. 148. PROMPT ACTION ON PAYMENT OF CLAIMS.
(a) REQUIREMENT.—The Service shall respond to a
notification of a claim by a provider of a contract care
service with either an individual purchase order or a denial
of the claim within 5 working days after the receipt of
such notification.
(b) FAILURE TO RESPOND.—If the Service fails to
respond to a notification of a claim in accordance with
subsection (a), the Service shall accept as valid the claim
submitted by the provider of a contract care service.
(c) PAYMENT.—The Service shall pay a valid contract
care service claim within 30 days after the completion of
the claim.

SEC. 149. LIABILITY FOR PAYMENT.
(a) NO LIABILITY.—A patient who receives contract
healthcare services that are authorized by the Service shall
not be liable for the payment of any charges or costs asso-
ciated with the provision of such services.
(b) NOTIFICATION.—The Secretary shall notify a
contract care provider and any patient who receives con-
tract healthcare services authorized by the Service that
such patient is not liable for the payment of any charges
or costs associated with the provision of such services.

(c) LIMITATION.—Following receipt of the notice pro-
vided under subsection (b), or, if a claim has been deemed
accepted under section 154(b), the provider shall have no
further recourse against the patient who received the serv-
ices involved.

SEC. 150. HEALTH SERVICES FOR INELIGIBLE PERSONS.

(a) INELIGIBLE PERSONS.—

(1) IN GENERAL.—Any individual who—

(A) has not attained 19 years of age;

(B) is the natural or adopted child, step-
child, foster-child, legal ward, or orphan of an
eligible Indian; and

(C) is not otherwise eligible for the health
services provided by the Service,
shall be eligible for all health services provided by
the Service on the same basis and subject to the
same rules that apply to eligible Indians until such
individual attains 19 years of age. The existing and
potential health needs of all such individuals shall be
taken into consideration by the Service in deter-
mining the need for, or the allocation of, the health
resources of the Service. If such an individual has
been determined to be legally incompetent prior to attaining 19 years of age, such individual shall re-
main eligible for such services until one year after the date such disability has been removed.

(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services pro-
vided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the Indian tribe being served are made eligible, as a class, by an appropriate reso-
lution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(b) PROGRAMS AND SERVICES.—

(1) PROGRAMS.—

(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other
subsection of this section or under any other provision of law if—

(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

(II) there is no reasonable alternative health program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under such funding agreement is authorized to deter-
mine whether health services should be provided
under such funding agreement to individuals
who are not eligible for such health services
under any other subsection of this section or
under any other provision of law. In making
such determinations, the governing body of the
Indian tribe or tribal organization shall take
into account the considerations described in
subparagraph (A)(ii).

(2) LIABILITY FOR PAYMENT.—

(A) IN GENERAL.—Persons receiving
health services provided by the Service by rea-
son of this subsection shall be liable for pay-
ment of such health services under a schedule
of charges prescribed by the Secretary which, in
the judgment of the Secretary, results in reim-
bursement in an amount not less than the ac-
tual cost of providing the health services. Not-
withstanding section 1880 of the Social Secu-
ritv Act or any other provision of law, amounts
collected under this subsection, including medi-
Care or medicaid reimbursements under titles
XVIII and XIX of the Social Security Act, shall
be credited to the account of the program pro-
viding the service and shall be used solely for
the provision of health services within that pro-
gram. Amounts collected under this subsection
shall be available for expenditure within such
program for not to exceed 1 fiscal year after
the fiscal year in which collected.

(B) Services for indigent persons.—
Health services may be provided by the Sec-
retary through the Service under this sub-
section to an indigent person who would not be
eligible for such health services but for the pro-
visions of paragraph (1) only if an agreement
has been entered into with a State or local gov-
ernment under which the State or local govern-
ment agrees to reimburse the Service for the
expenses incurred by the Service in providing
such health services to such indigent person.

(3) Service areas.—

(A) Service to only one tribe.—In the
case of a service area which serves only one In-
dian tribe, the authority of the Secretary to
provide health services under paragraph (1)(A)
shall terminate at the end of the fiscal year suc-
ceeding the fiscal year in which the governing
body of the Indian tribe revokes its concurrence
to the provision of such health services.
(B) Multi-tribal Areas.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

(e) Purpose for Providing Services.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

(1) achieve stability in a medical emergency;

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

(3) provide care to non-Indian women pregnant with an eligible Indian’s child for the duration of the pregnancy through post partum; or

(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

(d) Hospital Privileges.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian
Self-Determination Education Assistance Act may be extended to non-Service healthcare practitioners who provide services to persons described in subsection (a) or (b). Such non-Service healthcare practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

(e) DEFINITION.—In this section, the term “eligible Indian” means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

SEC. 151. DEFINITIONS.

For purposes of this chapter, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.

SEC. 152. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this chapter.
Subtitle E—Territories

SEC. 161. FUNDING FOR TERRITORIES.

(a) Temporary Elimination of Spending Cap.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking “subsection (g)” and inserting “subsections (g) and (h)”; and

(2) by adding at the end the following:

“(h) Temporary Elimination of Caps.—With respect to each of fiscal years 2004 through 2007, the Secretary shall make payments under title XIX to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa without regard to the limitations on the amount of such payments imposed under subsections (f) and (g).”.

(b) Temporary Increase in FMAP.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by inserting “(except that, only with respect to fiscal years 2004 through 2007 and only for purposes of expenditures under this title, such percentage shall be 77 percent)” after “50 per centum”.

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Subtitle F—Migrant Workers and Farmworkers Health

SEC. 171. DEMONSTRATION PROJECT REGARDING CONTINUITY OF COVERAGE OF MIGRANT WORKERS AND FARMWORKERS UNDER MEDICAID AND CHIP.

(a) Authority To Conduct Demonstration Project.—

(1) In general.—The Secretary of Health and Human Services shall conduct a demonstration project for the purpose of evaluating methods for strengthening the health coverage of, and continuity of coverage of, migrant workers and farmworkers under the medicaid and State children’s health insurance programs (42 U.S.C. 1396 et seq., 1397aa et seq.).

(2) Waiver authority.—The Secretary of Health and Human Services shall waive compliance with the requirements of titles XI, XIX, and XXI of the Social Security Act (42 U.S.C. 1301 et seq., 1396 et seq., 1397aa et seq.) to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project under this section.
(b) Requirements.—The demonstration project conducted under this section shall provide for—

(1) uniform eligibility criteria under the medicaid and State children’s health insurance programs with respect to migrant workers and farmworkers; and

(2) the portability of coverage of such workers under those programs between participating States.

(c) Report.—Not later than March 31, 2005, the Secretary of Health and Human Services shall submit a report to Congress on the demonstration project conducted under this section that contains such recommendations for legislative action as the Secretary determines is appropriate.

Subtitle G—Expanded Access to Health Care

SEC. 181. NATIONAL COMMISSION FOR EXPANDED ACCESS TO HEALTH CARE.

(a) Establishment.—There is established a commission to be known as the National Commission for Expanded Access to Health Care (referred to in this section as the “Commission”).

(b) Appointment of Members.—

(1) In general.—Not later than 45 days after the date of enactment of this Act—
(A) the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall each appoint 7 members of the Commission; and

(B) the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall appoint 1 member of the Commission.

(2) CRITERIA.—Members of the Commission shall include representatives of the following:

(A) Consumers of health insurance.

(B) Health care professionals.

(C) State and territorial officials.

(D) Health economists.

(E) Health care providers.

(F) Experts on health insurance.

(G) Experts on expanding health care to individuals who are uninsured.

(H) Experts on the elimination of racial and ethnic health disparities.

(I) Experts on health care in the United States territories.

(3) CHAIRPERSON.—At the first meeting of the Commission, the Commission shall select a Chairperson from among its members.
(c) MEETINGS.—

(1) IN GENERAL.—After the initial meeting of the Commission, which shall be called by the Secretary, the Commission shall meet at the call of the Chairperson.

(2) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(3) SUPERMAJORITY VOTING REQUIREMENT.—To approve a report required under paragraph (1), (2), or (3) of subsection (e), at least 60 percent of the membership of the Commission must vote in favor of such a report.

(d) DUTIES.—The Commission shall—

(1) assess the effectiveness of programs designed to expand health care coverage or make health care coverage affordable to uninsured individuals by identifying the accomplishments and needed improvements of each program;

(2) make recommendations regarding the benefits and cost-sharing that should be included in health care coverage for various groups, taking into account—

(A) the special health care needs of children and individuals with disabilities;
(B) the different ability of various populations to pay out-of-pocket costs for services;

(C) incentives for efficiency and cost-containment;

(D) racial and ethnic disparities in health status and health care;

(E) incremental changes to the United States health care delivery system and changes to achieve fundamental restructuring of the system;

(F) populations who are traditionally more difficult to cover, including immigrants and homeless persons;

(G) preventive care, diagnostic services, disease management services, and other factors;

(H) quality improvement initiatives among health institutions serving disadvantaged patient populations; and

(I) the feasibility of and barriers to the development of a comprehensive system of health care;

(3) recommend mechanisms to expand health care coverage to uninsured individuals;

(4) recommend automatic enrollment and retention procedures and other measures to increase
health care coverage among those eligible for assistance; and

(5) analyze the size, effectiveness, and efficiency of current tax and other subsidies for health care coverage and recommend improvements.

(e) Reports.—

(1) Annual reports.—The Commission shall submit annual reports to the President and the appropriate committees of Congress addressing the matters identified in subsection (d).

(2) Biennial report.—The Commission shall submit biennial reports to the President and the appropriate committees of Congress containing—

(A) recommendations concerning essential benefits and maximum out-of-pocket cost-sharing for—

(i) the general population; and

(ii) individuals with limited ability to pay; and

(B) proposed legislative language to implement such recommendations.

(3) Commission report.—Not later than January 15, 2007, the Commission shall submit a report to the President and the appropriate committees of Congress, which shall include—
(A) recommendations on policies to provide health care coverage to uninsured individuals;

(B) recommendations on changes to policies enacted under this Act; and

(C) proposed legislative language to implement such recommendations.

(f) ADMINISTRATION.—

(1) POWERS.—

(A) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(B) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(C) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other
departments and agencies of the Federal Gov-
ernment.

(D) GIFTS.—The Commission may accept,
use, and dispose of donations of services or
property.

(2) COMPENSATION.—

(A) IN GENERAL.—Each member of the
Commission who is not an officer or employee
of the Federal Government shall be com-
pensated at a rate equal to the daily equivalent
of the annual rate of basic pay prescribed for
level IV of the Executive Schedule under section
5315 of title 5, United States Code, for each
day (including travel time) during which such
member is engaged in the performance of duties
of the Commission. All members of the Com-
mission who are officers or employees of the
United States shall serve without compensation
in addition to that received for their services as
officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of
the Commission shall be allowed travel ex-
penses, as authorized by the Chairperson of the
Commission, including per diem in lieu of sub-
sistence, at rates authorized for employees of
agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF.—

(A) IN GENERAL.—The Chairperson of the Commission may appoint an executive director such other staff as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) STAFF COMPENSATION.—The Chairperson of the Commission may fix the compensation of personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(C) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without
interruption or loss of civil service status or privilege.

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

(g) TERMINATION.—Except with respect to activities in connection with the ongoing biennial report required under subsection (e)(2), the Commission shall terminate 90 days after the date on which the Commission submits the report required under subsection (e)(3).

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for fiscal year 2005 and each subsequent fiscal year.
TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTHCARE

SEC. 201. AMENDMENT TO 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 XXIX—MINORITY HEALTH

“SEC. 2900. DEFINITIONS.

“In this title, the definitions contained in section 801 of the Healthcare Equality and Accountability Act shall apply.

“Subtitle A—Culturally and Linguistically Appropriate Healthcare

“SEC. 2901. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

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

“(1) to improve access to Federally conducted and Federally assisted programs and activities for individuals who are limited in their English proficiency;

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

“(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide meaningful access to their limited English proficient applicants and beneficiaries;

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

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

“(b) Federally Conducted Programs and Activities.—

“(1) In general.—Not later than 120 days after the date of enactment of this Act, each Federal agency that carries out health care-related activities shall prepare a plan to improve access to the feder-
ally conducted health care-related programs and ac-
tivities of the agency by limited English proficient
individuals.

“(2) PLAN REQUIREMENT.—Each plan under
paragraph (1) shall be consistent with the standards
set forth in section 204 of the Healthcare Equality
and Accountability Act, and shall include the steps
the agency will take to ensure that limited English
proficient individuals have access to the agency’s
health care-related programs and activities. Each
agency shall send a copy of such plan to the Depart-
ment of Justice, which shall serve as the central re-
pository of the agencies’ plans.

“(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
ties.—

“(1) IN GENERAL.—Not later than 120 days
after the date of enactment of this Act, each Federal
agency providing health care-related Federal finan-
cial assistance shall ensure that the guidance for re-
cipients of Federal financial assistance developed by
the agency to ensure compliance with title VI of the
Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.)
is specifically tailored to the recipients of such as-
sistance and is consistent with the standards de-
scribed in section 204 of the Healthcare Equality
and Accountability Act. Each agency shall send a copy of such guidance to the Department of Justice which shall serve as the central repository of the agencies’ plans. After approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

“(2) REQUIREMENTS.—The agency-specific guidance developed under paragraph (1) shall—

“(A) detail how the general standards established under section 204 of the Healthcare Equality and Accountability Act will be applied to the agency’s recipients; and

“(B) take into account the types of health care services provided by the recipients, the individuals served by the recipients, and other factors set out in such standards.

“(3) EXISTING GUIDANCES.—A Federal agency that has developed a guidance for purposes of title VI of the Civil Rights Act of 1964 that the Department of Justice determines is consistent with the standards described in section 204 of the Healthcare Equality and Accountability Act shall examine such existing guidance, as well as the programs and activities to which such guidance applies, to determine
if modification of such guidance is necessary to comply with this subsection.

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

“(d) CONSULTATIONS.—

“(1) IN GENERAL.—In carrying out this section, each Federal agency that carries out health care-related activities shall ensure that stakeholders, such as limited English proficient individuals and their representative organizations, recipients of Federal assistance, and other appropriate individuals or entities, have an adequate and comparable opportunity to provide input with respect to the actions of the agency.

“(2) EVALUATION OF NEEDS.—Each Federal agency described in paragraph (1) shall evaluate the particular needs of the limited English proficient individuals served by the agency, and by a recipient of assistance provided by the agency, and the burdens of compliance with the agency guidance and its recipients of the requirements of this section.
“SEC. 2902. NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTHCARE.

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

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

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

“(3) offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;
“(4) notify patients of their right to receive language assistance services in their primary language;

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

“(A) except in case of emergency; or

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

“(6) make available easily understood patient-related materials including information or notices about termination of benefits and post signage in the languages of the commonly encountered groups or groups represented in the service area of the organization;

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

“(8) conduct initial and ongoing organizational self-assessments of culturally and linguistically appropriate services-related activities and integrate cul-
tural and linguistic competence-related measures
into the internal audits, performance improvement
programs, patient satisfaction assessments, and out-
comes-based evaluations of the organization;

“(9) ensure that, consistent with the privacy
protections provided for under the regulations pro-
mulgated under section 264(c) of the Health Insur-
ance Portability and Accountability Act of 1996 (42
U.S.C. 1320d–2 note)—

“(A) data on the individual patient’s race,
etnicity, and primary language are collected in
health records, integrated into the organiza-
tion’s management information systems, and
periodically updated; and

“(B) if the patient is a minor or is inca-
pacitated, the primary language of the parent
or legal guardian is collected;

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

“(11) develop participatory, collaborative part-
nerships with communities and utilize a variety of
formal and informal mechanisms to facilitate com-
community and patient involvement in designing and im-
plementing culturally and linguistically appropriate
services-related activities;

“(12) ensure that conflict and grievance resolu-
tion processes are culturally and linguistically sen-
sitive and capable of identifying, preventing, and re-
solving cross-cultural conflicts or complaints by pa-
tients;

“(13) regularly make available to the public in-
formation about their progress and successful inno-
vations in implementing the standards under this
section and provide public notice in their commu-

nities about the availability of this information; and

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

“SEC. 2903. CENTER FOR CULTURAL AND LINGUISTIC COM-
PETENCE IN HEALTHCARE.

“(a) Establishment.—The Secretary, acting
through the Director of the Office of Minority Health,
shall establish and support a center to be known as the
‘Center for Cultural and Linguistic Competence in Healthcare’ (referred to in this section as the ‘Center’) to carry out the following activities:

“(1) Remote Medical Interpretation.—The Center shall provide remote medical interpretation, directly or through contract, at no cost to healthcare providers. Methods of interpretation may include remote, simultaneous or consecutive interpreting through telephonic systems, video conferencing, and other methods determined appropriate by the Secretary for patients with limited English proficiency. The quality of such interpretation shall be monitored and reported publicly. Nothing in this paragraph shall be construed to limit the ability of healthcare providers or organizations to provide medical interpretation services directly and obtain reimbursement for such services as provided for under the medicare, medicaid or SCHIP programs under titles XVIII, XIX, or XXI of the Social Security Act.

“(2) Translation of Written Material.—The Center shall provide, directly or through contract, for the translation of written materials for healthcare providers and healthcare organizations (as defined in section 2902(b)) at no cost to such
providers and organizations. Materials may be submitted for translation into non-English languages. Translation services shall be provided in a timely and reasonable manner. The quality of such translation shall be monitored and reported publicly.

“(3) Model Language Assistance Programs.—The Center shall provide for the collection and dissemination of information on current model language assistance programs and strategies to improve language access to healthcare for individuals with limited English proficiency, including case studies using de-identified patient information, program summaries, and program evaluations.

“(4) Medical Interpretation Guidelines.—

“(A) In general.—The Center shall convene a working group to develop quality guidelines and standards for the training of medical interpreters and translators. Such group shall include—

“(i) representatives from the Office of Minority Health, the National Center on Minority Health and Health Disparities, the Agency for Healthcare Research and Quality, the Centers for Medicare and
Medicaid Services, the Office for Civil Rights of the Department of Health and Human Services, and other Federal agencies determined appropriate by the Secretary; and

“(ii) representatives of communities with a significant proportion of limited English proficient individuals, professional interpreter associations, medical interpretation service providers, and other public or private organizations determined appropriate by the Secretary.

“(B) PUBLICATION.—Not later than 18 months after the date of enactment of this Act, the Center shall publish guidelines and standards developed under this paragraph in the Federal Register.

“(5) INTERNET HEALTH CLEARINGHOUSE.—The Center shall develop and maintain an Internet clearinghouse to reduce medical errors and healthcare costs caused by communication with individuals with limited English proficiency or low functional health literacy and reduce or eliminate the duplication of effort to translate materials by—
“(A) developing and making available templates for standard documents that are necessary for patients and consumers to access and make educated decisions about their healthcare, including—

“(i) administrative and legal documents such as 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; and

“(iii) patient education and outreach materials such as immunization notices, health warnings, or screening notices;

“(B) ensuring that the documents are posted in English and non-English languages and are culturally appropriate;

“(C) allowing public review of the documents before dissemination in order to ensure that the documents are understandable and culturally appropriate for the target populations;

“(D) allowing healthcare providers to customize the documents for their use;
“(E) facilitating access to these documents;

“(F) providing technical assistance with respect to the access and use of such information; and

“(G) carrying out any other activities the Secretary determines to be useful to fulfill the purposes of the Clearinghouse.

“(6) Provision of Information.—The Center shall provide information relating to culturally and linguistically competent healthcare for minority populations residing in the United States to all healthcare providers and healthcare organizations at no cost. Such information shall include—

“(A) tenets of culturally and linguistically competent care;

“(B) cultural and linguistic competence self-assessment tools;

“(C) cultural and linguistic competence training tools;

“(D) strategic plans to increase cultural and linguistic competence in different types of healthcare organizations; and
“(E) resources for cultural competence information for educators, practitioners and researchers.

“(b) DIRECTOR.—The Center shall be headed by a Director to be appointed by the Director of the Office of Minority Health who shall report to the Director of the Office of Minority Health.

“(c) AVAILABILITY OF LANGUAGE ACCESS.—The Director shall collaborate with the Administrator of the Centers for Medicare and Medicaid Services and the Administrator of the Health Resources and Services Administration, to notify healthcare providers and healthcare organizations about the availability of language access services by the Center.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2005 through 2010.

“SEC. 2904. INNOVATIONS IN LANGUAGE ACCESS GRANTS.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Centers for Medicare and Medicaid Services, the Administrator of the Health Resources and Services Administration, and the Director of the Office of Minority Health, shall award grants to eligible entities to enable such entities to design, implement, and
evaluate innovative, cost-effective programs to improve linguistic access to healthcare for individuals with limited English proficiency.

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

“(1) be a city, county, Indian tribe, State, territory, community-based nonprofit organization, health center or community clinic, university, college, or other entity designated by the Secretary; and

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

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

“(1) develop, implement, and evaluate models of providing real-time interpretation services through in-person interpretation, communications, and computer technology, including the Internet, teleconferencing, or video conferencing;

“(2) develop short-term medical interpretation training courses and incentives for bilingual healthcare staff who are asked to interpret in the workplace;
“(3) develop formal training programs for individuals interested in becoming dedicated healthcare interpreters;

“(4) provide language training courses for healthcare staff;

“(5) provide basic healthcare-related English language instruction for limited English proficient individuals; and

“(6) develop other language assistance services as determined appropriate by the Secretary.

“(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to entities that have developed partnerships with organizations or agencies with experience in language access services.

“(e) EVALUATION.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes the activities carried out with funds received under the grant, and how such activities improved access to healthcare services and the quality of healthcare for individuals with limited English proficiency. Such evaluation shall be collected and disseminated through the Center for Linguistic and Cultural Competence in Healthcare established under section 2903.

“(f) GRANTEE CONVENTION.—The Secretary, acting through the Director of the Center for Linguistic and Cul-
tural Competence in Healthcare, shall at the end of the
grant cycle convene grantees under this section to share
findings and develop and disseminate model programs and
practices.

“(g) 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
2005 through 2010.

“SEC. 2905. RESEARCH ON LANGUAGE ACCESS.

“(a) IN GENERAL.—The Secretary, acting through
the Director of the Agency for Healthcare Research and
Quality, shall expand research concerning—

“(1) the barriers to healthcare services that are
faced by limited English proficient individuals;

“(2) the impact of language barriers on the
quality of healthcare and the health status of limited
English proficient individuals and populations;

“(3) healthcare provider attitudes, knowledge,
and awareness of the barriers described in para-
graphs (1) and (2); and

“(4) the means by which oral or written lan-
guage interpretation services are provided to limited
English proficient individuals and whether such serv-
ices are effective in improving the quality of care.
“(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 2005 through 2010.

“SEC. 2906. TOLL-FREE TELEPHONE NUMBER.

“The Secretary shall provide, through a toll-free number, for a means by which limited English proficient individuals who are seeking information about, or assistance with, Federal healthcare programs who phone such toll-free number are transferred (without charge) to appropriate translators for the provision of such information or assistance.”.

SEC. 203. STANDARDS FOR LANGUAGE ACCESS SERVICES.

Not later than 120 days after the date of enactment of this Act, the head of each Federal agency that carries out health care-related activities shall develop and adopt a guidance on language services for those with limited English proficiency who attempt to have access to or participate in such activities that provides at the minimum the factors and principles set forth in the Department of Justice guidance published on June 12, 2002.
SEC. 204. FEDERAL REIMBURSEMENT FOR CULTURALLY
AND LINGUISTICALLY APPROPRIATE SERV-
ICES UNDER THE MEDICARE, MEDICAID AND
STATE CHILDREN'S HEALTH INSURANCE
PROGRAM.

(a) Demonstration Project Promoting Access
for Medicare Beneficiaries With Limited English
Proficiency.—

(1) In General.—The Secretary shall conduct
a demonstration project (in this section referred to
as the ‘project’) to demonstrate the impact on costs
and health outcomes of providing reimbursement for
interpreter services to certain medicare beneficiaries
who are limited English proficient in urban and
rural areas.

(2) Scope.—The Secretary shall carry out the
project in not less than 30 States through contracts
with up to—

(A) ten health plans (under part C of title
XVIII of the Social Security Act);

(B) ten small providers; and

(C) ten hospitals.

(3) Duration.—Each contract entered into
under the project shall extend over a period of not
longer than 2 years.
(4) Report.—Upon completion of the project, the Secretary shall submit a report to Congress on the project which shall include recommendations regarding the extension of such project to the entire medicare program.

(5) Evaluation.—The Director of the Agency for Healthcare Research and Quality shall award grants to public and private nonprofit entities for the evaluation of the project. Such evaluations shall focus on access, utilization, efficiency, cost-effectiveness, patient satisfaction, and select health outcomes.

(b) Medicaid.—Section 1903(a)(3) of the Social Security Act (42 U.S.C. 1396b(a)(3)) is amended—

(1) in subparagraph (D), by striking “plus” at the end and inserting “and”; and

(2) by adding at the end the following:

“(E) 90 percent of the sums expended with respect to costs incurred during such quarter as are attributable to the provision of culturally and linguistically appropriate services, including oral interpretation, translations of written materials, and other cultural and linguistic services for individuals with limited English proficiency and disabilities who apply for, or receive, med-
ical assistance under the State plan (including
any waiver granted to the State plan); plus’’.

(c) SCHIP.—Section 2105(a)(1) of the Social Secu-

rity Act (42 U.S.C.1397ee(a)), as amended by section

515, is amended—

(1) in the matter preceding subparagraph (A),

by inserting “or, in the case of expenditures de-
scribed in subparagraph (D)(iv), 90 percent” after

“enhanced FMAP”; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking “and” at the

end;

(B) by redesignating clause (iv) as clause

(v); and

(C) by inserting after clause (iii) the fol-

lowing:

“(iv) for expenditures attributable to

the provision of culturally and linguistically

appropriate services, including oral inter-

pretation, translations of written materials,

and other language services for individuals

with limited English proficiency and dis-

abilities who apply for, or receive, child

health assistance under the plan; and”.

• HR 3459 IH
(d) Effective Date.—The amendments made by this section take effect on October 1, 2005.

SEC. 205. INCREASING UNDERSTANDING OF HEALTH LITERACY.

(a) In General.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities to improve healthcare for patient populations that have low functional health literacy.

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

(1) be a hospital, health center or clinic, health plan, or other health entity; and

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

(c) Use of Funds.—

(1) Agency for Healthcare Research and Quality.—Grants awarded under subsection (a) through the Agency for Healthcare Research and Quality shall be used—

(A) to define and increase the understanding of health literacy;
(B) to investigate the correlation between low health literacy and health and healthcare;

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

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

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

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

(B) the tailoring of existing disease management programs for patients with low health literacy;

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

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

(E) the conduct of educational campaigns for patients and providers about low health literacy; and
(F) other activities determined appropriate by the Administrator of the Health Resources and Services Administration.

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

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

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

Not later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the preparation and publication of a report that describes federal efforts to ensure that all individuals have meaningful access to culturally and linguistically appropriate healthcare services. Such report shall include—

(1) a description and evaluation of the activities carried out under this title; and
(2) a description of best practices, model programs, guidelines, and other effective strategies for providing access to culturally and linguistically appropriate healthcare services.

SEC. 207. GENERAL ACCOUNTING OFFICE REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States shall examine, and prepare and publish a report on, the impact of language access services on the health and healthcare of limited English proficient populations. Such report shall include—

(1) recommendations on the development and implementation of policies and practices by healthcare organizations and providers for limited English proficient patient populations;

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

(3) a description of the costs associated with or savings related to provision of language access services.
TITLE III—HEALTH WORKFORCE DIVERSITY

SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXIX of the Public Health Service Act, as added by section 202, is amended by adding at the end the following:

“Subtitle B—Workforce Diversity

“SEC. 2911. REPORT ON WORKFORCE DIVERSITY.

“(a) In General.—Not later than July 1, 2006, and biannually thereafter, the Secretary, acting through the director of each entity within the Department of Health and Human Services, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on health workforce diversity.

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

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

“(A) the number of grants made;

“(B) the purpose of the grants;
“(C) the populations served through the grants;

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

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

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

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

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

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

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

“(E) the impact that the Government Performance and Results Act (GPRA) has had on evaluating the performance of grantees and
whether the GPRA is the best assessment tool for programs under titles VII and VIII.

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

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

“SEC. 2912. NATIONAL WORKING GROUP ON WORKFORCE DIVERSITY.

“(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Professions within the Health Resources and Services Administration, shall award a grant to an entity determined appropriate by the Secretary for the establishment of a national working group on workforce diversity.

“(b) REPRESENTATION.—In establishing the national working group under subsection (a), the grantee shall ensure that the group has representation from the following entities:

“(1) The Health Resources and Services Administration.

“(2) The Department of Health and Human Services Data Council.

“(4) The Public Health Practice Program Office—Office of Workforce Policy and Planning.

“(5) The National Center on Minority Health and Health Disparities.


“(7) The Institute of Medicine Study Committee for the 2004 workforce diversity report.

“(8) The Indian Health Service.

“(9) Academic institutions.

“(10) Consumer organizations.

“(11) Health professional associations, including those that represent underrepresented minority populations.

“(12) Researchers in the area of health workforce.

“(13) Health workforce accreditation entities.

“(14) Private foundations that have sponsored workforce diversity initiatives.

“(15) Not less than 5 health professions students representing various health profession fields and levels of training.

“(c) ACTIVITIES.—The working group established under subsection (a) shall convene at least twice each year to complete the following activities:
“(1) Review current public and private health workforce diversity initiatives.

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

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

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

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

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

“(7) Develop curriculum guidelines for diversity training.

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

“(9) Other activities determined appropriate by the Secretary.
“(d) ANNUAL REPORT.—Not later than 1 year after
the establishment of the working group under subsection
(a), and annually thereafter, the working group shall pre-
pare and make available to the general public for com-
ment, an annual report on the activities of the working
group. Such report shall include the recommendations of
the working group for improving health workforce diver-
sity.

“(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
2005 through 2010.

“SEC. 2913. TECHNICAL CLEARINGHOUSE FOR HEALTH
WORKFORCE DIVERSITY.

“(a) IN GENERAL.—The Secretary, acting through
the Office of Minority Health, and in collaboration with
the Bureau of Health Professions within the Health Re-
sources and Services Administration, shall establish a
technical clearinghouse on health workforce diversity with-
in the Office of Minority Health and coordinate current
and future clearinghouses.

“(b) INFORMATION AND SERVICES.—The clearing-
house established under subsection (a) shall offer the fol-
lowing information and services:
“(1) Information on the importance of health workforce diversity.

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

“(3) Model health workforce diversity practices and programs.

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

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

“(6) Foundation and other large organizational initiatives relating to health workforce diversity.

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

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.
“SEC. 2914. EVALUATION OF WORKFORCE DIVERSITY INITIATIVES.

“(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Professions within the Health Resources and Services Administration, shall award grants to eligible entities for the conduct of an evaluation of current health workforce diversity initiatives funded by the Department of Health and Human Services.

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

“(1) be a city, county, Indian tribe, State, territory, community-based nonprofit organization, health center, university, college, or other entity determined appropriate by the Secretary;

“(2) with respect to an entity that is not an academic medical center, university, or private research institution, carry out activities under the grant in partnership with an academic medical center, university, or private research institution; and

“(3) 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 awarded under a grant under subsection (a) shall be used to support the following evaluation activities:
“(1) Determinations of measures of health workforce diversity success.

“(2) The short- and long-term tracking of participants in health workforce diversity pipeline programs funded by the Department of Health and Human Services.

“(3) Assessments of partnerships formed through activities to increase health workforce diversity.

“(4) Assessments of barriers to health workforce diversity.

“(5) Assessments of policy changes at the Federal, State, and local levels.

“(6) Assessments of coordination within and between Federal agencies and other institutions.

“(7) Other activities determined appropriate by the Secretary and the Working Group established under section 2912.

“(d) REPORT.—Not later than 1 year after the date of enactment of this title, the Bureau of Health Professions within the Health Resources and Services Administration shall prepare and make available for public comment a report that summarizes the findings made by entities under grants under this section.
“(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 2005 through 2010.

“SEC. 2915. DATA COLLECTION AND REPORTING BY HEALTH PROFESSIONAL SCHOOLS.

“(a) In General.—The Secretary, acting through the Bureau of Health Professions of the Health Resources and Services Administration and the Office of Minority Health, shall establish an aggregated database on health professional students.

“(b) Requirement To Collect Data.—Each health professional school (including medical, dental, and nursing schools) and allied health profession school and program that receives Federal funds shall collect race, ethnicity, and language proficiency data concerning those students enrolled at such schools or in such programs. In collecting such data, a school or program shall—

“(1) at a minimum, use the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available language standards; and
“(2) if practicable, collect data on additional population groups if such data can be aggregated into the minimum race and ethnicity data categories.

“(c) USE OF DATA.—Data on race, ethnicity, and primary language collected under this section shall be reported to the database established under subsection (a) on an annual basis. Such data shall be available for public use.

“(d) PRIVACY.—The Secretary shall ensure that all data collected under this section is protected from inappropriate internal and external use by any entity that collects, stores, or receives the data and that such data is collected without personally identifiable information.

“(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 2005 through 2010.

“SEC. 2916. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY.

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

“(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—
“(1) be an educational institution or entity that historically produces or trains meaningful numbers of underrepresented minority health professionals, including—

“(A) Historically Black Colleges and Universities;

“(B) Hispanic-Serving Health Professions Schools;

“(C) Hispanic-Serving Institutions;

“(D) Tribal Colleges and Universities;

“(E) Asian American and Pacific Islander-serving institutions;

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

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

“(H) institutions—

“(i) located in communities with predominantly underrepresented minority populations;
“(ii) with whom partnerships have been formed for the purpose of increasing workforce diversity; and

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

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

“(c) Use of Funds.—Amounts received under a grant under subsection (a) shall be used to expand existing workforce diversity programs, implement new workforce diversity programs, or evaluate existing or new workforce diversity programs. 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) post-baccalaureate programs;

“(4) academic enrichment programs, particularly targeting those who would not be competitive for health professions schools;
“(5) kindergarten through 12th grade and other health pipeline programs;

“(6) mentoring programs;

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

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

“(9) leadership training.

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

“(e) DEFINITION.—In this section, the term ‘Asian American and Pacific Islander-serving institutions’ means institutions—

“(1) that are eligible institutions under section 312(b) of the Higher Education Act of 1965; and

“(2) that, at the time of their application, have an enrollment of undergraduate students that is made up of at least 10 percent Asian American and Pacific Islander students.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years 2005 through 2010.

“SEC. 2917. 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 the Food and Drug Administration, and the Director of the Agency for Healthcare Research and Quality, shall award grants that expand existing opportunities for scientists and researchers and promote the inclusion of underrepresented minorities in the health professions.

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

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

“(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
retary shall establish a student loan reimbursement pro-
gram to provide student loan reimbursement assistance to
researchers who focus on minority health issues or minor-
ity racial and ethnic disparities in health. The Secretary
shall promulgate regulations to define the scope and pro-
cedures for the program under this subsection.

“(e) STUDENT LOAN CANCELLATION.—The Sec-
retary shall establish a student loan cancellation program
to provide student loan cancellation assistance to research-
ers who focus on minority health issues or minority racial
and ethnic disparities in health. Students participating in
the program shall make a minimum 5-year commitment
to work at an accredited health profession school. The Sec-
retary shall promulgate additional regulations to define
the scope and procedures for the program under this sub-
section.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There
is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2005 through 2010.

“SEC. 2918. CAREER SUPPORT FOR NON-RESEARCH
HEALTH PROFESSIONALS.

“(a) IN GENERAL.—The Secretary, acting through
the Director of the Centers for Disease Control and Pre-
vention, the Administrator of the Substance Abuse and
Mental Health Services Administration, the Administrator
of the Health Resources and Services Administration, and
the Administrator of the Centers for Medicare and Med-
icaid Services shall establish a program to award grants
to eligible individuals for career support in non-research-
related healthcare.

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

“(1) be a student in a health professions school,
a graduate of such a school who is working in a
health profession, or a faculty member of such a
school; and

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

“(c) USE OF FUNDS.—An individual shall use
amounts received under a grant under this section to—
“(1) support the individual’s health activities or projects that involve underserved communities, including racial and ethnic minority communities;

“(2) support health-related career advancement activities; and

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

“(d) DEFINITION.—In this section, the term ‘career in non-research-related healthcare’ means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, allied health, community health, or other fields determined appropriate by the Secretary, other than in a position that involves research.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

SEC. 2919. RESEARCH ON THE EFFECT OF WORKFORCE DIVERSITY ON QUALITY.

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

“(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; or
“(12) other topics determined appropriate by the Director.
“(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give individualized consideration to all relevant aspects of the applicant’s background. Consideration of prior research experience involving the health of underserved communities shall be such a factor.
“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

“SEC. 2920. HEALTH DISPARITIES EDUCATION PROGRAM.
“(a) ESTABLISHMENT.—The Secretary, acting through the National Center on Minority Health and Health Disparities and in collaboration with the Office of Minority Health, the Office for Civil Rights, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, and other appropriate public and private entities, shall establish and coordinate a health and healthcare disparities education program to support, develop, and implement educational initiatives and outreach
strategies that inform healthcare professionals and the public about the existence of and methods to reduce racial and ethnic disparities in health and healthcare.

“(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 healthcare, including disparities that are not otherwise attributable to known factors such as access to care, patient preferences, or appropriateness of intervention, as described in the 2002 Institute of Medicine Report, Unequal Treatment;

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

“(3) disseminate information about the impact of linguistic and cultural barriers on healthcare quality and the obligation of health providers who receive Federal financial assistance to ensure that people with limited English proficiency have access to language access services;
“(4) disseminate information about the importance and legality of racial, ethnic, 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 healthcare disparities and providing information on available resources.

“(c) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

“SEC. 2920A. CULTURAL COMPETENCE TRAINING FOR HEALTHCARE PROFESSIONALS.

“(a) In General.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, the Director of the Office of Minority Health, and the Director of the National Center for Minority Health and Health Disparities, shall award grants to eligible entities to test, implement, and evaluate models of cultural competence training for healthcare providers in coordination with the initiative under section 2920A(a).
“(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

“(1) be an academic medical center, a health center or clinic, a hospital, a health plan, or a health system;

“(2) partner with a minority serving institution, minority professional association, or community-based organization representing minority populations, in addition to a research institution to carry out activities under this grant; and

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

“(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.”.

SEC. 302. HEALTH CAREERS OPPORTUNITY PROGRAM.

(a) PURPOSE.—It is the purpose of this section to diversify the healthcare workforce by increasing the number of individuals from disadvantaged backgrounds in the health and allied health professions by enhancing the academic skills of students from disadvantaged backgrounds and supporting them in successfully competing, entering,
and graduating from health professions training programs.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 740(c) of the Public Health Service Act (42 U.S.C. 293d(c)) is amended by striking “$29,400,000” and all that follows through “2002” and inserting “$50,000,000 for fiscal year 2005, and such sums as may be necessary for each of fiscal years 2006 through 2010”.

SEC. 303. PROGRAM OF EXCELLENCE IN HEALTH PROFESSIONS EDUCATION FOR UNDERREPRESENTED MINORITIES.

(a) PURPOSE.—It is the purpose of this section to diversify the healthcare workforce by supporting programs of excellence in designated health professions schools that demonstrate a commitment to underrepresented minority populations with a focus on minority health issues, cultural and linguistic competence, and eliminating health disparities.

(b) AUTHORIZATION OF APPROPRIATION.—Section 737(h)(1) of the Public Health Service Act (42 U.S.C. 293(h)(1)) is amended to read as follows:

“(1) AUTHORIZATION OF APPROPRIATIONS.—

For the purpose of making grants under subsection (a), there are authorized to be appropriated $50,000,000 for fiscal year 2005, and such sums as
may be necessary for each of the fiscal years 2006 through 2010.”

SEC. 304. HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

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

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

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

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

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

“(2) has an enrollment of full-time equivalent students that is made up of at least 9 percent Hispanic students;
“(3) has been effective in carrying out programs to recruit Hispanic individuals to enroll in and graduate from the school;

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

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

SEC. 305. HEALTH PROFESSIONS STUDENT LOAN FUND; AUTHORIZATIONS OF APPROPRIATIONS REGARDING STUDENTS FROM DISADVANTAGED BACKGROUNDS.

Section 724(f)(1) of the Public Health Service Act (42 U.S.C. 292t(f)(1)) is amended by striking “$8,000,000” and all that follows and inserting “$35,000,000 for fiscal year 2005, and such sums as may be necessary for each of the fiscal years 2006 through 2010.”.

SEC. 306. NATIONAL HEALTH SERVICE CORPS; RECRUITMENT AND FELLOWSHIPS FOR INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS.

(a) In General.—Section 331(b) of the Public Health Service Act (42 U.S.C. 254d(b)) is amended by adding at the end the following:
“(3) The Secretary shall ensure that the individuals with respect to whom activities under paragraphs (1) and (2) are carried out include individuals from disadvantaged backgrounds, including activities carried out to provide health professions students with information on the Scholarship and Repayment Programs.”.

(b) ASSIGNMENT OF CORPS PERSONNEL.—Section 333(a) of the Public Health Service Act (42 U.S.C. 254f(a)) is amended by adding at the end the following:

“(4) In assigning Corps personnel under this section, the Secretary shall give preference to applicants who request assignment to a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act) or to a provider organization that has a majority of patients who are minorities or individuals from low-income families (families with a family income that is less than 200 percent of the Official Poverty Line).”.

SEC. 307. LOAN REPAYMENT PROGRAM OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

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

(1) by striking “and” after “1994,”; and

(2) by inserting before the period the following:

“$750,000 for fiscal year 2005, and such sums as
may be necessary for each of the fiscal years 2006 through 2010.”.

SEC. 308. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS AT SCHOOLS OF PUBLIC HEALTH AND SCHOOLS OF ALLIED HEALTH.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.), as amended by section 304, is further amended by adding at the end the following:

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

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

“(b) PRIORITY.—In awarding cooperative agreements under this section, the Secretary shall give priority to any school of public health or school of allied health that is located in a medically underserved community.
“(c) Requirements.—Awardees must design and implement an online degree program, that meet 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.

“(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 2005 through 2010.”.

SEC. 309. MID-CAREER HEALTH PROFESSIONS SCHOLARSHIP PROGRAM.

Part B of title VII of the Public Health Service Act (as amended by section 308) is further amended by adding at the end the following:

“SEC. 744. MID-CAREER HEALTH PROFESSIONS SCHOLARSHIP PROGRAM.

“(a) In General.—The Secretary may make grants to eligible schools for awarding scholarships to eligible individuals to attend the school involved, for the purpose of enabling the individuals to make a career change from a non-health profession to a health profession.
“(b) EXPENSES.—Amounts awarded as a scholarship under this section may be expended only for tuition exp-
senses, other reasonable educational expenses, and reason-
able living expenses incurred in the attendance of the school involved.

“(c) DEFINITIONS.—In this section:

“(1) ELIGIBLE SCHOOL.—The term ‘eligible school’ means a school of medicine, osteopathic med-
icine, dentistry, nursing (as defined in section 801), pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, or allied health, a school offering a graduate program in behavioral and mental health practice, or an entity providing programs for the training of physician assistants.

“(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible individual’ means an individual who has obtained a secondary school diploma or its recognized equiva-

“(d) PRIORITY.—In providing scholarships to eligible individuals, eligible schools shall give to individuals from disadvantaged backgrounds.

“(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 2005 through 2010.”.
SEC. 310. NATIONAL REPORT ON THE PREPAREDNESS OF HEALTH PROFESSIONALS TO CARE FOR DIVERSE POPULATIONS.

The Secretary of Health and Human Services shall include in the report prepared under section 1707(c) of the Public Health Service Act (as added by section 603 of this Act), information relating to the preparedness of health professionals to care for racially and ethnically diverse populations. Such information, which shall be collected by the Bureau of Health Professions, shall include—

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

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

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

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

(5) a description of model programs and practices.
SEC. 311. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.

Subtitle B of title XXIX of the Public Health Service Act, as amended by section 301, is further amended by adding at the end the following:

“SEC. 2920B. DAVID SATCHEL PUBLIC HEALTH AND HEALTH SERVICES CORPS.

“(a) IN GENERAL.—The Administrator of the Health Resources and Services Administration and Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority Health, shall award grants to eligible entities to increase awareness among post-primary and post-secondary 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 non-profit entity, or other entity determined appropriate by the Director of the Centers for Disease Control and Prevention;

“(2) serve a health professional shortage area, as determined by the Secretary;

“(3) work with students, including those from racial and ethnic minority backgrounds, that have expressed an interest in the health professions; and
“(4) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—Grant awards under subsection (a) shall be used to support internships that will increase awareness among students of non-research based and career opportunities in the following health professions:

“(1) Medicine.
“(2) Nursing.
“(3) Public Health.
“(4) Pharmacy.
“(5) Health Administration and Management.
“(6) Health Policy.
“(7) Psychology.
“(8) Dentistry.
“(9) International Health.
“(10) Social Work.
“(11) Allied Health.
“(12) Other professions deemed appropriate by the Director of the Centers for Disease Control and Prevention.

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

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

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

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

“(4) provide counseling or other services designed to assist disadvantaged individuals in successfully completing their education at the post-secondary level.

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

“(g) 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 2005 through 2010.
“SEC. 2920C. LOUIS STOKES PUBLIC HEALTH SCHOLARS PROGRAM.

“(a) In General.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority Health, shall award scholarships to postsecondary students who seek a career in public health.

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

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

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

“(3) have expressed an interest in public health;

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

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

“(6) comply with subsection (f); and

“(7) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.
“(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become public health professionals.

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

“(1) are from disadvantaged backgrounds;

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

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

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

“(f) REQUIREMENTS.—To be eligible to receive assistance under this section an individual shall—

“(1) have at minimum a grade point average of 2.75 at the time of entry to an entity described in
subsection (d)(2) and maintain such 2.75 average or above throughout their tenure at such institutions;

“(2) receive academic instruction that prepares the individual to enter the field of public health;

“(3) gain experience in public health through working at non-profit, community-based health facilities or at Federal, State, or local governmental healthcare institutions; and

“(4) meet at minimum twice a month with the identified health professions mentor.

“(g) 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 2005 through 2010.

“SEC. 2920D. 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 Director of the Office of Minority Health, the Administrator of the Substance Abuse and Mental Health Services Administration, and the Director of the Indian Health Services, shall award research fellowships to post-baccalaureate students to conduct research that will examine gender and health disparities and to pursue a career in the health professions.
“(b) Eligibility.—To be eligible to receive a fellowship under subsection (a) an individual shall—

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

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

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

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

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

“(6) comply with subsection (f); and

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

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

“(d) Priority.—In awarding grants under subsection (a), the Director of the Centers for Disease Con-
trol 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 (notwithstanding any other provision of law regarding the amount of fellowship).

“(f) REQUIREMENTS.—To be eligible to receive assistance under this section, an individual shall—

“(1) maintain a minimum a grade point average of 2.75 at the time of entry to an entity described in subsection (b)(5) and maintain a grade point average of 3.25 or above throughout their tenure at such institution;
“(2) undergo academic instruction to assist in
completion of the health professions or graduate de-
gree; and
“(3) attend twice-monthly meetings with an
academic advisor throughout the tenure of the fel-
lowship.
“(g) 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
2005 through 2010.

“SEC. 2920E. PAUL DAVID WELLSTONE INTERNATIONAL
HEALTH FELLOWSHIP PROGRAM.
“(a) IN GENERAL.—The Director of the Agency for
Healthcare Research and Quality, in collaboration with
the Director of the Office of Minority Health, shall award
research fellowships to college students or recent grad-
duates to advance their understanding of international
health.
“(b) ELIGIBILITY.—To be eligible to receive a fellow-
ship under subsection (a) an individual shall—
“(1) have educational experience in the field of
international health;
“(2) reside in a health professional shortage
area as determined by the Secretary;
“(3) demonstrate promise for becoming a leader in the field of international health;

“(4) be a college senior or recent graduate of a four year higher education institution;

“(5) comply with subsection (f); and

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

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

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

“(1) are from a disadvantaged background; and

“(2) have identified a mentor at a health professions school or institution, an academic advisor to assist in the completion of their graduate or professional degree, and an advisor from an international health Non-Governmental Organization, Private Volunteer Organization, or other international institution or program that focuses on increasing
healthcare access and quality for residents in developing countries.

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

“(f) REQUIREMENTS.—To be eligible to receive assistance under this section, an individual shall—

“(1) maintain a minimum grade point average of 2.75 at the time of application; and

“(2) undergo academic instruction in global health, and issues relating to access and quality of healthcare;

“(g) 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 2005 through 2010.

“SEC. 2920F. EDWARD R. ROYBAL HEALTHCARE SCHOLAR PROGRAM.

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

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

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

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

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

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

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

“(1) public health policy;

“(2) healthcare and pharmaceutical policy;
“(3) healthcare administration and management;

“(4) health economics; and

“(5) other professions determined appropriate by the Director of the Agency for Healthcare Research and Quality.

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

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

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

“(3) provide counseling or other services designed to assist such individuals in successfully completing their education at the post-secondary level.

“(e) STIPENDS.—The Secretary may approve the payment of stipends for individuals under this section for any period of education in student-enhancement programs (other than regular courses) at health professions schools or entities, except that such a stipend may not be provided to an individual for more than 2 months, and such a stipend may not exceed $100 per day (notwithstanding any other provision of law regarding the amount of stipends).
“(f) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2005 through 2010.”.

TITLE IV—REDUcing disease AND disease-related complications

Subtitle A—Eliminating disparities in prevention, detection, and treatment of disease

CHAPTER 1—GENERAL PROVISIONS

SEC. 401. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) In General.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations which have a higher than average risk for many chronic diseases and cancers.

(b) Participants.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;
(3) healthcare researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health and the National Institutes of Health; and

(5) other experts determined appropriate by the Secretary.

(c) Diseases.—Screening guidelines for minority populations shall be developed under subsection (a) for—

(1) hypertension;

(2) hypercholesterolemia;

(3) diabetes;

(4) cardiovascular disease;

(5) prostate cancer;

(6) breast cancer;

(7) colon cancer;

(8) kidney disease;

(9) glaucoma; and

(10) other diseases determined appropriate by the Secretary.

(d) Dissemination.—Not later than 24 months after the date of enactment of this title, the Secretary shall publish and disseminate to healthcare provider organizations the guidelines developed under subsection (a).
(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, sums as may be necessary for each of fiscal years 2005 through 2010.

SEC. 402. PREVENTIVE HEALTH SERVICES BLOCK GRANTS, USE OF ALLOTMENTS.

Section 1904(a)(1) of the Public Health Service Act (42 U.S.C. 300w–3(a)(1)) is amended—

(1) in subparagraph (G)—

(A) by striking “through (F)” and inserting “through (G)”;

(B) by redesignating such subparagraph as subparagraph (H); and

(2) by inserting after subparagraph (F), the following:

“(G) Community outreach and education programs and other activities designed to address and prevent minority health conditions (as defined in section 485E(c)(2)).”.

SEC. 403. PROGRAM FOR INCREASING IMMUNIZATION RATES FOR ADULTS AND ADOLESCENTS; COLLECTION OF ADDITIONAL IMMUNIZATION DATA.

(a) Activities of Centers for Disease Control and Prevention.—Section 317(j) of the Public Health
Service Act (42 U.S.C. 247b(j)) is amended by adding at the end the following paragraphs:

“(3)(A) For the purpose of carrying out activities toward increasing immunization rates for adults and adolescents through the immunization program under this subsection, and for the purpose of carrying out subsection (k)(2), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2004 through 2010. Such authorization is in addition to amounts available under paragraphs (1) and (2) for such purposes.

“(B) In expending amounts appropriated under subparagraph (A), the Secretary shall give priority to adults and adolescents who are medically underserved and are at risk for vaccine-preventable diseases, including as appropriate populations identified through projects under subsection (k)(2)(E).

“(C) The purposes for which amounts appropriated under subparagraph (A) are available include (with respect to immunizations for adults and adolescents) payment of the costs of storing vaccines, outreach activities to inform individuals of the availability of the immunizations, and other program expenses necessary for the establishment or operation of immunization programs carried
out or supported by States or other public entities pursuant to this subsection.

“(4) The Secretary shall annually submit to the Congress a report that—

“(A) evaluates the extent to which the immunization system in the United States has been effective in providing for adequate immunization rates for adults and adolescents, taking into account the applicable year 2010 health objectives established by the Secretary regarding the health status of the people of the United States; and

“(B) describes any issues identified by the Secretary that may affect such rates.

“(5) In carrying out this subsection and paragraphs (1) and (2) of subsection (k), the Secretary shall consider recommendations regarding immunizations that are made in reports issued by the Institute of Medicine.”.

(b) Research, Demonstrations, and Education.—Section 317(k) of the Public Health Service Act (42 U.S.C. 247b(k)) is amended—

(1) by redesignating paragraphs (2) through (4) as paragraphs (3) through (5), respectively; and

(2) by inserting after paragraph (1) the following paragraph:
“(2) The Secretary, directly and through grants under paragraph (1), shall provide for a program of research, demonstration projects, and education in accordance with the following:

“(A) The Secretary shall coordinate with public and private entities (including nonprofit private entities), and develop and disseminate guidelines, toward the goal of ensuring that immunizations are routinely offered to adults and adolescents by public and private health care providers.

“(B) The Secretary shall cooperate with public and private entities to obtain information for the annual evaluations required in subsection (j)(4)(A).

“(C) The Secretary shall (relative to fiscal year 2001) increase the extent to which the Secretary collects data on the incidence, prevalence, and circumstances of diseases and adverse events that are experienced by adults and adolescents and may be associated with immunizations, including collecting data in cooperation with commercial laboratories.

“(D) The Secretary shall ensure that the entities with which the Secretary cooperates for
purposes of subparagraphs (A) through (C) include managed care organizations, community-based organizations that provide health services, and other health care providers.

“(E) The Secretary shall provide for projects to identify racial and ethnic minority groups and other health disparity populations for which immunization rates for adults and adolescents are below such rates for the general population, and to determine the factors underlying such disparities.”.

SEC. 404. INNOVATIVE CHRONIC DISEASE MANAGEMENT PROGRAMS.

(a) IN GENERAL.—The Secretary, acting in coordination with the Administrator of the Centers for Medicare and Medicaid Services, the Administrator of the Health Resources and Services Administration, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, and the Director of the Office of Minority Health, shall award grants to eligible entities for the identification, implementation, and evaluation of programs for patients with chronic disease.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—
(1) be a health center or clinic, public health
department, health plan, hospital, health system,
community-based or non-profit organization, or
other health entity determined appropriate by the
Secretary; and

(2) prepare and submit to the Secretary an ap-
lication at such time, in such manner, and con-
taining such information as the Secretary may re-
quire.

(c) USE OF FUNDS.—An entity shall use amounts re-
ceived under a grant under subsection (a) to identify, im-
plement, and evaluate chronic disease management pro-
grams that are tailored for racially and ethnically diverse
populations. In carrying out such activities, an entity shall
focus on—

(1) self-management training;
(2) patient empowerment;
(3) group visits;
(4) community health workers;
(5) case management;
(6) work- and school-based interventions;
(7) home visitation; or
(8) other activities determined appropriate by
the Secretary.
(d) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2004 through 2010.

SEC. 405. GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.

(a) Purpose.—It is the purpose of this section to provide for the awarding of grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate disparities in health and healthcare experienced by racial and ethnic minority individuals.

(b) Authority To Award Grants.—The Secretary, acting through the Centers for Disease Control and Prevention and the Office of Minority Health, shall award planning, implementation, and evaluation grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based, and community-driven strategies to eliminate racial and ethnic health and healthcare disparities.

(c) Eligible Entities.—To be eligible to receive a grant under this section, an entity shall—

(1) represent a coalition—

(A) whose principal purpose is to develop and implement interventions to reduce or elimi-
nate a health or healthcare disparity in a tar-
geted racial or ethnic minority group in the
community served by the coalition; and
(B) that includes—
(i) at least 3 members selected from
among—
(I) public health departments;
(II) community-based organizations;
(III) university and/or research organizations;
(IV) Indian tribal organizations
or national Indian organizations;
(V) Papa Ola Lokahi; and
(VI) interested public or private sector healthcare providers or organi-
izations;
(ii) at least 1 member that is from a community-based organization that rep-
resents the targeted racial or ethnic minor-
ity group; and
(iii) at least 1 member that is a Na-
tional Center for Minority Health and Health Disparities Center of Excellence
(unless such a Center does not exist within
the community involved, declines or refuses to participate, or the coalition demonstrates to the Secretary that such participation would not further the goals of the program or would be unduly burdensome); and

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

(A) a description of the targeted racial or ethnic population in the community to be served under the grant;

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted population; and

(C) a demonstration of the proven record of accomplishment of the coalition members in serving and working with the targeted community.

(d) PLANNING GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants to eligible entities described in subsection (c) to support the planning and development of culturally and linguistically appropriate programs that utilize science-based and community-driven strate-
gies to reduce or eliminate a health or healthcare disparity in the targeted population. Such grants may be used to—

(A) expand the coalition that is represented by the entity through the identification of additional partners, particularly among the targeted community, and establish linkages with national and State public and private partners;

(B) establish community working groups;

(C) conduct a needs assessment for the targeted population in the area of the health disparity using input from the targeted community;

(D) participate in workshops sponsored by the Office of Minority Health or the Centers for Disease Control and Prevention for technical assistance, planning, evaluation, and other programmatic issues;

(E) identify promising intervention strategies; and

(F) develop a plan with the input of the targeted community that includes strategies for—

(i) implementing intervention strategies that have the most promising potential
for reducing the health disparity in the
target population;

(ii) identifying other sources of rev-

enue and integrating current and proposed

funding sources to ensure long-term sus-
tainability of the program; and

(iii) evaluating the program, including
collecting data and measuring progress to-
ward reducing or eliminating the health
disparity in the targeted population that
takes into account the evaluation model de-
veloped by the Centers for Disease Control
and Prevention in collaboration with the
Office of Minority Health.

(2) Duration.—The period during which pay-
ments may be made under a grant under paragraph
(1) shall not exceed 1 year, except where the Sec-
retary determines that extraordinary circumstances
exist as described in section 340(c)(3) of the Public
Health Service Act.

(e) Implementation Grants.—

(1) In general.—The Secretary shall award
grants to eligible entities that have received a plan-
ning grant under subsection (d) to enable such enti-
ty to—
(A) implement a plan to address the selected health disparity for the target population, in an effective and timely manner;

(B) collect data appropriate for monitoring and evaluating the program carried out under the grant;

(C) analyze and interpret data, or collaborate with academic or other appropriate institutions, for such analysis and collection;

(D) participate in conferences and workshops for the purpose of informing and educating others regarding the experiences and lessons learned from the project;

(E) collaborate with appropriate partners to publish the results of the project for the benefit of the public health community;

(F) establish mechanisms with other public or private groups to maintain financial support for the program after the grant terminates; and

(G) maintain relationships with local partners and continue to develop new relationships with State and national partners.

(2) DURATION.—The period during which payments may be made under a grant under paragraph (1) shall not exceed 4 years. Such payments shall be
subject to annual approval by the Secretary and to
the availability of appropriations for the fiscal year
involved.

(f) Evaluation Grants.—

(1) In General.—The Secretary shall award
grants to eligible entities that have received an im-
plementation grant under subsection (e) that require
additional assistance for the purpose of rigorous
data analysis, program evaluation (including process
and outcome measures), or dissemination of find-
ings.

(2) Priority.—In awarding grants under this
subsection, the Secretary shall give priority to—

(A) entities that in previous funding cy-
cles—

(i) have received a planning grant
under subsection (d); and

(ii) implemented activities of the type
described in subsection (e)(1);

(B) entities that fulfilled the goals of their
planning grant under subsection (d) in an espe-
cially timely manner;

(C) entities that incorporate best practices
or build on successful models in their action
plan, including the use of community health
workers; and

(D) entities that would enable the Sec-
retary to provide for an equitable distribution of
such grants among the 5 categories for race
and ethnicity described in the 1997 Office of
Management and Budget Standards for Main-
taining, Collecting, and Presenting Federal
Data on Race and Ethnicity.

(g) MAINTENANCE OF EFFORT.—The Secretary may
not award a grant to an eligible entity under this section
unless the entity agrees that, with respect to the costs to
be incurred by the entity in carrying out the activities for
which the grant was awarded, the entity (and each of the
participating partners in the coalition represented by the
entity) will maintain its expenditures of non-Federal funds
for such activities at a level that is not less than the level
of such expenditures during the fiscal year immediately
preceding the first fiscal year for which the grant is
awarded.

(h) TECHNICAL ASSISTANCE.—The Secretary may,
either directly or by grant or contract, provide any entity
that receives a grant under this section with technical and
other nonfinancial assistance necessary to meet the re-
quirements of this section.
(i) Administrative Burdens.—The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on grantees in the process of applying for grants under subsection (d), (e), or (f).

(j) Report.—Not later than September 30, 2007, the Secretary shall publish a report that describes the extent to which the activities funded under this section have been successful in reducing and eliminating disparities in health and healthcare in targeted populations, and provides examples of best practices or model programs funded under this section.

(k) Authorization of Appropriations.—There is authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2005 through 2010.

SEC. 406. IOM STUDY REQUEST.

(a) In General.—The Secretary of Health and Human Services shall request that the Institute of Medicine conduct, or contract with another entity to conduct, a study to investigate promising strategies for improving minority health and reducing and eliminating racial and ethnic disparities in health and healthcare.

(b) Content.—The study under subsection (a) shall—
(1) identify key stakeholders for intervention in the public and private sector;

(2) identify the barriers to eliminating racial and ethnic disparities in health and healthcare;

(3) explore approaches for addressing disparities in health and healthcare using a quality improvement framework;

(4) suggest an evaluation and research agenda that will advance effective strategies for reducing and eliminating racial and ethnic disparities in health and healthcare; and

(5) assess the capacity of the Department of Health and Human Services, as currently structured, to implement and evaluate promising strategies to improve minority health and reduce and eliminate racial and ethnic disparities in health and healthcare.

(c) AGENDA.—The agenda described in subsection (b)(4) shall include a focus on the following:

(1) Observational studies of race-discordant and race-concordant physician-patient clinical encounters.

(2) Studies of the behaviors and expressed attitudes toward race and ethnicity during education and training of health professionals.
(3) Expansion of prospective studies of disparities in care, combining clinical data with qualitative interviews with patients and providers.

(4) Studies of the natural history of social categorization in medical education and practice.

(5) Studies of the effectiveness of standard clinical guidelines in reducing disparities across disease categories.

(6) Exploration of health system characteristics that may contribute to or mitigate disparities in health care.

(7) Evaluation of cultural competency programs and their impact on the attitudes, knowledge, skills, and behaviors of healthcare providers.

(8) Expansion of community-participatory research with a focus on such topics as increasing trust and patient empowerment.

(9) Studies on appropriate indicators of socio-economic status, and methods for incorporating such indicators in patient records.

(10) Interventional studies designed to eliminate disparities.

(d) REPORT.—Not later than 24 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate commit-
tees of Congress a report containing the results of the study conducted under subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 and 2006.

SEC. 407. STRATEGIC PLAN.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall formulate a strategic plan for implementing the 2001 report by the Surgeon General of the Public Health Service entitled ‘Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General’ and the 2003 report by the President’s New Freedom Commission on Mental Health entitled ‘Achieving the Promise: Transforming Mental Health Care in America’.

(b) SUBMISSION.—Not later than 6 months after the date of the enactment of this title, the Secretary shall submit to the Congress the strategic plan formulated under this section.

CHAPTER 2—ENVIRONMENTAL JUSTICE

SEC. 410. SHORT TITLE; PURPOSES.

(a) SHORT TITLE.—This chapter may be cited as the “Environmental Justice Act of 2003”.
(b) PURPOSES.—The purposes of this chapter are—

(1) to ensure that all Federal health agencies develop practices that promote environmental jus-
tice;

(2) to provide minority, low-income, and Native American communities greater access to public in-
formation and opportunity for participation in deci-
sionmaking affecting human health and the environ-
ment; and

(3) to mitigate the inequitable distribution of the burdens and benefits of Federal programs hav-
ing significant impact on human health and the en-
vironment.

SEC. 411. DEFINITIONS.
For purposes of this chapter:

(1) ENVIRONMENTAL JUSTICE.—

(A) IN GENERAL.—The term “environment-
al justice” means the fair treatment of people of all races, cultures, and socioeconomic
groups with respect to the development, adop-
tion, implementation, and enforcement of laws, reg-
ulations, and policies affecting the environ-
ment.

(B) FAIR TREATMENT.—The term “fair

...
will minimize the likelihood that a minority, low-income, or Native American community will bear a disproportionate share of the adverse environmental consequences, or be denied reasonable access to the environmental benefits, resulting from implementation of a Federal program or policy.

(2) **Federal agency.**—The term “Federal agency” means—

(A) each Federal entity represented on the Working Group;

(B) any other entity that conducts any Federal program or activity that substantially affects human health or the environment; and

(C) each Federal agency that implements any program, policy, or activity applicable to Native Americans.

(3) **Working Group.**—The term “Working Group” means the interagency working group established by section 413.

(4) **Advisory Committee.**—The term “the Advisory Committee” means the advisory committee established by section 415.
SEC. 412. ENVIRONMENTAL JUSTICE RESPONSIBILITIES OF FEDERAL AGENCIES.

(a) Environmental Justice Mission.—To the greatest extent practicable, the head of each Federal agency shall make achieving environmental justice part of its mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of its programs, policies, and activities on minority and low-income populations in the United States and its territories and possessions, including the District of Columbia, the Commonwealth of Puerto Rico, Virgin Islands, Guam, and the Commonwealth of the Mariana Islands.

(b) Nondiscrimination.—Each Federal agency shall conduct its programs, policies, and activities in a manner that ensures that such programs, policies, and activities do not have the effect of excluding any person or group from participation in, denying any person or group the benefits of, or subjecting any person or group to discrimination under, such programs, policies, and activities, because of race, color, national origin, or income.

SEC. 413. INTERAGENCY ENVIRONMENTAL JUSTICE WORKING GROUP.

(a) Creation and Composition.—There is hereby established the Interagency Working Group on Environ-
mental Justice, comprising the heads of the following executive agencies and offices, or their designees:

(1) The Department of Defense.
(2) The Department of Health and Human Services.
(3) The Department of Housing and Urban Development.
(5) The Department of Labor.
(6) The Department of Agriculture.
(7) The Department of Transportation.
(8) The Department of Justice;
(9) The Department of the Interior.
(10) The Department of Commerce.
(11) The Department of Energy.
(12) The Environmental Protection Agency.
(13) The Office of Management and Budget.
(14) Any other official of the United States that the President may designate.

(b) Functions.—The Working Group shall—

(1) provide guidance to Federal agencies on criteria for identifying disproportionately high and adverse human health or environmental effects on minority, low-income, and Native American populations;
(2) coordinate with, provide guidance to, and serve as a clearinghouse for, each Federal agency as it develops or revises an environmental justice strategy as required by this chapter, in order to ensure that the administration, interpretation and enforcement of programs, activities, and policies are undertaken in a consistent manner;

(3) assist in coordinating research by, and stimulating cooperation among, the Environmental Protection Agency, the Department of Health and Human Services, the Department of Housing and Urban Development, and other Federal agencies conducting research or other activities in accordance with section 7;

(4) assist in coordinating data collection, maintenance, and analysis required by this chapter;

(5) examine existing data and studies on environmental justice;

(6) hold public meetings and otherwise solicit public participation and consider complaints as required under subsection (c);

(7) develop interagency model projects on environmental justice that evidence cooperation among Federal agencies; and
(8) in coordination with the Department of the Interior and after consultation with tribal leaders, coordinate steps to be taken pursuant to this chapter that affect or involve federally-recognized Indian Tribes.

(c) PUBLIC PARTICIPATION.—The Working Group shall—

(1) hold public meetings and otherwise solicit public participation, as appropriate, for the purpose of fact-finding with regard to implementation of this chapter, and prepare for public review a summary of the comments and recommendations provided; and

(2) receive, consider, and in appropriate instances conduct inquiries concerning complaints regarding environmental justice and the implementation of this chapter by Federal agencies.

(d) ANNUAL REPORTS.—

(1) IN GENERAL.—Each fiscal year following enactment of this Act, the Working Group shall submit to the President, through the Office of the Deputy Assistant to the President for Environmental Policy and the Office of the Assistant to the President for Domestic Policy, a report that describes the implementation of this chapter, including, but not limited to, a report of the final environmental justice
strategies described in section 6 of this chapter and annual progress made in implementing those strategies.

(2) COPY OF REPORT.—The President shall transmit to the Speaker of the House of Representatives and the President of the Senate a copy of each report submitted to the President pursuant to paragraph (1).

(e) CONFORMING CHANGE.—The Interagency Working Group on Environmental Justice established under Executive Order No. 12898, dated February 11, 1994, is abolished.

SEC. 414. FEDERAL AGENCY STRATEGIES.

(a) AGENCY-WIDE STRATEGIES.—Each Federal agency shall develop an agency-wide environmental justice strategy that identifies and addresses disproportionally high and adverse human health or environmental effects or disproportionally low benefits of its programs, policies, and activities with respect to minority, low-income, and Native American populations.

(b) REVISIONS.—Each strategy developed pursuant to subsection (a) shall identify programs, policies, planning, and public participation processes, rulemaking, and enforcement activities related to human health or the environment that should be revised to—
(1) promote enforcement of all health and environmental statutes in areas with minority, low-income, or Native American populations;

(2) ensure greater public participation;

(3) improve research and data collection relating to the health of and environment of minority, low-income, and Native American populations; and

(4) identify differential patterns of use of natural resources among minority, low-income, and Native American populations.

(c) Timetables.—Each strategy developed pursuant to subsection (a) shall include, where appropriate, a timetable for undertaking revisions identified pursuant to subsection (b).

SEC. 415. FEDERAL ENVIRONMENTAL JUSTICE ADVISORY COMMITTEE.

(a) Establishment.—There is established a committee to be known as the “Federal Environmental Justice Advisory Committee”.

(b) Duties.—The Advisory Committee shall provide independent advice and recommendations to the Environmental Protection Agency and the Working Group on areas relating to environmental justice, which may include any of the following:
(1) Advice on Federal agencies’ framework development for integrating socioeconomic programs into strategic planning, annual planning, and management accountability for achieving environmental justice results agency-wide.

(2) Advice on measuring and evaluating agencies’ progress, quality, and adequacy in planning, developing, and implementing environmental justice strategies, projects, and programs.

(3) Advice on agencies’ existing and future information management systems, technologies, and data collection, and the conduct of analyses that support and strengthen environmental justice programs in administrative and scientific areas.

(4) Advice to help develop, facilitate, and conduct reviews of the direction, criteria, scope, and adequacy of the Federal agencies’ scientific research and demonstration projects relating to environmental justice.

(5) Advice for improving how the Environmental Protection Agency and others participate, cooperate, and communicate within that agency and between other Federal agencies, State or local governments, federally recognized Tribes, environmental justice leaders, interest groups, and the public.
(6) Advice regarding the Environmental Protection Agency’s administration of grant programs relating to environmental justice assistance (not to include the review or recommendations of individual grant proposals or awards).

(7) Advice regarding agencies’ awareness, education, training, and other outreach activities involving environmental justice.

(e) ADVISORY COMMITTEE.—The Advisory Committee shall be considered an advisory committee within the meaning of the Federal Advisory Committee Act (5 U.S.C. App.).

(d) MEMBERSHIP.—

(1) IN GENERAL.—The Advisory Committee shall be composed of 21 members to be appointed in accordance with paragraph (2). Members shall include representatives of—

(A) community-based groups;

(B) industry and business;

(C) academic and educational institutions;

(D) minority health organizations;

(E) State and local governments, federally recognized tribes, and indigenous groups; and

(F) nongovernmental and environmental groups.
(2) APPOINTMENTS.—Of the members of the Advisory Committee—

(A) five members shall be appointed by the majority leader of the Senate;

(B) five members shall be appointed by the minority leader of the Senate;

(C) five members shall be appointed by the Speaker of the House of Representatives;

(D) five members shall be appointed by the minority leader of the House of Representatives; and

(E) one member to be appointed by the President.

(e) MEETINGS.—The Advisory Committee shall meet at least twice annually. Meetings shall occur as needed and approved by the Director of the Office of Environmental Justice of the Environmental Protection Agency, who shall serve as the officer required to be appointed under section 10(e) of the Federal Advisory Committee Act (5 U.S.C. App.) with respect to the Committee (in this subsection referred to as the “Designated Federal Officer”). The Administrator of the Environmental Protection Agency may pay travel and per diem expenses of members of the Advisory Committee when determined necessary and appropriate. The Designated Federal Officer or a designee of
such Officer shall be present at all meetings, and each meeting will be conducted in accordance with an agenda approved in advance by such Officer. The Designated Federal Officer may adjourn any meeting when the Designated Federal Officer determines it is in the public interest to do so. As required by the Federal Advisory Committee Act, meetings of the Advisory Committee shall be open to the public unless the President determines that a meeting or a portion of a meeting may be closed to the public in accordance with subsection (c) of section 552b of title 5, United States Code. Unless a meeting or portion thereof is closed to the public, the Designated Federal Officer shall provide an opportunity for interested persons to file comments before or after such meeting or to make statements to the extent that time permits.

(f) Duration.—The Advisory Committee shall remain in existence until otherwise provided by law.

SEC. 416. HUMAN HEALTH AND ENVIRONMENTAL RESEARCH, DATA COLLECTION AND ANALYSIS.

(a) Disproportionate Impact.—To the extent permitted by other applicable law, including section 552a of title 5, United States Code, popularly known as the Privacy Act of 1974, the Administrator of the Environmental Protection Agency, or the head of such other Federal agency as the President may direct, shall collect, maintain,
and analyze information assessing and comparing environmental and human health risks borne by populations identified by race, national origin, or income. To the extent practical and appropriate, Federal agencies shall use this information to determine whether their programs, policies, and activities have disproportionately high and adverse human health or environmental effects on, or disproportionately low benefits for, minority, low-income, and Native American populations.

(b) Information Related to Non-Federal Facilities.—In connection with the development and implementation of agency strategies in section 4, the Administrator of the Environmental Protection Agency, or the head of such other Federal agency as the President may direct, shall collect, maintain, and analyze information on the race, national origin, and income level, and other readily accessible and appropriate information, for areas surrounding facilities or sites expected to have a substantial environmental, human health, or economic effect on the surrounding populations, if such facilities or sites become the subject of a substantial Federal environmental administrative or judicial action.

(e) Impact from Federal Facilities.—The Administrator of the Environmental Protection Agency, or the head of such other Federal agency as the President
may direct, shall collect, maintain, and analyze information on the race, national origin, and income level, and
other readily accessible and appropriate information, for areas surrounding Federal facilities that are—

(1) subject to the reporting requirements under the Emergency Planning and Community Right-to-
Know Act (42 U.S.C. 11001 et seq.) as mandated in Executive Order No. 12856; and

(2) expected to have a substantial environmental, human health, or economic effect on sur-
rounding populations.

(d) INFORMATION SHARING.—

(1) IN GENERAL.—In carrying out the respons-
sibilities in this section, each Federal agency, to the extent practicable and appropriate, shall share infor-
mation and eliminate unnecessary duplication of ef-
forts through the use of existing data systems and cooperative agreements among Federal agencies and with State, local, and tribal governments.

(2) PUBLIC AVAILABILITY.—Except as prohib-
ited by other applicable law, information collected or maintained pursuant to this section shall be made available to the public.

(e) PUBLIC COMMENT.—Federal agencies shall pro-
vide minority, low-income, and Native American popu-
lations the opportunity to participate in the development,

design, and conduct of activities undertaken pursuant to

this section.

**CHAPTER 3—BORDER HEALTH**

**SEC. 421. SHORT TITLE.**

This chapter may be cited as the “Border Health Se-
curity Act of 2003”.

**SEC. 422. DEFINITIONS.**

In this chapter:

(1) **BORDER AREA.**—The term “border area”

has the meaning given the term “United States-
Mexico Border Area” in section 8 of the United
States-Mexico Border Health Commission Act (22

(2) **SECRETARY.**—The term “Secretary” means

the Secretary of Health and Human Services.

**SEC. 423. BORDER HEALTH GRANTS.**

(a) **ELIGIBLE ENTITY DEFINED.**—In this section,
the term “eligible entity” means a State, public institution
of higher education, local government, tribal government,
nonprofit health organization, community health center, or
community clinic receiving assistance under section 330
of the Public Health Service Act (42 U.S.C. 254b), that
is located in the border area.
(b) Authorization.—From funds appropriated under subsection (f), the Secretary, acting through the United States members of the United States-Mexico Border Health Commission, shall award grants to eligible entities to address priorities and recommendations to improve the health of border area residents that are established by—

(1) the United States members of the United States-Mexico Border Health Commission;

(2) the State border health offices; and

(3) the Secretary.

(c) Application. An eligible entity that desires a grant under subsection (b) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) Use of Funds. An eligible entity that receives a grant under subsection (b) shall use the grant funds for—

(1) programs relating to—

(A) maternal and child health;

(B) primary care and preventative health;

(C) public health and public health infrastructure;

(D) health education and promotion;

(E) oral health;
(F) behavioral and mental health;
(G) substance abuse;
(H) health conditions that have a high prevalence in the border area;
(I) medical and health services research;
(J) workforce training and development;
(K) community health workers or promotoras;
(L) health care infrastructure problems in the border area (including planning and construction grants);
(M) health disparities in the border area;
(N) environmental health; and
(O) outreach and enrollment services with respect to Federal programs (including programs authorized under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 and 1397aa)); and
(2) other programs determined appropriate by the Secretary.

(e) SUPPLEMENT, NOT SUPPLANT.—Amounts provided to an eligible entity awarded a grant under subsection (b) shall be used to supplement and not supplant other funds available to the eligible entity to carry out the activities described in subsection (d).
(f) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, $200,000,000 for fiscal year 2005, and such sums as may be necessary for each succeeding fiscal year.

SEC. 424. UNITED STATES-MEXICO BORDER HEALTH COMMISSION ACT AMENDMENTS.

The United States-Mexico Border Health Commission Act (22 U.S.C. 290n et seq.) is amended by adding at the end the following:

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SEC. 9. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated to carry out this Act $10,000,000 for fiscal year 2005 and such sums as may be necessary for each succeeding fiscal year.”.

CHAPTER 4—PATIENT NAVIGATOR, OUTREACH, AND CHRONIC DISEASE PREVENTION

SEC. 425. SHORT TITLE.

This chapter may be cited as the “Patient Navigator, Outreach, and Chronic Disease Prevention Act of 2003”.
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SEC. 426. HRSA GRANTS FOR MODEL COMMUNITY CANCER
AND CHRONIC DISEASE CARE AND PREVEN-
TION; HRSA GRANTS FOR PATIENT NAVA-
ATORS.

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:

“SEC. 330I. MODEL COMMUNITY CANCER AND CHRONIC
DISEASE CARE AND PREVENTION; PATIENT
NAVIGATORS.

“(a) MODEL COMMUNITY CANCER AND CHRONIC
DISEASE CARE AND PREVENTION.—

“(1) IN GENERAL.—The Secretary, acting
through the Administrator of the Health Resources
and Services Administration, may make grants to
public and nonprofit private health centers (including
health centers under section 330, Indian Health
Service Centers, tribal governments, urban Indian
organizations, tribal organizations, clinics serving
Asian Americans and Pacific Islanders and Alaska
Natives, and rural health clinics and qualified non-
profit entities that partner with one or more centers
providing healthcare to provide navigation services,
which demonstrate the ability to perform all of the
functions outlined in this subsection and subsections
(b) and (c)) for the development and operation of model programs that—

“(A) provide to individuals of health disparity populations prevention, early detection, treatment, and appropriate follow-up care services for cancer and chronic diseases;

“(B) ensure that the health services are provided to such individuals in a culturally competent manner;

“(C) assign patient navigators, in accordance with applicable criteria of the Secretary, for managing the care of individuals of health disparity populations to—

“(i) accomplish, to the extent possible, the follow-up and diagnosis of an abnormal finding and the treatment and appropriate follow-up care of cancer or other chronic disease; and

“(ii) facilitate access to appropriate healthcare services within the healthcare system to ensure optimal patient utilization of such services, including aid in coordinating and scheduling appointments and referrals, community outreach, assistance with transportation arrangements,
and assistance with insurance issues and
other barriers to care and providing infor-
mation about clinical trials;
“(D) require training for patient naviga-
tors employed through such model programs to
ensure the ability of navigators to perform all
of the duties required in this subsection and in
subsection (b), including training to ensure that
navigators are informed about health insurance
systems and are able to aid patients in resolv-
ing access issues; and
“(E) ensure that consumers have direct ac-
cess to patient navigators during regularly
scheduled hours of business operation.
“(2) OUTREACH SERVICES.—A condition for
the receipt of a grant under paragraph (1) is that
the applicant involved agree to provide ongoing out-
reach activities while receiving the grant, in a man-
ner that is culturally competent for the health dis-
parity population served by the program, to inform
the public and the specific community that the pro-
gram is serving, about the services of the model pro-
gram under the grant. Such activities shall include
facilitating access to appropriate healthcare services
and patient navigators within the healthcare system
to ensure optimal patient utilization of these services.

“(3) DATA COLLECTION AND REPORT.—In order to allow for effective program evaluation, the grantee shall collect specific patient data recording services provided to each patient served by the program and shall establish and implement procedures and protocols, consistent with applicable Federal and State laws (including 45 C.F.R. 160 and 164) to ensure the confidentiality of all information shared by a participant in the program, or their personal representative and their healthcare providers, group health plans, or health insurance insurers with the program. The program may, consistent with applicable Federal and State confidentiality laws, collect, use or disclose aggregate information that is not individually identifiable (as defined in 45 C.F.R. 160 and 164). With this data, the grantee shall submit an annual report to the Secretary that summarizes and analyzes these data, provides information on needs for navigation services, types of access difficulties resolved, sources of repeated resolution and flaws in the system of access, including insurance barriers.
“(4) Application for Grant.—A grant may be made under paragraph (1) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

“(5) Evaluations.—

“(A) In General.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall, directly or through grants or contracts, provide for evaluations to determine which outreach activities under paragraph (2) were most effective in informing the public and the specific community that the program is serving, about the model program services and to determine the extent to which such programs were effective in providing culturally competent services to the health disparity population served by the programs.

“(B) Dissemination of Findings.—The Secretary shall as appropriate disseminate to public and private entities the findings made in evaluations under subparagraph (A).
“(6) Coordination with other programs.—The Secretary shall coordinate the program under this subsection with the program under subsection (b), with the program under section 417D, and to the extent practicable, with programs for prevention centers that are carried out by the Director of the Centers for Disease Control and Prevention.

“(b) Program for Patient Navigators.—

“(1) In general.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to public and nonprofit private health centers (including health centers under section 330, Indian Health Service Centers, tribal governments, urban Indian organizations, tribal organizations, clinics serving Asian Americans and Pacific Islanders and Alaska Natives, and rural health clinics and qualified nonprofit entities that partner with one or more centers providing healthcare to provide navigation services, which demonstrate the ability to perform all of the functions outlined in this subsection and subsections (a) and (e)) for the development and operation of programs to pay the costs of such health centers in—
“(A) assigning patient navigators, in accordance with applicable criteria of the Secretary, for managing the care of individuals of health disparity populations for the duration of receiving health services from the health centers, including aid in coordinating and scheduling appointments and referrals, community outreach, assistance with transportation arrangements, and assistance with insurance issues and other barriers to care and providing information about clinical trials;

“(B) ensuring that the services provided by the patient navigators to such individuals include case management and psychosocial assessment and care or information and referral to such services;

“(C) ensuring that patient navigators with direct knowledge of the communities they serve provide services to such individuals in a culturally competent manner;

“(D) developing model practices for patient navigators, including with respect to—

“(i) coordination of health services, including psychosocial assessment and care;
“(ii) appropriate follow-up care, including psychosocial assessment and care;

“(iii) determining coverage under health insurance and health plans for all services;

“(iv) ensuring the initiation, continuation and/or sustained access to care prescribed by the patients’ healthcare providers; and

“(v) aiding patients with health insurance coverage issues;

“(E) requiring training for patient navigators to ensure the ability of navigators to perform all of the duties required in this subsection and in subsection (a), including training to ensure that navigators are informed about health insurance systems and are able to aid patients in resolving access issues; and

“(F) ensuring that consumers have direct access to patient navigators during regularly scheduled hours of business operation.

“(2) OUTREACH SERVICES.—A condition for the receipt of a grant under paragraph (1) is that the applicant involved agree to provide ongoing outreach activities while receiving the grant, in a man-
ner that is culturally competent for the health dis-
parity population served by the program, to inform
the public and the specific community that the pa-
tient navigator is serving of the services of the model
program under the grant.

“(3) DATA COLLECTION AND REPORT.—In
order to allow for effective patient navigator pro-
gram evaluation, the grantee shall collect specific pa-
tient data recording navigation services provided to
each patient served by the program and shall estab-
lish and implement procedures and protocols, con-
sistent with applicable Federal and State laws (in-
cluding 45 C.F.R. 160 and 164) to ensure the con-
fidentiality of all information shared by a participant
in the program, or their personal representative and
their healthcare providers, group health plans, or
health insurance insurers with the program. The pa-
tient navigator program may, consistent with appli-
cable Federal and State confidentiality laws, collect,
use or disclose aggregate information that is not in-
dividually identifiable (as defined in 45 C.F.R. 160
and 164). With this data, the grantee shall submit
an annual report to the Secretary that summarizes
and analyzes these data, provides information on
needs for navigation services, types of access difficul-
ties resolved, sources of repeated resolution and flaws in the system of access, including insurance barriers.

“(4) APPLICATION FOR GRANT.—A grant may be made under paragraph (1) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

“(5) EVALUATIONS.—

“(A) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall, directly or through grants or contracts, provide for evaluations to determine the effects of the services of patient navigators on the individuals of health disparity populations for whom the services were provided, taking into account the matters referred to in paragraph (1)(C).

“(B) DISSEMINATION OF FINDINGS.—The Secretary shall as appropriate disseminate to public and private entities the findings made in evaluations under subparagraph (A).
“(6) Coordination with Other Programs.—The Secretary shall coordinate the program under this subsection with the program under subsection (a) and with the program under section 417D.

“(e) Requirements Regarding Fees.—

“(1) In General.—A condition for the receipt of a grant under subsection (a)(1) or (b)(1) is that the program for which the grant is made have in effect—

“(A) a schedule of fees or payments for the provision of its healthcare services related to the prevention and treatment of disease that is consistent with locally prevailing rates or charges and is designed to cover its reasonable costs of operation; and

“(B) a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the ability of the patient to pay.

“(2) Rule of Construction.—Nothing in this section shall be construed to require payment for navigation services or to require payment for healthcare services in cases where care is provided free of charge, including the case of services pro-
vided through programs of the Indian Health Serv-

ice.

“(d) Model.—Not later than five years after the
date of the enactment of this section, the Secretary shall
develop a peer-reviewed model of systems for the services
provided by this section. The Secretary shall update such
model as may be necessary to ensure that the best prac-
tices are being utilized.

“(e) Duration of Grant.—The period during
which payments are made to an entity from a grant under
subsection (a)(1) or (b)(1) may not exceed five years. The
provision of such payments are subject to annual approval
by the Secretary of the payments and subject to the avail-
ability of appropriations for the fiscal year involved to
make the payments. This subsection may not be construed
as establishing a limitation on the number of grants under
such subsection that may be made to an entity.

“(f) Definitions.—For purposes of this section:

“(1) The term ‘culturally competent’, with re-
spect to providing health-related services, means
services that, in accordance with standards and
measures of the Secretary, are designed to effec-
tively and efficiently respond to the cultural and lin-
guistic needs of patients.
“(2) The term ‘appropriate follow-up care’ includes palliative and end-of-life care.

“(3) The term ‘health disparity population’ means a population in which there exists a significant disparity in the overall rate of disease incidence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population. Such term includes—

“(A) racial and ethnic minority groups as defined in section 1707; and

“(B) medically underserved groups, such as rural and low-income individuals and individuals with low levels of literacy.

“(4)(A) The term ‘patient navigator’ means an individual whose functions include—

“(i) assisting and guiding patients with a symptom or an abnormal finding or diagnosis of cancer or other chronic disease within the healthcare system to accomplish the follow-up and diagnosis of an abnormal finding as well as the treatment and appropriate follow-up care of cancer or other chronic disease including providing information about clinical trials; and

“(ii) identifying, anticipating, and helping patients overcome barriers within the healthcare
system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.

“(B) Such term includes representatives of the target health disparity population, such as nurses, social workers, cancer survivors, and patient advocates.

“(g) Authorization of Appropriations.—

“(1) In general.—

“(A) Model programs.—For the purpose of carrying out subsection (a) (other than the purpose described in paragraph (2)(A)), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

“(B) Patient navigators.—For the purpose of carrying out subsection (b) (other than the purpose described in paragraph (2)(B)), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

“(C) Bureau of primary healthcare.—Amounts appropriated under subparagraph (A) or (B) shall be administered through the Bureau of Primary Health Care.
“(2) Programs in rural areas.—

“(A) Model programs.—For the purpose of carrying out subsection (a) by making grants under such subsection for model programs in rural areas, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

“(B) Patient navigators.—For the purpose of carrying out subsection (b) by making grants under such subsection for programs in rural areas, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

“(C) Office of rural health policy.—Amounts appropriated under subparagraph (A) or (B) shall be administered through the Office of Rural Health Policy.

“(3) Relation to other authorizations.—Authorizations of appropriations under paragraphs (1) and (2) are in addition to other authorizations of appropriations that are available for the purposes described in such paragraphs.”.
SEC. 427. NCI GRANTS FOR MODEL COMMUNITY CANCER AND CHRONIC DISEASE CARE AND PREVENTION; NCI GRANTS FOR PATIENT NAVIGATORS.

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 section:

“SEC. 417D. MODEL COMMUNITY CANCER AND CHRONIC DISEASE CARE AND PREVENTION; PATIENT NAVIGATORS.

“(a) MODEL COMMUNITY CANCER AND CHRONIC DISEASE CARE AND PREVENTION.—

“(1) IN GENERAL.—The Director of the Institute may make grants to eligible entities for the development and operation of model programs that—

“(A) provide to individuals of health disparity populations prevention, early detection, treatment, and appropriate follow-up care services for cancer and chronic diseases;

“(B) ensure that the health services are provided to such individuals in a culturally competent manner;

“(C) assign patient navigators, in accordance with applicable criteria of the Secretary, for managing the care of individuals of health disparity populations to—
“(i) accomplish, to the extent possible, the follow-up and diagnosis of an abnormal finding and the treatment and appropriate follow-up care of cancer or other chronic disease; and

“(ii) facilitate access to appropriate healthcare services within the healthcare system to ensure optimal patient utilization of such services, including aid in coordinating and scheduling appointments and referrals, community outreach, assistance with transportation arrangements, and assistance with insurance issues and other barriers to care and providing information about clinical trials;

“(D) require training for patient navigators employed through such model programs to ensure the ability of navigators to perform all of the duties required in this subsection and in subsection (b), including training to ensure that navigators are informed about health insurance systems and are able to aid patients in resolving access issues; and
“(E) ensure that consumers have direct access to patient navigators during regularly scheduled hours of business operation.

“(2) ELIGIBLE ENTITIES.—For purposes of this section, an eligible entity is a designated cancer center of the Institute, an academic institution, Indian Health Service Clinics, tribal governments, urban Indian organizations, tribal organizations, a hospital, a qualified nonprofit entity that partners with one or more centers providing healthcare to provide navigation services, which demonstrates the ability to perform all of the functions outlined in this subsection and subsections (b) and (c), or any other public or private entity determined to be appropriate by the Director of the Institute, that provides services described in paragraph (1)(A) for cancer and chronic diseases.

“(3) DATA COLLECTION AND REPORT.—In order to allow for effective program evaluation, the grantee shall collect specific patient data recording services provided to each patient served by the program and shall establish and implement procedures and protocols, consistent with applicable Federal and State laws (including 45 C.F.R. 160 and 164) to ensure the confidentiality of all information shared by
a participant in the program, or their personal rep-
resentative and their healthcare providers, group
health plans, or health insurance insurers with the
program. The program may, consistent with applica-
ble Federal and State confidentiality laws, collect,
use or disclose aggregate information that is not in-
dividually identifiable (as defined in 45 C.F.R. 160
and 164). With this data, the grantee shall submit
an annual report to the Secretary that summarizes
and analyzes these data, provides information on
needs for navigation services, types of access difficul-
ties resolved, sources of repeated resolution and
flaws in the system of access, including insurance
barriers.

“(4) OUTREACH SERVICES.—A condition for
the receipt of a grant under paragraph (1) is that
the applicant involved agree to provide ongoing out-
reach activities while receiving the grant, in a man-
ner that is culturally competent for the health dis-
parity population served by the program, to inform
the public and the specific community that the pro-
gram is serving of the services of the model program
under the grant. Such activities shall include facili-
tating access to appropriate healthcare services and
patient navigators within the healthcare system to
effect optimal patient utilization of these services.

“(5) APPLICATION FOR GRANT.—A grant may
be made under paragraph (1) only if an application
for the grant is submitted to the Director of the In-
stitute and the application is in such form, is made
in such manner, and contains such agreements, as-
surances, and information as the Director deter-
mines to be necessary to carry out this section.

“(6) EVALUATIONS.—

“(A) IN GENERAL.—The Director of the
Institute, directly or through grants or con-
tracts, shall provide for evaluations to deter-
mine which outreach activities under paragraph
(3) were most effective in informing the public
and the specific community that the program is
serving of the model program services and to
determine the extent to which such programs
were effective in providing culturally competent
services to the health disparity population
served by the programs.

“(B) DISSEMINATION OF FINDINGS.—The
Director of the Institute shall as appropriate
disseminate to public and private entities the
findings made in evaluations under subpar-
graph (A).

“(7) COORDINATION WITH OTHER PRO-
GRAMS.—The Secretary shall coordinate the pro-
gram under this subsection with the program under
subsection (b), with the program under section 330I,
and to the extent practicable, with programs for pre-
vention centers that are carried out by the Director
of the Centers for Disease Control and Prevention.

“(b) PROGRAM FOR PATIENT NAVIGATORS.—

“(1) IN GENERAL.—The Director of the Insti-
tute may make grants to eligible entities for the de-
development and operation of programs to pay the
costs of such entities in—

“(A) assigning patient navigators, in ac-
cordance with applicable criteria of the Sec-
retary, for managing the care of individuals of
health disparity populations for the duration of
receiving health services from the health cen-
ters, including aid in coordinating and sched-
uling appointments and referrals, community
outreach, assistance with transportation ar-
rangements, and assistance with insurance
issues and other barriers to care and providing
information about clinical trials;
“(B) ensuring that the services provided by
the patient navigators to such individuals in-
clude case management and psychosocial as-
essment and care or information and referral
to such services;

“(C) ensuring that the patient navigators
with direct knowledge of the communities they
serve provide services to such individuals in a
culturally competent manner;

“(D) developing model practices for patient
navigators, including with respect to—

“(i) coordination of health services,
including psychosocial assessment and
care;

“(ii) follow-up services, including psy-
chosocial assessment and care;

“(iii) determining coverage under
health insurance and health plans for all
services;

“(iv) ensuring the initiation, continu-
ation and/or sustained access to care pre-
scribed by the patients’ healthcare pro-
viders; and

“(v) aiding patients with health insur-
ance coverage issues;
“(E) requiring training for patient navigators to ensure the ability of navigators to perform all of the duties required in this subsection and in subsection (a), including training to ensure that navigators are informed about health insurance systems and are able to aid patients in resolving access issues; and

“(F) ensuring that consumers have direct access to patient navigators during regularly scheduled hours of business operation.

“(2) Outreach Services.—A condition for the receipt of a grant under paragraph (1) is that the applicant involved agree to provide ongoing outreach activities while receiving the grant, in a manner that is culturally competent for the health disparity population served by the program, to inform the public and the specific community that the patient navigator is serving of the services of the model program under the grant.

“(3) Data Collection and Report.—In order to allow for effective patient navigator program evaluation, the grantee shall collect specific patient data recording navigation services provided to each patient served by the program and shall establish and implement procedures and protocols, con-
sistent with applicable Federal and State laws (in-
cluding 45 C.F.R. 160 and 164) to ensure the con-
fidentiality of all information shared by a participant
in the program, or their personal representative and
their healthcare providers, group health plans, or
health insurance insurers with the program. The pa-
tient navigator program may, consistent with appli-
cable Federal and State confidentiality laws, collect,
use or disclose aggregate information that is not in-
dividually identifiable (as defined in 45 C.F.R. 160
and 164). With this data, the grantee shall submit
an annual report to the Secretary that summarizes
and analyzes these data, provides information on
needs for navigation services, types of access difficul-
ties resolved, sources of repeated resolution and
flaws in the system of access, including insurance
barriers.

“(4) APPLICATION FOR GRANT.—A grant may
be made under paragraph (1) only if an application
for the grant is submitted to the Director of the In-
stitute and the application is in such form, is made
in such manner, and contains such agreements, as-
surances, and information as the Director deter-
mines to be necessary to carry out this section.

“(5) EVALUATIONS.—
“(A) IN GENERAL.—The Director of the Institute, directly or through grants or contracts, shall provide for evaluations to determine the effects of the services of patient navigators on the health disparity population for whom the services were provided, taking into account the matters referred to in paragraph (1)(C).

“(B) DISSEMINATION OF FINDINGS.—The Director of the Institute shall as appropriate disseminate to public and private entities the findings made in evaluations under subparagraph (A).

“(6) COORDINATION WITH OTHER PROGRAMS.—The Secretary shall coordinate the program under this subsection with the program under subsection (a) and with the program under section 330I.

“(c) REQUIREMENTS REGARDING FEES.—

“(1) IN GENERAL.—A condition for the receipt of a grant under subsection (a)(1) or (b)(1) is that the program for which the grant is made have in effect—

“(A) a schedule of fees or payments for the provision of its healthcare services related
to the prevention and treatment of disease that
is consistent with locally prevailing rates or
charges and is designed to cover its reasonable
costs of operation; and

“(B) a corresponding schedule of discounts
to be applied to the payment of such fees or
payments, which discounts are adjusted on the
basis of the ability of the patient to pay.

“(2) RULE OF CONSTRUCTION.—Nothing in
this section shall be construed to require payment
for navigation services or to require payment for
healthcare services in cases where care is provided
free of charge, including the case of services pro-
vided through programs of the Indian Health Serv-
ice.

“(d) MODEL.—Not later than five years after the
date of the enactment of this section, the Director of the
Institute shall develop a peer-reviewed model of systems
for the services provided by this section. The Director shall
update such model as may be necessary to ensure that
the best practices are being utilized.

“(e) DURATION OF GRANT.—The period during
which payments are made to an entity from a grant under
subsection (a)(1) or (b)(1) may not exceed five years. The
provision of such payments are subject to annual approval
by the Director of the Institute of the payments and sub-
ject to the availability of appropriations for the fiscal year
involved to make the payments. This subsection may not
be construed as establishing a limitation on the number
of grants under such subsection that may be made to an
entity.

“(f) DEFINITIONS.—For purposes of this section:

“(1) The term ‘culturally competent’, with re-
spect to providing health-related services, means
services that, in accordance with standards and
measures of the Secretary, are designed to effec-
tively and efficiently respond to the cultural and lin-
guistic needs of patients.

“(2) the term ‘appropriate follow-up care’ in-
cludes palliative and end-of-life care.

“(3) the term ‘health disparity population’
means a population where there exists a significant
disparity in the overall rate of disease incidence,
morbidity, mortality, or survival rates in the popu-
lation as compared to the health status of the gen-
eral population. Such term includes—

“(A) racial and ethnic minority groups as
defined in section 1707; and
“(B) medically underserved groups, such as rural and low-income individuals and individuals with low levels of literacy.

“(4)(A) the term ‘patient navigator’ means an individual whose functions include—

“(i) assisting and guiding patients with a symptom or an abnormal finding or diagnosis of cancer or other chronic disease within the healthcare system to accomplish the follow-up and diagnosis of an abnormal finding as well as the treatment and appropriate follow-up care of cancer or other chronic disease, including providing information about clinical trials; and

“(ii) identifying, anticipating, and helping patients overcome barriers within the healthcare system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.

“(B) Such term includes representatives of the target health disparity population, such as nurses, social workers, cancer survivors, and patient advocates.

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) MODEL PROGRAMS.—For the purpose of carrying out subsection (a), there are authorized to
be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

“(2) Patient Navigators.—For the purpose of carrying out subsection (b), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

“(3) Relation to Other Authorizations.—Authorizations of appropriations under paragraphs (1) and (2) are in addition to other authorizations of appropriations that are available for the purposes described in such paragraphs.”.

SEC. 428. IHS GRANTS FOR MODEL COMMUNITY CANCER AND CHRONIC DISEASE CARE AND PREVENTION; IHS GRANTS FOR PATIENT NAVIGATORS.

(a) Model Community Cancer and Chronic Disease Care and Prevention.—

(1) In General.—The Director of the Indian Health Service may make grants to Indian Health Service Centers, tribal governments, urban Indian organizations, tribal organizations, and qualified nonprofit entities demonstrating the ability to perform all of the functions outlined in this subsection and subsections (b) and (c) that partner with providers or centers providing healthcare serving Native
American populations to provide navigation services, for the development and operation of model programs that—

(A) provide to individuals of health disparity populations prevention, early detection, treatment, and appropriate follow-up care services for cancer and chronic diseases;

(B) ensure that the health services are provided to such individuals in a culturally competent manner;

(C) assign patient navigators, in accordance with applicable criteria of the Secretary, for managing the care of individuals of health disparity populations to—

(i) accomplish, to the extent possible, the follow-up and diagnosis of an abnormal finding and the treatment and appropriate follow-up care of cancer or other chronic disease; and

(ii) facilitate access to appropriate healthcare services within the healthcare system to ensure optimal patient utilization of such services, including aid in coordinating and scheduling appointments and referrals, community outreach, assist-
ance with transportation arrangements, and assistance with insurance issues and other barriers to care and providing information about clinical trials;

(D) require training for patient navigators employed through such model programs to ensure the ability of navigators to perform all of the duties required in this subsection and in subsection (b), including training to ensure that navigators are informed about health insurance systems and are able to aid patients in resolving access issues; and

(E) ensure that consumers have direct access to patient navigators during regularly scheduled hours of business operation.

(2) OUTREACH SERVICES.—A condition for the receipt of a grant under paragraph (1) is that the applicant involved agree to provide ongoing outreach activities while receiving the grant, in a manner that is culturally competent for the health disparity population served by the program, to inform the public and the specific community that the program is serving of the services of the model program under the grant. Such activities shall include facilitating access to appropriate healthcare services and patient
navigators within the healthcare system to ensure optimal patient utilization of these services.

(3) DATA COLLECTION AND REPORT.—In order to allow for effective program evaluation, the grantee shall collect specific patient data recording services provided to each patient served by the program and shall establish and implement procedures and protocols, consistent with applicable Federal and State laws (including 45 C.F.R. 160 and 164) to ensure the confidentiality of all information shared by a participant in the program, or their personal representative and their healthcare providers, group health plans, or health insurance insurers with the program. The program may, consistent with applicable Federal and State confidentiality laws, collect, use or disclose aggregate information that is not individually identifiable (as defined in 45 C.F.R. 160 and 164). With this data, the grantee shall submit an annual report to the Secretary that summarizes and analyzes these data, provides information on needs for navigation services, types of access difficulties resolved, sources of repeated resolution and flaws in the system of access, including insurance barriers.
(4) Application for Grant.—A grant may be made under paragraph (1) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

(5) Evaluations.—

(A) In General.—The Secretary, acting through the Director of the Indian Health Service, shall, directly or through grants or contracts, provide for evaluations to determine which outreach activities under paragraph (2) were most effective in informing the public and the specific community that the program is serving of the model program services and to determine the extent to which such programs were effective in providing culturally competent services to the health disparity population served by the programs.

(B) Dissemination of Findings.—The Secretary shall as appropriate disseminate to public and private entities the findings made in evaluations under subparagraph (A).
(6) Coordination with other programs.—

The Secretary shall coordinate the program under this subsection with the program under subsection (b), with the program under section 417D, and to the extent practicable, with programs for prevention centers that are carried out by the Director of the Centers for Disease Control and Prevention.

(b) Program for Patient Navigators.—

(1) In general.—The Secretary, acting through the Director of the Indian Health Service, may make grants to Indian Health Service Centers, tribal governments, urban Indian organizations, tribal organizations, and qualified nonprofit entities demonstrating the ability to perform all of the functions outlined in this subsection and subsections (a) and (c) that partner with providers or centers providing healthcare serving Native American populations to provide navigation services, for the development and operation of model programs to pay the costs of such organizations in—

(A) assigning patient navigators, in accordance with applicable criteria of the Secretary, for individuals of health disparity populations for the duration of receiving health services from the health centers, including aid in coordi-
nating and scheduling appointments and referrals, community outreach, assistance with transportation arrangements, and assistance with insurance issues and other barriers to care and providing information about clinical trials;

(B) ensuring that the services provided by the patient navigators to such individuals include case management and psychosocial assessment and care or information and referral to such services;

(C) ensuring that patient navigators with direct knowledge of the communities they serve provide services to such individuals in a culturally competent manner;

(D) developing model practices for patient navigators, including with respect to—

(i) coordination of health services, including psychosocial assessment and care;

(ii) appropriate follow-up care, including psychosocial assessment and care;

(iii) determining coverage under health insurance and health plans for all services;

(iv) ensuring the initiation, continuation and/or sustained access to care pre-
scribed by the patients' healthcare providers; and

(v) aiding patients with health insurance coverage issues;

(E) requiring training for patient navigators to ensure the ability of navigators to perform all of the duties required in this subsection and in subsection (a), including training to ensure that navigators are informed about health insurance systems and are able to aid patients in resolving access issues; and

(F) ensuring that consumers have direct access to patient navigators during regularly scheduled hours of business operation.

(2) Outreach Services.—A condition for the receipt of a grant under paragraph (1) is that the applicant involved agree to provide ongoing outreach activities while receiving the grant, in a manner that is culturally competent for the health disparity population served by the program, to inform the public and the specific community that the patient navigator is serving of the services of the model program under the grant.

(3) Data Collection and Report.—In order to allow for effective patient navigator program eval-
uation, the grantee shall collect specific patient data recording navigation services provided to each pa-

tient served by the program and shall establish and

implement procedures and protocols, consistent with

applicable Federal and State laws (including 45

C.F.R. 160 and 164) to ensure the confidentiality of

all information shared by a participant in the pro-

gram, or their personal representative and their

healthcare providers, group health plans, or health

insurance insurers with the program. The patient

navigator program may, consistent with applicable

Federal and State confidentiality laws, collect, use or

disclose aggregate information that is not individ-

ually identifiable (as defined in 45 C.F.R. 160 and

164). With this data, the grantee shall submit an

annual report to the Secretary that summarizes and

analyzes these data, provides information on needs

for navigation services, types of access difficulties re-
solved, sources of repeated resolution and flaws in

the system of access, including insurance barriers.

(4) APPLICATION FOR GRANT.—A grant may be

made under paragraph (1) only if an application for

the grant is submitted to the Secretary and the ap-

plication is in such form, is made in such manner,

and contains such agreements, assurances, and in-
formation as the Secretary determines to be necessary to carry out this section.

(5) EVALUATIONS.—

(A) IN GENERAL.—The Secretary, acting through the Director of the Indian Health Service, shall, directly or through grants or contracts, provide for evaluations to determine the effects of the services of patient navigators on the individuals of health disparity populations for whom the services were provided, taking into account the matters referred to in paragraph (1)(C).

(B) DISSEMINATION OF FINDINGS.—The Secretary shall as appropriate disseminate to public and private entities the findings made in evaluations under subparagraph (A).

(6) COORDINATION WITH OTHER PROGRAMS.—

The Secretary shall coordinate the program under this subsection with the program under subsection (a) and with the program under section 417D.

(c) REQUIREMENTS REGARDING FEES.—

(1) IN GENERAL.—A condition for the receipt of a grant under subsection (a)(1) or (b)(1) is that the program for which the grant is made have in effect—
(A) a schedule of fees or payments for the provision of its healthcare services related to the prevention and treatment of disease that is consistent with locally prevailing rates or charges and is designed to cover its reasonable costs of operation; and

(B) a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the ability of the patient to pay.

(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require payment for navigation services or to require payment for healthcare services in cases, such as with the Indian Health Service, where care is provided free of charge.

(d) MODEL.—Not later than five years after the date of the enactment of this section, the Secretary shall de-velop a peer-reviewed model of systems for the services provided by this section. The Secretary shall update such model as may be necessary to ensure that the best prac-tices are being utilized.

(e) DURATION OF GRANT.—The period during which payments are made to an entity from a grant under sub-section (a)(1) or (b)(1) may not exceed five years. The
provision of such payments are subject to annual approval by the Secretary of the payments and subject to the availability of appropriations for the fiscal year involved to make the payments. This subsection may not be construed as establishing a limitation on the number of grants under such subsection that may be made to an entity.

(f) DEFINITIONS.—For purposes of this section:

(1) The term “culturally competent”, with respect to providing health-related services, means services that, in accordance with standards and measures of the Secretary, are designed to effectively and efficiently respond to the cultural and linguistic needs of patients.

(2) The term “appropriate follow-up care” includes palliative and end-of-life care.

(3) The term “health disparity population” means a population where there exists a significant disparity in the overall rate of disease incidence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population. Such term includes—

(A) racial and ethnic minority groups as defined in section 1707; and
(B) medically underserved groups, such as rural and low-income individuals and individuals with low levels of literacy.

(4)(A) The term “patient navigator” means an individual whose functions include—

(i) assisting and guiding patients with a symptom or an abnormal finding or diagnosis of cancer or other chronic disease within the healthcare system to accomplish the follow-up and diagnosis of an abnormal finding as well as the treatment and appropriate follow-up care of cancer or other chronic disease, including providing information about clinical trials; and

(ii) identifying, anticipating, and helping patients overcome barriers within the healthcare system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.

(B) Such term includes representatives of the target health disparity population, such as nurses, social workers, cancer survivors, and patient advocates.

(g) Authorization of Appropriations.—

(1) In general.—
(A) MODEL PROGRAMS.—For the purpose of carrying out subsection (a) (other than the purpose described in paragraph (2)(A)), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

(B) PATIENT NAVIGATORS.—For the purpose of carrying out subsection (b) (other than the purpose described in paragraph (2)(B)), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

(C) BUREAU OF PRIMARY HEALTH CARE.—Amounts appropriated under subparagraph (A) or (B) shall be administered through the Bureau of Primary Health Care.

(2) PROGRAMS IN RURAL AREAS.—

(A) MODEL PROGRAMS.—For the purpose of carrying out subsection (a) by making grants under such subsection for model programs in rural areas, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

(B) PATIENT NAVIGATORS.—For the purpose of carrying out subsection (b) by making...
grants under such subsection for programs in rural areas, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.

(C) Office of Rural Health Policy.—

Amounts appropriated under subparagraph (A) or (B) shall be administered through the Office of Rural Health Policy.

(3) Relation to Other Authorizations.—

Authorizations of appropriations under paragraphs (1) and (2) are in addition to other authorizations of appropriations that are available for the purposes described in such paragraphs.

CHAPTER 5—COMMUNITY HEALTH WORKERS

SEC. 431. SHORT TITLE.

This chapter may be cited as the “Community Health Workers Act of 2003”.

SEC. 432. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN.

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. 399O. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN.

“(a) Grants Authorized.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and other Federal officials determined appropriate by the Secretary, is authorized to award grants to States or local or tribal units, to promote positive health behaviors for women in target populations, especially racial and ethnic minority women in medically underserved communities.

“(b) Use of Funds.—Grants awarded pursuant to subsection (a) may be used to support community health workers—

“(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent among women and especially among racial and ethnic minority women;

“(2) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors;

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

“(4) 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;

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

“(6) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services.

“(c) APPLICATION.—

“(1) IN GENERAL.—Each State or local or tribal unit (including federally recognized tribes and Alaska native villages) that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

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

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

“(B) contain an assurance that with respect to each community health worker program receiving funds under the grant awarded,
such program provides training and supervision
to community health workers to enable such
workers to provide authorized program services;

“(C) contain an assurance that the appli-
cant will evaluate the effectiveness of commu-
nity health worker programs receiving funds
under the grant;

“(D) contain an assurance that each com-
munity health worker program receiving funds
under the grant will provide services in the cul-
tural context most appropriate for the individ-
uals served by the program;

“(E) contain a plan to document and dis-
seminate project description and results to
other States and organizations as identified by
the Secretary; and

“(F) describe plans to enhance the capac-
ity of individuals to utilize health services and
health-related social services under Federal,
State, and local programs by—

“(i) assisting individuals in estab-
lishing eligibility under the programs and
in receiving the services or other benefits
of the programs; and
“(ii) providing other services as the Secretary determines to be appropriate, that may include transportation and translation services.

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

“(1) who propose to target geographic areas—

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

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

“(C) that encompass the United States-Mexico border region;

“(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

“(3) with documented community activity and experience with community health workers.

“(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to col-
laborate with academic institutions. Nothing in this sec-

tion shall be construed to require such collaboration.

“(f) QUALITY ASSURANCE AND COST-EFFECTIVENESS.—The Secretary shall establish guidelines for assur-
ing the quality of the training and supervision of commu-
nity health workers under the programs funded under this
section and for assuring the cost-effectiveness of such pro-
grams.

“(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 (e).

“(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 sub-
mit to Congress a report regarding the grant
project.
“(2) CONTENTS.—The report required under paragraph (1) shall include the following:

“(A) A description of the programs for which grant funds were used.

“(B) The number of individuals served.

“(C) An evaluation of—

“(i) the effectiveness of these programs;

“(ii) the cost of these programs; and

“(iii) the impact of the project on the health outcomes of the community residents.

“(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

“(E) Recommendations regarding training to enhance career opportunities for community health workers.

“(j) DEFINITIONS.—In this section:

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

“(A) by serving as a liaison between communities and health care agencies;
“(B) by providing guidance and social assistance to community residents;

“(C) by enhancing community residents’ ability to effectively communicate with health care providers;

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

“(E) by advocating for individual and community health or nutrition needs; and

“(F) by providing referral and followup services.

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

“(3) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State—

“(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and
“(B) a significant portion of which is a health professional shortage area as designated under section 332.

“(4) 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.

“(5) TARGET POPULATION.—The term ‘target population’ means women of reproductive age, regardless of their current childbearing status.

“(k) 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 2005 through 2010.”.

CHAPTER 6—HEALTH EMPOWERMENT ZONES

SEC. 440. HEALTH EMPOWERMENT ZONES.

(a) HEALTH EMPOWERMENT ZONE PROGRAMS.—

(1) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Director of the Office of Minority Health, and in cooperation with the Director of the Office of Community Services and the Director of the National Center for Minority Health
and Health Disparities, shall make grants to partnerships of private and public entities to establish health empowerment zone programs in communities that disproportionately experience disparities in health status and healthcare for the purpose described in paragraph (2).

(2) USE OF FUNDS.—

(A) IN GENERAL.—Subject to subparagraph (B), the purpose of a health empowerment zone program under this section shall be to assist individuals, businesses, schools, minority health associations, non-profit organizations, community-based organizations, hospitals, healthcare clinics, foundations, and other entities in communities that disproportionately experience disparities in health status and healthcare which are seeking—

(i) to improve the health or environment of minority individuals in the community and to reduce disparities in health status and healthcare by assisting individuals in accessing Federal programs; and

(ii) to coordinate the efforts of governmental and private entities regarding
the elimination of racial and ethnic disparities in health status and healthcare.

(B) MEDICARE AND MEDICAID.—A health empowerment zone program under this section shall not provide any assistance (other than referral and follow-up services) that is duplicative of programs under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 and 1396 et seq.).

(3) DISTRIBUTION.—The Secretary shall make at least 1 grant under this section to a partnership for a health empowerment zone program in communities that disproportionately experience disparities in health status and healthcare that is located in a territory or possession of the United States.

(4) APPLICATION.—To obtain a grant under this section, a partnership shall submit to the Secretary an application in such form and in such manner as the Secretary may require. An application under this paragraph shall—

(A) demonstrate that the communities to be served by the health empowerment zone program are those that disproportionately experience disparities in health status and healthcare;
(B) set forth a strategic plan for accomplishing the purpose described in paragraph (2), by—

(i) describing the coordinated health, economic, human, community, and physical development plan and related activities proposed for the community;

(ii) describing the extent to which local institutions and organizations have contributed and will contribute to the planning process and implementation;

(iii) identifying the projected amount of Federal, State, local, and private resources that will be available in the area and the private and public partnerships to be used (including any participation by or cooperation with universities, colleges, foundations, non-profit organizations, medical centers, hospitals, health clinics, school districts, or other private and public entities);

(iv) identifying the funding requested under any Federal program in support of the proposed activities;
(v) identifying benchmarks for measuring the success of carrying out the strategic plan;

(vi) demonstrating the ability to reach and service the targeted underserved minority community populations in a culturally appropriate and linguistically responsive manner; and

(vii) demonstrating a capacity and infrastructure to provide long-term community response that is culturally appropriate and linguistically responsive to communities that disproportionately experience disparities in health and healthcare; and

(C) include such other information as the Secretary may require.

(5) PREFERENCE.—In awarding grants under this subsection, the Secretary shall give preference to proposals from indigenous community entities that have an expertise in providing culturally appropriate and linguistically responsive services to communities that disproportionately experience disparities in health and healthcare.

(b) FEDERAL ASSISTANCE FOR HEALTH EMPOWERMENT ZONE GRANT PROGRAMS.—The Secretary, the Ad-
ministrator of the Small Business Administration, the Secretary of Agriculture, the Secretary of Education, the Secretary of Labor, and the Secretary of Housing and Urban Development shall each—

(1) where appropriate, provide entity-specific technical assistance and evidence-based strategies to communities that disproportionately experience disparities in health status and healthcare to further the purposes served by a health empowerment zone program established with a grant under subsection (a);

(2) identify all programs administered by the Department of Health and Human Services, Small Business Administration, Department of Agriculture, Department of Education, Department of Labor, and the Department of Housing and Urban Development, respectively, that may be used to further the purpose of a health empowerment zone program established with a grant under subsection (a); and

(3) in administering any program identified under paragraph (2), consider the appropriateness of giving priority to any individual or entity located in communities that disproportionately experience disparities in health status and healthcare served by a
health empowerment zone program established with a grant under subsection (a), if such priority would further the purpose of the health empowerment zone program.

(c) HEALTH EMPOWERMENT ZONE COORDINATING COMMITTEE.—

(1) ESTABLISHMENT.—For each health empowerment zone program established with a grant under subsection (a), the Secretary acting through the Director of Office of Minority Health and the Administrator of the Health Resources and Services Administration shall establish a health empowerment zone coordinating committee.

(2) DUTIES.—Each coordinating committee established, in coordination with the Director of the Office of Minority Health and the Administrator of the Health Resources and Services Administration, shall provide technical assistance and evidence-based strategies to the grant recipient involved, including providing guidance on research, strategies, health outcomes, program goals, management, implementation, monitoring, assessment, and evaluation processes.

(3) MEMBERSHIP.—
(A) APPOINTMENT.—The Director of the Office of Minority Health and the Administrator of the Health Resources and Services Administration, in consultation with the respective grant recipient shall appoint the members of each coordinating committee.

(B) COMPOSITION.—The Director of the Office of Minority Health, and the Administrator of the Health Resources and Services Administration shall ensure that each coordinating committee established—

(i) has not more than 20 members;

(ii) includes individuals from communities that disproportionately experience disparities in health status and healthcare;

(iii) includes community leaders and leaders of community-based organizations;

(iv) includes representatives of academia and lay and professional organizations and associations including those having expertise in medicine, technical, social and behavioral science, health policy, advocacy, cultural and linguistic competency, research management, and organization; and
(v) represents a reasonable cross-section of knowledge, views, and application of expertise on societal, ethical, behavioral, educational, policy, legal, cultural, linguistic, and workforce issues related to eliminating disparities in health and healthcare.

(C) INDIVIDUAL QUALIFICATIONS.—The Director of the Office of Minority Health and the Administrator of the Health Resources and Services Administration may not appoint an individual to serve on a coordinating committee unless the individual meets the following qualifications:

(i) The individual is not employed by the Federal Government.

(ii) The individual has appropriate experience, including experience in the areas of community development, cultural and linguistic competency, reducing and eliminating racial and ethnic disparities in health and health care, or minority health.

(D) SELECTION.—In selecting individuals to serve on a coordinating committee, the Director of Office of Minority Health and the Ad-
ministrator Health Resources and Services Ad-
ministration shall give due consideration to the
recommendations of the Congress, industry
leaders, the scientific community (including the
Institute of Medicine), academia, community
based non-profit organizations, minority health
and related organizations, the education com-
community, State and local governments, and other
appropriate organizations.

(E) CHAIRPERSON.—The Director of the
Office of Minority Health and the Adminis-
trator of the Health Resources and Services Ad-
ministration, in consultation with the members
of the coordinating committee involved, shall
designate a chairperson of the coordinating
committee, who shall serve for a term of 3
years and who may be reappointed at the expi-
ration of each such term.

(F) TERMS.—Each member of a coordi-
nating committee shall be appointed for a term
of 1 to 3 years in overlapping staggered terms,
as determined by the Director of the Office of
Minority Health and the Administrator of the
Health Resources and Services Administration
at the time of appointment, and may be re-appointed at the expiration of each such term.

(G) VACANCIES.—A vacancy on a coordinating committee shall be filled in the same manner in which the original appointment was made.

(H) COMPENSATION.—Each member of a coordinating committee shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay for level IV of the Executive Schedule for each day (including travel time) during which such member is engaged in the performance of the duties of the coordinating committee.

(I) TRAVEL EXPENSES.—Each member of a coordinating committee shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code.

(4) MEETINGS.—A coordinating committee shall meet 3 to 5 times each year, at the call of the coordinating committee’s chairperson and in consultation with the Director of Office of Minority
Health and the Administrator Health Resources and Services Administration.

(5) REPORT.—Each coordinating committee shall transmit to the Congress an annual report that, with respect to the health empowerment zone program involved, includes the following:

(A) A review of the program’s effectiveness in achieving stated goals and outcomes.

(B) A review of the program’s management and the coordination of the entities involved.

(C) A review of the activities in the program’s portfolio and components.

(D) An identification of policy issues raised by the program.

(E) An assessment of the program’s capacity, infrastructure, and number of underserved minority communities reached.

(F) Recommendations for new program goals, research areas, enhanced approaches, partnerships, coordination and management mechanisms, and projects to be established to achieve the program’s stated goals, to improve outcomes, monitoring, and evaluation.
(G) A review of the degree of minority entity participation in the program, and an identification of a strategy to increase such participation.

(H) Any other reviews or recommendations determined to be appropriate by the coordinating committee.

(d) REPORT.—The Director of the Office of Minority Health and the Administrator of the Health Resources and Services Administration shall submit a joint annual report to the appropriate committees of Congress on the results of the implementation of programs under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

Subtitle B—Targeting Diseases and Conditions with Particularly Disparate Impact

CHAPTER 1—CANCER REDUCTION

SEC. 441. CANCER REDUCTION.

(a) PREVENTIVE HEALTH MEASURES WITH RESPECT TO BREAST AND CERVICAL CANCER.—
(1) IN GENERAL.—Section 1510(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)) is amended by striking “2003” and inserting “2008”.

(2) SUPPLEMENTAL GRANTS FOR ADDITIONAL PREVENTIVE HEALTH SERVICES.—Section 1509(d)(1) of the Public Health Service Act (42 U.S.C. 300n–4a(d)(1)) is amended by striking “2003” and inserting “2008”.

(b) TREATMENT AND PREVENTION.—Title XXIX of the Public Health Service Act, as amended by section 302, is further amended by adding at the end the following:

“Subtitle C—Reducing Disease and Disease-Related Complications

“CHAPTER 1—CANCER REDUCTION

“SEC. 2921. CANCER PREVENTION AND TREATMENT FOR UNDERSERVED MINORITY OR OTHER POPULATIONS.

“(a) GRANTS.—The Secretary may make grants to qualifying health centers, non-profit organizations, and public institutions for the development, expansion, or operation of programs that, for individuals otherwise served by such centers, provide—

“(1) information and education on cancer prevention;

“(2) screenings for cancer;
“(3) counseling on cancer, including counseling upon a diagnosis of cancer; and
“(4) treatment for cancer.
“(b) Qualifying Health Centers and Public Institutions.—For purposes of this section:
“(1) Qualifying Health Centers.—The term ‘qualifying health center’ includes community health centers, migrant health centers, health centers for the homeless, health centers for residents of public housing, and community clinics.
“(2) Qualifying Public Institutions.—The term ‘qualifying public institutions’ means an entity that meets the requirements of section 2971(b)(1).
“(c) Preference in Making Grants.—In making grants under subsection (a), the Secretary shall give preference to applicants that—
“(1) have service populations that include a significant number of low-income minority individuals who are at-risk for cancer;
“(2) will, through programs under subsection (b)—
“(A) emphasize early detection of and comprehensive treatment for cancer;
“(B) provide comprehensive treatment services for cancer in its earliest stages; and
“(C) carry out subparagraphs (A) and (B) for two or more types of cancer; and

“(3) in order to provide treatment for cancer, have established or will establish referral arrangements with entities that provide screenings for low-income individuals.

“(d) APPROPRIATE CULTURAL CONTEXT.—As a condition for the receipt of a grant under subsection (a), the applicant shall agree that, in the program carried out with the grant, services will be provided in the languages most appropriate for, and with consideration for the cultural background of, the individuals for whom the services are provided.

“(e) OUTREACH SERVICES.—As a condition for the receipt of a grant under subsection (a), the applicant shall agree to provide outreach activities to inform the public of the services of the program, and to provide information on cancer; and

“(f) APPLICATION FOR GRANT.—A grant may be made under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.
“(g) Designation of Type of Cancer.—In making a grant under subsection (a), the Secretary shall designate the type or types of cancer with respect to which the grant is being made.

“(h) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.”.

CHAPTER 2—HIV/AIDS REDUCTION

SEC. 442. HIV/AIDS REDUCTION.

Subtitle C of title XXIX of the Public Health Service Act, as added by section 441, is amended by adding at the end the following:

“CHAPTER 2—HIV/AIDS REDUCTION

SEC. 2922. HIV/AIDS REDUCTION IN THE MINORITY COMMUNITY.

“(a) Expanded Funding.—The Secretary, in collaboration with the Director of the Office of Minority Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Administrator of the Substance Abuse and Mental Health Administration, shall provide funds and carry out activities to expand the Minority HIV/AIDS Initiative.
“(b) USE OF FUNDS.—The additional funds made available under this section may be used, through the Minority HIV/AIDS Initiative, to support the following activities:

“(1) The provision of technical assistance and infrastructure support to reduce HIV/AIDS in minority populations.

“(2) To increase minority populations’ access to HIV/AIDS prevention and care services.

“(3) To build stronger community programs and partnerships to address HIV prevention and the healthcare needs of specific minority racial and ethnic populations.

“(c) PRIORITY INTERVENTIONS.—Within the minority populations referred to in subsection (b), priority in conducting intervention services shall be given to—

“(1) women;

“(2) youth;

“(3) men who engage in homosexual activity;

“(4) persons who engage in intravenous drug abuse;

“(5) homeless individuals; and

“(6) individuals incarcerated or in the penal system.
“(d) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated $610,000,000 for fiscal year 2005, and such sums as may be necessary for each of the fiscal years 2006 through 2010.”.

CHAPTER 3—INFANT MORTALITY REDUCTION

SEC. 443. INFANT MORTALITY REDUCTION.

Subtitle C of title XXIX of the Public Health Service Act, as amended by section 442, is further amended by adding at the end the following:

“CHAPTER 3—INFANT MORTALITY REDUCTION

SEC. 2923. INFANT MORTALITY REDUCTION.

“(a) Back to Sleep Campaign.—

“(1) In general.—The Secretary shall support collaborations through the National Institute of Child Health and Human Development.

“(2) Use of Funds.—Collaborations funded under paragraph (1) shall be directed towards the goal of reducing the incidence of Sudden Infant Death Syndrome in minority communities, particularly the African American and American Indian and Native Alaskan communities, through increased education on the importance of back sleeping for in-
fants. Such increased education shall include child

care centers and other secondary child caregivers.

“(b) GUIDELINES FOR CHILD CARE LICENSURE.—

“(1) IN GENERAL.—The Secretary, acting

through the Director of the National Institute of

Child Health and Human Development, shall con-

vene a working group to develop health guidelines

relating to infant mortality reduction for use by

child care licensing entities, including State, terri-

torial, tribal, and local governments.

“(2) FOCUS.—The guidelines developed under

paragraph (1) shall focus specifically on appropriate

actions to reduce the incidence of Sudden Infant

Death Syndrome in child care settings.

“(3) REPORT.—Not later than 1 year after the

date of enactment of this title, the Secretary shall

submit to the appropriate committees of Congress

and the States a report that describes the guidelines

developed under this subsection.

“(c) AUTHORIZATION OF APPROPRIATIONS.—There

is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years

2005 through 2010.”.
CHAPTER 4—FETAL ALCOHOL SYNDROME

TREATMENT AND DIAGNOSIS

SEC. 444. FETAL ALCOHOL SYNDROME.

Subtitle C of title XXIX of the Public Health Service Act, as amended added by section 443, is further amended by adding at the end the following:

“CHAPTER 4—FETAL ALCOHOL SYNDROME TREATMENT AND DIAGNOSIS

SEC. 2924. FETAL ALCOHOL SYNDROME.

“(a) SURVEILLANCE AND IDENTIFICATION RESEARCH.—The Secretary shall direct the National Center for Birth Defects and Developmental Disabilities (referred to in this section as the ‘Center’) to—

“(1) develop a uniform surveillance case definition for Fetal Alcohol Syndrome (referred to in this section as ‘FAS’) and a uniform surveillance definition for Alcohol Related Neurodevelopmental Disorder (referred to in this section as ‘ARND’);

“(2) develop a comprehensive screening process for FAS and ARND to include all age groups; and

“(3) disseminate the screening process developed under paragraph (2) to—

“(A) hospitals, outpatient programs, and other healthcare providers;
“(B) incarceration and detainment facilities;
“(C) primary and secondary schools;
“(D) social work and child welfare offices;
“(E) State offices and others providing services to individuals with disabilities; and
“(F) others determined appropriate by the Secretary.

“(b) CLINICAL CHARACTERIZATION OF FAS AND RELATED DISEASES.—The Secretary shall direct the National Institute of Alcohol Abuse and Alcoholism to—

“(1) research methods to quantify the central nervous system impairments associated with fetal alcohol exposure and to develop clinical diagnostic tools for the intellectual and behavioral problems associated with FAS and related diseases;
“(2) develop a neurocognitive phenotype for FAS and ARND; and
“(3) include all relevant scientific and clinical characterizations of FAS and related diseases in relevant diagnostic codes.

“(c) COMMUNITY-BASED AND SUPPORT SERVICES COORDINATION GRANTS.—The Secretary shall award grants to States, Indian tribes and tribal organizations,
and nongovernmental organizations for the establishment
of—

“(1) pilot projects to identify and implement
best practices for—

“(A) educating children with fetal alcohol
spectrum disorders, including—

“(i) activities and programs designed
specifically for the identification, treat-
ment, and education of such children; and

“(ii) curricula development and
credentialing of teachers, administrators,
and social workers who implement such
programs;

“(B) educating judges, attorneys, child ad-
vocates, law enforcement officers, prison war-
dens, alternative incarceration administrators,
and incarceration officials on how to treat and
support individuals suffering from a fetal alco-
hol spectrum disorder within the criminal jus-
tice system, including—

“(i) programs designed specifically for
the identification, treatment, and education
of those with a fetal alcohol spectrum dis-
order; and
“(ii) curricula development and credentialing within justice system for individuals who implement such programs; and

“(C) educating adoption or foster care agency officials about available and necessary services for children with fetal alcohol spectrum disorders, including—

“(i) programs designed specifically for the identification, treatment, and education of those with a fetal alcohol spectrum disorder; and

“(ii) education and training for potential parents of an adopted child with a fetal alcohol spectrum disorder;

“(2) nationally coordinated systems that integrate transitional services for those affected by prenatal alcohol exposure such as housing assistance, vocational training and placement, and medication monitoring by—

“(A) providing training and support to family services programs, children’s mental health programs, and other local efforts;

“(B) recruiting and training mentors for teenagers with a fetal alcohol spectrum disorder; and
“(C) maintaining a clearinghouse including all relevant neurobehavioral information needed for supporting individuals with a fetal alcohol spectrum disorder; and

“(3) programs to disseminate and coordinate fetal alcohol spectrum disorder awareness and identification efforts by community health centers, including—

“(A) education of health professionals regarding available support services; and

“(B) implementation of a tracking system targeting the rates of fetal alcohol spectrum disorders among individuals from certain racial, ethnic, and economic backgrounds.

“(d) APPLICATION.—To be eligible to receive a grant under subsection (d), an entity shall submit to the Secretary an application in such form, in such manner, and containing such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

“(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 2005 through 2010.”.
CHAPTER 5—DIABETES PREVENTION AND TREATMENT

SEC 445. MONITORING THE QUALITY OF AND DISPARITIES IN DIABETES CARE.

Part A of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended by adding at the end the following:

"SEC. 904. AREAS OF SPECIAL EMPHASIS.

“The Secretary, acting through the Director, shall incorporate within the annual quality report required under section 913(b)(2) and the annual disparities report required under section 903(a)(6), scientific evidence and information appropriate for monitoring the quality and safety of diabetes care and identifying, understanding, and reducing disparities in care.”.

SEC. 446. DIABETES PREVENTION, TREATMENT, AND CONTROL.

(a) DETERMINATION.—The Secretary, in consultation with Indian tribes and tribal organizations, shall determine—

(1) by tribe, tribal organization, and service unit of the Service, the prevalence of, and the types of complications resulting from, diabetes among Indians; and
(2) based on paragraph (1), the measures (including patient education) each service unit should take to reduce the prevalence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that service unit.

(b) SCREENING.—The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by an Indian tribe or tribal organization operating healthcare programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act.

(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2015, each effective model diabetes project in existence on the date of the enactment of this Act and such other diabetes programs operated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.
(d) Dialysis Programs.—The Secretary shall provide funding through the Service, Indian tribes and tribal organizations to establish dialysis programs, including funds to purchase dialysis equipment and provide necessary staffing.

(e) Other Activities.—The Secretary shall, to the extent funding is available—

(1) in each area office of the Service, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

(2) establish in each area office of the Service a registry of patients with diabetes to track the prevalence of diabetes and the complications from diabetes in that area; and

(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to tribes, tribal organizations, and all other area offices.

(f) Definitions.—For purposes of this section, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.
SEC. 447. GENETICS OF DIABETES.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended by inserting after section 430 the following:

“SEC. 430A. GENETICS OF DIABETES.

“The Diabetes Mellitus Interagency Coordinating Committee, in collaboration with the Directors of the National Human Genome Research Institute, the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Institute of Environmental Health Sciences, and other voluntary organizations and interested parties, shall—

“(1) coordinate and assist efforts of the Type 1 Diabetes Genetics Consortium, which will collect and share valuable DNA information from type 1 diabetes patients from studies around the world; and

“(2) provide continued coordination and support for the consortia of laboratories investigating the genomics of diabetes.”.

SEC. 448. RESEARCH AND TRAINING ON DIABETES IN UNDERSERVED AND MINORITY POPULATIONS.

(a) RESEARCH.—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:
‘‘SEC. 434B. RESEARCH ON DIABETES IN UNDERSERVED AND MINORITY POPULATIONS.

(a) In General.—The Director of the Institute, in coordination with the Director of the National Center on Minority Health and Health Disparities, the Director of the Office of Minority Health, and other appropriate institutes and centers, shall expand, intensify, and coordinate research programs on pre-diabetes, type 1 diabetes and type 2 diabetes in underserved populations and minority groups.

(b) Research.—The research described in subsection (a) shall include research on—

(1) behavior, including diet and physical activity and other aspects of behavior;

(2) environmental factors related to type 2 diabetes that are unique to, more serious, or more prevalent, among underserved or high-risk populations;

(3) research on the prevention of complications, which are unique to, more serious, or more prevalent among minorities, as well as research on how to effectively translate the findings of clinical trials and research to improve methods for self-management and health-care delivery; and

(4) genetic studies of diabetes, consistent with research conducted under section 430A.
“(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for purposes of carrying out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.”.

(b) DIVISION DIRECTORS.—Section 428(b)(1) of the Public Health Service Act (42 U.S.C. 285c–2(b)(1)) is amended by inserting “(including research training of members of minority populations in order to facilitate their conduct of diabetes-related research in underserved populations and minority groups)” after “research programs”.

SEC. 449. AUTHORIZATION OF APPROPRIATIONS.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) (as amended by section 448(a)) is amended by adding at the end the following:

“SEC. 434C. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out this subpart with respect to the programs of the National Institute of Diabetes and Digestive and Kidney Diseases, other than section 434B, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2005 through 2010.”.
SEC. 450. MODEL COMMUNITY DIABETES AND CHRONIC DISEASE CARE AND PREVENTION AMONG PACIFIC ISLANDERS AND NATIVE HAWAIANS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 432, is further amended by adding at the end the following:

“SEC. 399P. MODEL COMMUNITY DIABETES AND CHRONIC DISEASE CARE AND PREVENTION AMONG PACIFIC ISLANDERS AND NATIVE HAWAIANS.

“(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants and enter into cooperative agreements and contracts with eligible entities to establish a model community demonstration project to provide training and support for community-based prevention and control programs targeting diabetes, hypertension, cardiovascular disease, and other related health problems in American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, the Federated States of Micronesia, Hawaii, the Republic of the Marshall Islands, and the Republic of Palau.

“(b) ELIGIBLE ENTITY DEFINED.—In this section the term ‘eligible entity’ means any organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.
“(c) PRIORITY.—The Secretary shall give priority for
grants, agreements, and contracts under this section to
eligible entities that have previously administered cul-
turally appropriate Centers for Disease Control and Pre-
vention programs intended to prevent and control diabetes
in the areas described in subsection (a).

“(d) REGULATIONS.—The Secretary is authorized to
promulgate such regulations as may be necessary to carry
out this section.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There
are authorized to be appropriated to carry out this section,
such sums as may be necessary for fiscal years 2005
through 2010.”.

SEC. 451. PROGRAMS OF CENTERS FOR DISEASE CONTROL
AND PREVENTION.

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

“SEC. 317H. DIABETES IN CHILDREN AND YOUTH.

“(a) SURVEILLANCE ON TYPE 1 DIABETES.—The
Secretary, acting through the Director of the Centers for
Disease Control and Prevention and in consultation with
the Director of the National Institutes of Health, shall de-
velop a sentinel system to collect data on type 1 diabetes,
including the incidence and prevalence of type 1 diabetes
and shall establish a national database for such data.

“(b) Type 2 Diabetes in Youth.—The Secretary
shall implement a national public health effort to address
type 2 diabetes in youth, including—

“(1) enhancing surveillance systems and ex-
panding research to better assess the prevalence and
incidence of type 2 diabetes in youth and determine
the extent to which type 2 diabetes is incorrectly di-
agnosed as type 1 diabetes among children;

“(2) standardizing and improving methods to
assist in diagnosis, treatment, and prevention of dia-
betes including developing less invasive ways to mon-
itor blood glucose to prevent hypoglycemia such as
nonmydriatic retinal imaging and improving existing
 glucometers that measure blood glucose; and

“(3) developing methods to identify obstacles
facing children in traditionally underserved popu-
lations to obtain care to prevent or treat type 2 dia-
betes.

“(c) Long-Term Epidemiological Studies on Di-
abetes in Children.—The Secretary, acting through
the Director of the Centers for Disease Control and Pre-
vention and the Director of the National Institute of Dia-
betes and Digestive and Kidney Diseases, shall conduct
or support long-term epidemiology studies in children with diabetes or at risk for diabetes. Such studies shall investigate the causes and characteristics of the disease and its complications.

“(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 2005 through 2010.”.

CHAPTER 6—HEART DISEASE AND STROKE PREVENTION AND TREATMENT

SEC. 455. SYSTEMS FOR HEART DISEASE AND STROKE.

Title XXIX of the Public Health Service Act, as amended by section 443, is further amended by adding at the end the following:

“Subtitle D—Systems for Heart Disease and Stroke

“CHAPTER 1—HEART DISEASE

“SEC. 2941. HEART DISEASE.

“(a) In General.—The Secretary, acting through the National Heart, Lung and Blood Institute and the Centers for Disease Control, shall award competitive grants to eligible entities to provide for community-based interventions to encourage healthy lifestyles to reduce morbidity and mortality from heart disease.
“(b) Eligible Entities.—To be eligible to receive a grant under subsection (a), an entity shall—

“(1) be a community-based or non-profit organization, academic medical institution, hospital, health center, health plan, health department, or other health-related entity determined appropriate by the Secretary; and

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

“(c) Use of Funds.—An entity shall use amounts received under a grant under this section to—

“(1) carry out interventions that address primary prevention of heart disease in the minority community, including educational outreach efforts concerning risk factors for, and the prevention of, heart disease;

“(2) carry out activities to facilitate healthy lifestyles in minority populations through—

“(A) behavioral change interventions to increase physical activity and improve nutrition;

“(B) the increased use of community facilities and public spaces for exercise;
“(C) school, after-school, or intramural physical activity or sports programs for children and youth;
“(D) employment-based interventions to increase physical activity or nutrition; or
“(3) expand or evaluate existing programs of the type described in paragraphs (1) and (2).
“(d) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

“CHAPTER 2—STROKE EDUCATION CAMPAIGN

“SEC. 2945. STROKE EDUCATION CAMPAIGN.
“(a) In General.—The Secretary shall carry out a national education and information campaign to promote stroke prevention and increase the number of stroke patients who seek immediate treatment. In implementing such education and information campaign, the Secretary shall avoid duplicating existing stroke education efforts by other Federal Government agencies and may consult with national and local associations that are dedicated to increasing the public awareness of stroke, consumers of stroke awareness products, and providers of stroke care.
“(b) Use of Funds.—The Secretary may use amounts appropriated to carry out the campaign described in subsection (a)—

“(1) to make public service announcements about the warning signs of stroke and the importance of treating stroke as a medical emergency;

“(2) to provide education regarding ways to prevent stroke and the effectiveness of stroke treatment;

“(3) to purchase media time and space;

“(4) to pay for advertising production costs;

“(5) to test and evaluate advertising and educational materials for effectiveness, especially among groups at high risk for stroke, including women, older adults, and African-Americans;

“(6) to develop alternative campaigns that are targeted to unique communities, including rural and urban communities, and States with a particularly high incidence of stroke;

“(7) to measure public awareness prior to the start of the campaign on a national level and in targeted communities to provide baseline data that will be used to evaluate the effectiveness of the public awareness efforts; and
“(8) to carry out other activities that the Secretary determines will promote prevention practices among the general public and increase the number of stroke patients who seek immediate care.

“(c) CONSULTATIONS.—In carrying out this section, the Secretary shall consult with medical, surgical, rehabilitation, and nursing specialty groups, hospital associations, voluntary health organizations, emergency medical services, State directors, and associations, experts in the use of telecommunication technology to provide stroke care, national disability, minority health professional organizations and consumer organizations representing individuals with disabilities and chronic illnesses, concerned advocates, and other interested parties.

“(d) STROKE.—In this section, the term ‘stroke’ means a ‘brain attack’ in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (b), such sums as may be necessary for each of fiscal years 2005 through 2010.”.
CHAPTER 7—OBESITY AND OVERWEIGHT REDUCTION

SEC. 461. OVERWEIGHT AND OBESITY PREVENTION AND TREATMENT.

(a) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention, the Administrator of the National Center for Minority Health and Health Disparities, and the Administrator of the Health Resources and Services Administration, shall establish grant programs for the purpose of preventing and treating overweight and obesity in underserved minority populations.

(b) DEFINITIONS.—In this section, with respect to an individual:

(1) OBESITY.—The term “obesity” means a Body Mass Index greater than or equal to 30.0 kg/m².

(2) OVERWEIGHT.—The term “overweight” means a Body Mass Index of 25 to 29.9 kg/m².

(c) CENTERS FOR DISEASE CONTROL AND PREVENTION.—The Director of the Centers for Disease Control and Prevention shall expand overweight and obesity reduction activities that include the following:

(1) Surveillance in minority racial and ethnic populations.
(2) Communication strategies, including the use of social marketing for minority populations, about the dangers of obesity.

(3) Creation of partnerships with State health departments in developing obesity prevention and treatment interventions.

(4) Development of work-based wellness programs to encourage adoption of healthy lifestyles by employees.

(d) National Center for Minority Health and Health Disparities.—The Director of the Centers for Disease Control and Prevention shall establish and implement a grant program to support research in the following areas:

(1) Behavioral and environmental causes of overweight and obesity in minority populations.

(2) Prevention and treatment interventions for overweight and obesity, tailored for minority populations.

(3) Disparities in the prevalence of overweight and obesity among racial and ethnic minority groups.

(4) Development and dissemination of best practice guidelines for treatment of overweight and
obesity, tailored for gender and age groups within minority populations.

(5) Data collection and reporting relating to overweight and obesity in minority populations.

(e) Health Resources and Services Administration.—The Administrator of the Health Resources and Services Administration, in collaboration with the Director of the Office of Minority Health, the Secretary of Education, and the Secretary of Agriculture, shall establish and implement a school-based obesity prevention and treatment program that may include the following activities:

(1) Projects to change the perception of overweight and obesity of children from racially and ethnically diverse backgrounds at all ages.

(2) Culturally appropriate student education about healthy eating habits, based on the Dietary Guidelines for Americans.

(3) Student programs to increase knowledge, attitudes, skills, behaviors, and confidence needed to be physically active for life.

(4) Student peer advisor programs to increase awareness and model healthy lifestyles among fellow students.
(5) Teacher education using scientifically evaluated physical education and nutrition curricula tailored to minority populations.

(6) Family-focused initiatives to encourage the adoption of strategies relating to healthy lifestyles for parents (or guardians) and children.

(7) The creation of partnerships with community, fitness, or health organizations that will promote healthy eating and physical activity among children.

(8) Incentive programs to ensure the provision of healthful foods and beverages on school campuses and at school events.

(f) EVALUATION.—A grantee under this section shall submit to the Secretary an evaluation, in collaboration with an academic health center or other qualified entity, that describes activities carried out with funds received under the grant and the effectiveness of such activities in preventing or treating overweight and obesity.

(g) 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 2005 through 2010.
CHAPTER 8—TUBERCULOSIS CONTROL, PREVENTION, AND TREATMENT

SEC. 465. ADVISORY COUNCIL FOR THE ELIMINATION OF TUBERCULOSIS.

Section 317E(f) of the Public Health Service Act (42 U.S.C. 247b–6(f)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by striking paragraphs (2) through (4), and inserting the following:

“(2) DUTIES.—For the purpose of making progress toward the goal of eliminating tuberculosis from the United States, the Council shall provide to the Secretary and other appropriate Federal officials advice on coordinating the activities of the Public Health Service and other Federal agencies that relate to such disease and on efficiently utilizing the Federal resources involved.

“(3) NATIONAL PLAN.—In carrying out paragraph (2), the Council, in consultation with appropriate public and private entities, shall make recommendations on the development, revision, and implementation of a national plan to eliminate tuberculosis in the United States. In carrying out this paragraph, the Council shall—
“(A) consider the recommendations of the Institute of Medicine regarding the elimination of tuberculosis;

“(B) address the development and application of new technologies; and

“(C) review the extent to which progress has been made toward eliminating tuberculosis.

“(4) GLOBAL ACTIVITIES.—In carrying out paragraph (2), the Council, in consultation with appropriate public and private entities, shall make recommendations for the development and implementation of a plan to guide the involvement of the United States in global and cross border tuberculosis-control activities, including recommendations regarding policies, strategies, objectives, and priorities. Such recommendations for the plan shall have a focus on countries where a high incidence of tuberculosis directly affects the United States, such as Mexico, and on access to a comprehensive package of tuberculosis control measures, as defined by the World Health Organization directly observed treatment, short course strategy (commonly known as DOTS).

“(5) COMPOSITION.—The Council shall be composed of—
“(A) representatives from the Centers for Disease Control and Prevention, the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the U.S.-Mexico Border Health Commission, and other Federal departments and agencies that carry out significant activities relating to tuberculosis; and

“(B) members appointed from among individuals who are not officers or employees of the Federal Government.”.

**SEC. 466. NATIONAL PROGRAM FOR TUBERCULOSIS ELIMINATION.**

Section 317E of the Public Health Service Act (42 U.S.C. 247b–6) is amended—

(1) by striking the heading for the section and inserting the following:

“NATIONAL PROGRAM FOR TUBERCULOSIS ELIMINATION”;

(2) by amending subsection (b) to read as follows:

“(b) RESEARCH, DEMONSTRATION PROJECTS, EDUCATION, AND TRAINING.—With respect to the prevention, control, and elimination of tuberculosis, the Secretary may, directly or through grants to public or nonprofit private entities, carry out the following:
“(1) Research, with priority given to research concerning—

“(A) diagnosis and treatment of latent infection of tuberculosis;

“(B) strains of tuberculosis resistant to drugs;

“(C) cases of tuberculosis that affect certain high-risk populations; and

“(D) clinical trials, including those conducted through the Tuberculosis Trials Consortium.

“(2) Demonstration projects, including for—

“(A) the development of regional capabilities for the prevention, control, and elimination of tuberculosis particularly in low-incidence regions; and

“(B) collaboration with the Immigration and Naturalization Service to identify and treat immigrants with active or latent tuberculosis infection.

“(3) Public information and education programs.

“(4) Education, training and clinical skills improvement activities for health professionals, including allied health personnel.
“(5) Support of model centers to carry out activities under paragraphs (2) through (4).

“(6) Collaboration with international organizations and foreign countries, including Mexico, in coordination with the United States Agency for International Development, in carrying out such activities, including coordinating activities through the Advisory Council for the Elimination of Tuberculosis.

“(7) Capacity support to States and large cities for strengthening tuberculosis programs.”; and

(3) by striking subsection (g) and inserting the following:

“(g) REPORTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with the Advisory Council for the Elimination of Tuberculosis, shall biennially prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report on the activities carried out under this section. Each report shall include the opinion of the Council on the extent to which its recommendations under section 317E(f)(3) regarding tuberculosis have been implemented.
“(h) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.”.

SEC. 467. INCLUSION OF INPATIENT HOSPITAL SERVICES FOR THE TREATMENT OF TB-INFECTED INDIVIDUALS.

(a) In General.—Section 1902(z)(2) of the Social Security Act (42 U.S.C. 1396a(z)(2)) is amended by adding at the end the following:

“(G) Inpatient hospital services.”.

(b) Effective Date.—The amendment made by subsection (a) takes effect on October 1, 2004.

CHAPTER 9—ASTHMA

SEC. 471. PROVISIONS REGARDING NATIONAL ASTHMA EDUCATION AND PREVENTION PROGRAM OF NATIONAL HEART, LUNG, AND BLOOD INSTITUTE.

In addition to any other authorization of appropriations that is available to the National Heart, Lung, and Blood Institute for the purpose of carrying out the National Asthma Education and Prevention Program, there is authorized to be appropriated to such Institute for such purpose such sums as may be necessary for each of fiscal years 2005 through 2010. Amounts appropriated under
the preceding sentence shall be expended to expand such Program.

SEC. 472. ASTHMA-RELATED ACTIVITIES OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) Expansion of Public Health Surveillance Activities; Program for Providing Information and Education to Public.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall collaborate with the States to expand the scope of—

(1) activities that are carried out to determine the incidence and prevalence of asthma; and

(2) activities that are carried out to prevent the health consequences of asthma, including through the provision of information and education to the public regarding asthma, which may include the use of public service announcements through the media and such other means as such Director determines to be appropriate.

(b) Compilation of Data.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and in consultation with the National Asthma Education Prevention Program Coordinating Committee, shall—
(1) conduct local asthma surveillance activities to collect data on the prevalence and severity of asthma and the quality of asthma management, including—

(A) telephone surveys to collect sample household data on the local burden of asthma; and

(B) health care facility specific surveillance to collect asthma data on the prevalence and severity of asthma, and on the quality of asthma care; and

(2) compile and annually publish data on—

(A) the prevalence of children suffering from asthma in each State; and

(B) the childhood mortality rate associated with asthma nationally and in each State.

(c) ADDITIONAL FUNDING.—In addition to any other authorization of appropriations that is available to the Centers for Disease Control and Prevention for the purpose of carrying out this section, there is authorized to be appropriated to such Centers for such purpose such sums as may be necessary for each of fiscal years 2005 through 2010.
SEC. 473. GRANTS FOR COMMUNITY OUTREACH REGARDING ASTHMA INFORMATION, EDUCATION, AND SERVICES.

(a) IN GENERAL.—The Secretary may make grants to nonprofit private entities for projects to carry out, in communities identified by entities applying for the grants, outreach activities to provide for residents of the communities the following:

(1) Information and education on asthma.

(2) Referrals to health programs of public and nonprofit private entities that provide asthma-related services, including such services for low-income individuals. The grant may be expended to make arrangements to coordinate the activities of such entities in order to establish and operate networks or consortia regarding such referrals.

(b) PREFERENCES IN MAKING GRANTS.—In making grants under subsection (a), the Secretary shall give preference to applicants that will carry out projects under such subsection in communities that are disproportionately affected by asthma or underserved with respect to the activities described in such subsection and in which a significant number of low-income individuals reside.

(c) EVALUATIONS.—A condition for a grant under subsection (a) is that the applicant for the grant agree to provide for the evaluation of the projects carried out
under such subsection by the applicant to determine the extent to which the projects have been effective in carrying out the activities referred to in such subsection.

(d) FUNDING.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2005 through 2010.

SEC. 474. ACTION PLANS OF LOCAL EDUCATIONAL AGENCIES REGARDING ASTHMA.

(a) IN GENERAL.—

(1) SCHOOL-BASED ASTHMA ACTIVITIES.—The Secretary of Education (in this section referred to as the “Secretary”), in consultation with the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, may make grants to local educational agencies for programs to carry out at elementary and secondary schools specified in paragraph (2) asthma-related activities for children who attend such schools.

(2) ELIGIBLE SCHOOLS.—The elementary and secondary schools referred to in paragraph (1) are such schools that are located in communities with a significant number of low-income or underserved individuals (as defined by the Secretary).
(b) **DEVELOPMENT OF PROGRAMS.**—Programs under subsection (a) shall include grants under which local education agencies and State public health officials collaborate to develop programs to improve the management of asthma in school settings.

(c) **CERTAIN GUIDELINES.**—Programs under subsection (a) shall be carried out in accordance with applicable guidelines or other recommendations of the National Institutes of Health (including the National Heart, Lung, and Blood Institute) and the Environmental Protection Agency.

(d) **CERTAIN ACTIVITIES.**—Activities that may be carried out in programs under subsection (a) include the following:

1. Identifying and working directly with local hospitals, community clinics, advocacy organizations, parent-teacher associations, minority health organizations, and asthma coalitions.
2. Identifying asthmatic children and training them and their families in asthma self-management.
3. Purchasing asthma equipment.
4. Hiring school nurses.
5. Training teachers, nurses, coaches, and other school personnel in asthma-symptom recognition and emergency responses.
(6) Simplifying procedures to improve students’ safe access to their asthma medications.

(7) Such other asthma-related activities as the Secretary determines to be appropriate.

e) DEFINITIONS.—For purposes of this section, the terms “elementary school”, “local educational agency”, and “secondary school” have the meanings given such terms in the Elementary and Secondary Education Act of 1965.

(f) FUNDING.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2005 through 2010.

CHAPTER 10—SICKLE CELL DISEASE

SEC. 481. DEMONSTRATION PROGRAM FOR THE DEVELOPMENT AND ESTABLISHMENT OF SYSTEMIC MECHANISMS FOR THE PREVENTION AND TREATMENT OF SICKLE CELL DISEASE.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Administrator, through the Bureau of Primary Health Care and the Maternal and Child Health Bureau, shall conduct a demonstration program by making grants to up to 40 eligible entities for each fiscal year in which the pro-
gram is conducted under this section for the purpose
of developing and establishing systemic mechanisms
to improve the prevention and treatment of Sickle
Cell Disease, including through—

(A) the coordination of service delivery for
individuals with Sickle Cell Disease;

(B) genetic counseling and testing;

(C) bundling of technical services related
to the prevention and treatment of Sickle Cell
Disease;

(D) training of health professionals; and

(E) identifying and establishing other ef-
forts related to the expansion and coordination
of education, treatment, pain management, and
continuity of care programs for individuals with
Sickle Cell Disease.

(2) GRANT AWARD REQUIREMENTS.—

(A) GEOGRAPHIC DIVERSITY.—The Ad-
ministrator shall, to the extent practicable,
award grants under this section to eligible enti-
ties located in different regions of the United
States.

(B) PRIORITY.—In awarding grants under
this section, the Administrator shall give pri-
ority to awarding grants to eligible entities that

are—

(i) Federally-qualified health centers

that have a partnership or other arrange-

ment with a comprehensive Sickle Cell Dis-

ease treatment center that does not receive

funds from the National Institutes of

Health; or

(ii) Federally-qualified health centers

that intend to develop a partnership or

other arrangement with a comprehensive

Sickle Cell Disease treatment center that

does not receive funds from the National

Institutes of Health.

(b) ADDITIONAL REQUIREMENTS.—An eligible entity

awarded a grant under this section shall use funds made

available under the grant to carry out, in addition to the

activities described in subsection (a)(1), the following ac-

tivities:

(1) To facilitate and coordinate the delivery of

education, treatment, and continuity of care for indi-

viduals with Sickle Cell Disease under—

(A) the entity’s collaborative agreement

with a community-based Sickle Cell Disease or-
ganization or a nonprofit entity that works with individuals who have Sickle Cell Disease;

(B) the Sickle Cell Disease newborn screening program for the State in which the entity is located; and

(C) the maternal and child health program under title V of the Social Security Act (42 U.S.C. 701 et seq.) for the State in which the entity is located.

(2) To train nursing and other health staff who specialize in pediatrics, obstetrics, internal medicine, or family practice to provide healthcare and genetic counseling for individuals with the sickle cell trait.

(3) To enter into a partnership with adult or pediatric hematologists in the region and other regional experts in Sickle Cell Disease at tertiary and academic health centers and State and county health offices.

(c) NATIONAL COORDINATING CENTER.—

(1) ESTABLISHMENT.—The Administrator shall enter into a contract with an entity to serve as the National Coordinating Center for the demonstration program conducted under this section.

(2) ACTIVITIES DESCRIBED.—The National Coordinating Center shall—
(A) collect, coordinate, monitor, and distribute data, best practices, and findings regarding the activities funded under grants made to eligible entities under the demonstration program;

(B) develop a model protocol for eligible entities with respect to the prevention and treatment of Sickle Cell Disease;

(C) develop educational materials regarding the prevention and treatment of Sickle Cell Disease; and

(D) prepare and submit to Congress a final report that includes recommendations regarding the effectiveness of the demonstration program conducted under this section and such direct outcome measures as—

(i) the number and type of healthcare resources utilized (such as emergency room visits, hospital visits, length of stay, and physician visits for individuals with Sickle Cell Disease); and

(ii) the number of individuals that were tested and subsequently received genetic counseling for the sickle cell trait.
(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit an application to the Administrator at such time, in such manner, and containing such information as the Administrator may require.

(e) DEFINITIONS.—In this section:

(1) ADMINISTRATOR.—The term “Administrator” means the Administrator of the Health Resources and Services Administration.

(2) ELIGIBLE ENTITY.—The term “eligible entity” means a Federally-qualified health center, a nonprofit hospital or clinic, or a university health center that provides primary healthcare, that—

(A) has a collaborative agreement with a community-based Sickle Cell Disease organization or a nonprofit entity with experience in working with individuals who have Sickle Cell Disease; and

(B) demonstrates to the Administrator that either the Federally-qualified health center, the nonprofit hospital or clinic, the university health center, the organization or entity described in subparagraph (A), or the experts described in subsection (b)(3), has at least 5
years of experience in working with individuals
who have Sickle Cell Disease.

(3) Federally-qualified health center.—The term “Federally-qualified health center”
has the meaning given that term in section
1905(l)(2)(B) of the Social Security Act (42 U.S.C.
1396d(l)(2)(B)).

(f) Authorization of Appropriations.—There is
authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years
2005 through 2010.

CHAPTER 11—AUTOIMMUNE DISEASE IN
MINORITY POPULATIONS

SEC. 482. RESEARCH FUNDING FOR AUTOIMMUNE DISEASE
IN MINORITY POPULATIONS.

Part B of title IV of the Public Health Service Act
is amended by inserting after section 409E (42 U.S.C.
284i) the following:

“SEC. 490E–1. RESEARCH FUNDING FOR AUTOIMMUNE DIS-
EASE IN MINORITY POPULATIONS.

“(a) Expansion and intensification of activities regarding autoimmune diseases on minorities.—With respect to the plan under section 409E(c)(1),
the Coordinating Committee shall ensure that provisions
of the plan developed under paragraph (2) of such sub-
section include provisions for the following:

“(1)(A) Basic research, epidemiological re-
search, and other appropriate research concerning
the etiology and causes of autoimmune diseases in
all minorities, including genetic, hormonal, and envi-
ronmental factors.

“(B)(i) Giving priority under subparagraph (A)
to research regarding environmental factors.

“(ii) The coordination of (to the extent prac-
ticable and appropriate), and providing additional
support for, research described in clause (i) that is
conducted by public or nonprofit private entities.

“(2)(A) The development of information and
education programs for patients, healthcare pro-
viders, and others as appropriate on genetic, hor-
monal, and environmental risk factors associated
with autoimmune diseases in minorities, and on the
importance of the prevention or control of such risk
factors and timely referral with appropriate diag-
nosis and treatment.

“(B) The inclusion in programs under subpara-
graph (A) of information and education on the prev-
ance and nature of autoimmune diseases, on risk
factors, and on health-related behaviors that can improve health status in minority populations.

“(3) Outreach programs for purposes of paragraphs (1) and (2) that—

“(A) are directed toward minority individuals, particularly those who are at-risk for autoimmune diseases; and

“(B) are carried out through community health centers, community clinics, or other health centers under section 330, through State, territory, or local health departments, Indian tribes, or through primary care physicians.

“(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 2005 through 2010.”.

CHAPTER 12—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

SEC. 485. PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES.

(a) In General.—Section 318(e)(1) of the Public Health Service Act (42 U.S.C. 247e(e)(1)) is amended by striking “1998” and inserting “2008”.
(b) PREVENTABLE CASES OF INFERTILITY.—Section 318A of the Public Health Service Act (42 U.S.C. 247e–1) is amended—

(1) in subsection (q), by striking “1998” and inserting “2010”; and

(2) in subsection (r)(2), by striking “1998” and inserting “2010”.

CHAPTER 13—DENTAL DISEASE

SEC. 486. GRANTS TO IMPROVE THE PROVISION OF DENTAL SERVICES UNDER MEDICAID AND SCHIP.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following:

“SEC. 511. GRANTS TO IMPROVE THE PROVISION OF DENTAL SERVICES UNDER MEDICAID AND SCHIP.

“(a) Authority To Make Grants.—In addition to any other payments made under this title to a State, the Secretary shall award grants to States that satisfy the requirements of subsection (b) to improve the provision of dental services to children who are enrolled in a State plan under title XIX or a State child health plan under title XXI (in this section, collectively referred to as the ‘State plans’).

“(b) Requirements.—In order to be eligible for a grant under this section, a State shall provide the Secretary with the following assurances:

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“(1) **Improved Service Delivery.**—The State shall have a plan to improve the delivery of dental services to children, including children with special health care needs, who are enrolled in the State plans, including providing outreach and administrative case management, improving collection and reporting of claims data, and providing incentives, in addition to raising reimbursement rates, to increase provider participation.

“(2) **Adequate Payment Rates.**—The State has provided for payment under the State plans for dental services for children at levels consistent with the market-based rates and sufficient enough to enlist providers to treat children in need of dental services.

“(3) **Ensured Access.**—The State shall ensure it will make dental services available to children enrolled in the State plans to the same extent as such services are available to the general population of the State.

“(c) **Use of Funds.**—

“(1) **In General.**—Funds provided under this section may be used to provide administrative resources (such as program development, provider training, data collection and analysis, and research-
related tasks) to assist States in providing and assessing services that include preventive and therapeutic dental care regimens.

“(2) LIMITATION.—Funds provided under this section may not be used for payment of direct dental, medical, or other services or to obtain Federal matching funds under any Federal program.

“(d) APPLICATION.—A State shall submit an application to the Secretary for a grant under this section in such form and manner and containing such information as the Secretary may require.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make grants under this section, such sums as may be necessary for fiscal year 2005 and each fiscal year thereafter.

“(f) APPLICATION OF OTHER PROVISIONS OF TITLE.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

“(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under subsection (a) to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):
“(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

“(B) Section 504(e) (relating to the use of funds for the purchase of technical assistance).

“(C) Section 504(d) (relating to a limitation on administrative expenditures).

“(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

“(E) Section 507 (relating to penalties for false statements).

“(F) Section 508 (relating to nondiscrimination).

“(G) Section 509 (relating to the administration of the grant program).”.

SEC. 487. STATE OPTION TO PROVIDE WRAP-AROUND SCHIP COVERAGE TO CHILDREN WHO HAVE OTHER HEALTH COVERAGE.

(a) In General.—

(1) SCHIP.—

(A) State option to provide wrap-around coverage.—Section 2110(b) of the
Social Security Act (42 U.S.C. 1397jj(b)) is amended—

(i) in paragraph (1)(C), by inserting “, subject to paragraph (5),” after “under title XIX or”; and

(ii) by adding at the end the following:

“(5) STATE OPTION TO PROVIDE WRAP-AROUND COVERAGE.—A State may waive the requirement of paragraph (1)(C) that a targeted low-income child may not be covered under a group health plan or under health insurance coverage, if the State satisfies the conditions described in subsection (c)(8). The State may waive such requirement in order to provide—

“(A) dental services;

“(B) cost-sharing protection; or

“(C) all services.

In waiving such requirement, a State may limit the application of the waiver to children whose family income does not exceed a level specified by the State, so long as the level so specified does not exceed the maximum income level otherwise established for other children under the State child health plan.”.
(B) CONDITIONS DESCRIBED.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following:

“(8) CONDITIONS FOR PROVISION OF WRAP-AROUND COVERAGE.—For purposes of section 2110(b)(5), the conditions described in this paragraph are the following:

“(A) INCOME ELIGIBILITY.—The State child health plan (whether implemented under title XIX or this XXI)—

“(i) has the highest income eligibility standard permitted under this title as of January 1, 2002;

“(ii) subject to subparagraph (B), does not limit the acceptance of applications for children; and

“(iii) provides benefits to all children in the State who apply for and meet eligibility standards.

“(B) NO WAITING LIST IMPOSED.—With respect to children whose family income is at or below 200 percent of the poverty line, the State does not impose any numerical limitation, waiting list, or similar limitation on the eligibility of
such children for child health assistance under such State plan.

“(C) No more favorable treatment.—
The State child health plan may not provide more favorable coverage of dental services to the children covered under section 2110(b)(5) than to children otherwise covered under this title.”.

(C) State option to waive waiting period.—Section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) is amended—

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

(ii) in clause (ii), by striking the period and inserting “; and”;

(iii) by adding at the end the following:

“(iii) at State option, may not apply a waiting period in the case of a child described in section 2110(b)(5), if the State satisfies the requirements of section 2105(e)(8).”.
(2) Application of enhanced match under Medicaid.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in subsection (b), in the fourth sentence, by striking “or subsection (u)(3)” and inserting “(u)(3), or (u)(4)”;

(B) in subsection (u)—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following:

“(4) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for items and services for children described in section 2110(b)(5), but only in the case of a State that satisfies the requirements of section 2105(c)(8).”.

(3) Application of secondary payor provisions.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B) through (D) as subparagraphs (C) through (E), respectively; and

(B) by inserting after subparagraph (A) the following:
“(B) Section 1902(a)(25) (relating to coordination of benefits and secondary payor provisions) with respect to children covered under a waiver described in section 2110(b)(5).”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2004, and shall apply to child health assistance and medical assistance provided on or after that date.

SEC. 488. GRANTS TO IMPROVE THE PROVISION OF DENTAL HEALTH SERVICES THROUGH COMMUNITY HEALTH CENTERS AND PUBLIC HEALTH DEPARTMENTS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by insert before section 330, the following:

“SEC. 329. GRANT PROGRAM TO EXPAND THE AVAILABILITY OF SERVICES.

“(a) IN GENERAL.—The Secretary, acting through the Health Resources and Services Administration, shall establish a program under which the Secretary may award grants to eligible entities and eligible individuals to expand the availability of primary dental care services in dental health professional shortage areas or medically underserved areas.

“(b) ELIGIBILITY.—
“(1) ENTITIES.—To be eligible to receive a grant under this section an entity—

“(A) shall be—

“(i) a health center receiving funds under section 330 or designated as a Federally qualified health center;

“(ii) a county or local public health department, if located in a federally-designated dental health professional shortage area;

“(iii) an Indian tribe or tribal organization (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b));

“(iv) a dental education program accredited by the Commission on Dental Accreditation; or

“(v) a community-based program whose child service population is made up of at least 33 percent of children who are eligible children, including at least 25 percent of such children being children with mental retardation or related developmental disabilities, unless specific docu-
mentation of a lack of need for access by
this sub-population is established; and

“(B) shall prepare and submit to the Sec-
retary an application at such time, in such
manner, and containing such information as the
Secretary may require, including information
concerning dental provider capacity to serve in-
dividuals with developmental disabilities.

“(2) INDIVIDUALS.—To be eligible to receive a
grant under this section an individual shall—

“(A) be a dental health professional li-
censed or certified in accordance with the laws
of State in which such individual provides den-
tal services;

“(B) prepare and submit to the Secretary
an application at such time, in such manner,
and containing such information as the Sec-
retary may require; and

“(C) provide assurances that—

“(i) the individual will practice in a
federally-designated dental health profes-
sional shortage area; or

“(ii) not less than 25 percent of the
patients of such individual are—
“(I) receiving assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);
“(II) receiving assistance under a State plan under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.); or
“(III) uninsured.
“(c) USE OF FUNDS.—
“(1) ENTITIES.—An entity shall use amounts received under a grant under this section to provide for the increased availability of primary dental services in the areas described in subsection (a). Such amounts may be used to supplement the salaries offered for individuals accepting employment as dentists in such areas.
“(2) INDIVIDUALS.—A grant to an individual under subsection (a) shall be in the form of a $1,000 bonus payment for each month in which such individual is in compliance with the eligibility requirements of subsection (b)(2)(C).
“(d) AUTHORIZATION OF APPROPRIATIONS.—
“(1) IN GENERAL.—Notwithstanding any other amounts appropriated under section 330 for health
centers, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2005 through 2010 to hire and retain dental healthcare providers under this section.

“(2) USE OF FUNDS.—Of the amount appropriated for a fiscal year under paragraph (1), the Secretary shall use—

“(A) not less than 65 percent of such amount to make grants to eligible entities; and

“(B) not more than 35 percent of such amount to make grants to eligible individuals.”.

CHAPTER 14—PREVENTION AND CONTROL OF INJURIES

SEC. 491. PREVENTION AND CONTROL OF INJURIES.

(a) In General.—Section 394A of the Public Health Service Act (42 U.S.C. 280b–3) is amended—

(1) by striking “and” after “1994,”;

(2) by striking “and” after “1998,”; and

(3) by striking “through 2005” and all that follows and inserting the following: “through 2004, $300,000,000 for fiscal year 2005, and such sums as may be necessary for each of the fiscal years 2006 through 2010.”.

(b) Demonstration Projects in Urban Areas.—

Section 394A of the Public Health Service Act (42 U.S.C.
314

1 280b–3) is amended by adding at the end the following
sentence: “For the purpose of carrying out section
2 393(a)(6) in urban areas, there are authorized to be ap-
3 propriated such sums as may be necessary for each of the
4 fiscal years 2005 through 2010, in addition to amounts
5 available for such purpose pursuant to the preceding sen-
6 tence.”.
7
8  (c) DEMONSTRATION PROJECTS REGARDING VIO-
9 LENCE.—Section 393 of the Public Health Service Act (42
10 U.S.C. 280b–1a) is amended—
11
12      (1) by redesignating subsection (b) as sub-
13          section (c); and
14
15      (2) by inserting after subsection (a) the fol-
16          lowing subsection:
17
18          “(b) Grants under subsection (a)(6) shall include
19          grants to public or nonprofit private trauma centers for
20          demonstration projects to reduce violence.”.
21
22  CHAPTER 15—UTERINE FIBROID
23  RESEARCH AND EDUCATION
24
25  SEC. 495. RESEARCH WITH RESPECT TO UTERINE
26          FIBROIDS.
27
28      (a) IN GENERAL.—The Director of the National In-
29          stitutes of Health (in this section referred to as the “Di-
30          rector of NIH”) shall expand, intensify, and coordinate
programs for the conduct and support of research with
respect to uterine fibroids.

(b) Administration.—

(1) In general.—The Director of NIH shall
carry out this section through the appropriate insti-
tutes, offices, and centers, including the National In-
stitute of Child Health and Human Development,
the National Institute of Environmental Health
Sciences, the Office of Research on Women’s Health,
the National Center on Minority Health and Health
Disparities, and any other agencies that the Director
of NIH determines to be appropriate.

(2) Coordination of activities.—The Office
of Research on Women’s Health shall coordinate ac-
tivities under paragraph (1) among the institutes,
offices, and centers of the National Institutes of
Health.

(c) Authorization of Appropriations.—For the
purpose of carrying out this section, there are authorized
to be appropriated such sums as may be necessary for
each of the fiscal years 2005 through 2010.

SEC. 496. INFORMATION AND EDUCATION WITH RESPECT
TO UTERINE FIBROIDS.

(a) Uterine Fibroids Public Education Pro-
gram.—
(1) IN GENERAL.—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, shall develop and disseminate to the public information regarding uterine fibroids, including information on—

(A) the incidence and prevalence of uterine fibroids;

(B) the elevated risk for minority women; and

(C) the availability, as medically appropriate, of a range of treatment options for symptomatic uterine fibroids.

(2) DISSEMINATION.—The Secretary may disseminate information under paragraph (1) directly, or through arrangements with 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)), Federal, State, or local agencies, or the media.

(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 the fiscal years 2005 through 2010.

(b) Uterine Fibroids Information Program for Health Care Providers.—

(1) In general.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall develop and disseminate to health care providers information on uterine fibroids, including information on the elevated risk for minority women and the range of available options for the treatment of symptomatic uterine fibroids.

(2) 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 the fiscal years 2005 through 2010.

(c) Definition.—For purposes of this section, the term “minority”, with respect to women, means women who are members of racial or ethnic minority groups within the meaning of section 1707 of the Public Health Service Act (42 U.S.C. 300u–6).
TITLE V—DATA COLLECTION AND REPORTING.
Subtitle A—General Provisions

SEC. 501. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) PURPOSE.—It is the purpose of this section to promote data collection, analysis, and reporting by race, ethnicity, and primary language among federally supported health programs.

(b) AMENDMENT.—Title XXIX of the Public Health Service Act, as amended by section 463, is further amended by adding at the end the following:

“Subtitle E—Data Collection and Reporting

“SEC. 2951. DATA ON RACE, ETHNICITY AND PRIMARY LANGUAGE.

“(a) REQUIREMENTS.—

“(1) IN GENERAL.—Each health-related program operated by or that receives funding or reimbursement, in whole or in part, either directly or indirectly from the Department of Health and Human Services shall—

“(A) require the collection, by the agency or program involved, of data on the race, ethnicity, and primary language of each applicant
for and recipient of health-related assistance under such program—

“(i) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

“(ii) using the standards developed under subsection (e) for the collection of language data;

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

“(iv) where practicable, through self-report;

“(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

“(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and
“(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

“(C) systematically analyze such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities in health and healthcare and when appropriate, for men and women separately, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

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

“(E) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, and primary language data.

“(2) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed to—
“(A) permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

“(B) require health care providers to collect data.

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

“(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

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

“(c) NATIONAL PLAN OF THE DATA COUNCIL.—The Secretary shall develop and implement a national plan to
improve the collection, analysis, and reporting of racial, ethnic, and primary language data at the Federal, State, territorial, Tribal, and local levels, including data to be collected under subsection (a). The Data Council of the Department of Health and Human Services, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other appropriate public and private entities, shall make recommendations to the Secretary concerning the development, implementation, and revision of the national plan. Such plan shall include recommendations on how to—

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

“(2) expand awareness among Federal agencies, States, territories, Indian tribes, health providers, health plans, health insurance issuers, and the general public that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of healthcare services;

“(3) ensure that future patient record systems have data code sets for racial, ethnic, and primary language identifiers and that such identifiers can be
retrieved from clinical records, including records transmitted electronically;

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

“(5) provide researchers with greater access to racial, ethnic, and primary language data, subject to privacy and confidentiality regulations; and 

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

“(d) COMPLIANCE WITH STANDARDS.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes) in accordance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (at a minimum).

“(e) LANGUAGE COLLECTION STANDARDS.—Not later than 1 year after the date of enactment of this title, the Director of the Office of Minority Health, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall develop and dissemi-
nate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

“(f) Technical Assistance for the Collection and Reporting of Data.—

“(1) In general.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a healthcare program or an entity operating under such program to comply with the requirements of this section.

“(2) Types of assistance.—Assistance provided under this subsection may include assistance to—

“(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

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

“(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and
“(D) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, and the general public that data collection and reporting by race, ethnicity, and preferred language are legal and essential for eliminating health and healthcare disparities.

“(g) Analysis of Racial and Ethnic Data.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in coordination with the Administrator of the Centers for Medicare and Medicaid Services, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting Federal standards for race, ethnicity, and primary language data collection and analysis of racial and ethnic disparities in health and healthcare in public programs by—

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

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

“(3) developing new quality measures relating to racial and ethnic disparities in health and healthcare;
“(4) identifying the level at which data analysis should be conducted; and

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

“(h) NATIONAL CONFERENCE.—

“(1) IN GENERAL.—The Secretary shall sponsor a biennial national conference on racial, ethnic, and primary language data collection to enhance coordination, build partnerships, and share best practices in racial, ethnic, and primary language data collection, analysis, and reporting.

“(2) REPORTS.—Not later than 6 months after the date on which a national conference has convened under paragraph (1), the Secretary shall publish in the Federal Register and 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 concerning the proceedings and findings of the conference.

“(i) REPORT.—Not later than 2 years after the date of enactment of this title, and biennially thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the effectiveness of data collection,
analysis, and reporting on race, ethnicity, and primary language under the programs and activities of the Department of Health and Human Services and under other Federal data collection systems with which the Department interacts to collect relevant data on race and ethnicity. The report shall evaluate the progress made in the Department with respect to the national plan under subsection (c) or subsequent revisions thereto.

“(j) Grants for Data Collection by Health Plans, Health Centers, and Hospitals.—

“(1) In general.—The Secretary, in consultation with the Administrator of the Centers for Medicare and Medicaid Services, is authorized to award grants for the conduct of 20 demonstration programs by health plans, health centers, or hospitals to enhance their ability to collect, analyze, and report the data required under subsection (a).

“(2) Eligibility.—To be eligible to receive a grant under paragraph (1), a health plan or hospital shall—

“(A) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a plan to eliminate racial, ethnic, and primary language dis-
parities in health and healthcare through one or more of the activities described in paragraph (3); and

“(B) provide assurances that the health plan or hospital will use, at a minimum, the racial and ethnic categories and the standards for collection described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available standards for language.

“(3) ACTIVITIES.—A grantee shall use amounts received under a grant under paragraph (1) to—

“(A) collect, analyze, and report data by race, ethnicity, and primary language for patients served by the hospital (including emergency room patients and patients served on an outpatient basis) or health center, or, in the case of a private health plan, such data for enrollees;

“(B) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

“(C) provide analyses of racial and ethnic disparities in health and healthcare, including
specific disease conditions, diagnostic and therapeutic procedures, or outcomes;

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

“(E) develop mechanisms for sharing collected data subject to privacy and confidentiality regulations;

“(F) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, patients, enrollees, and the general public that data collection, analysis, and reporting by race, ethnicity, and preferred language are legal and essential for eliminating disparities in health and healthcare; and

“(G) develop quality assurance systems designed to track disparities and quality improvement systems designed to eliminate disparities.

“(l) DEFINITION.—In this section, the term ‘health-related program’ mean a program—
“(1) under the Social Security Act (42 U.S.C. 301 et seq.) that pay for healthcare and services; and
“(2) under this Act that provide Federal financial assistance for healthcare, biomedical research, health services research, and programs designed to improve the public’s health.
“(m) 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 2005 through 2010.

“SEC. 2952. PROVISIONS RELATING TO NATIVE AMERICANS.
“(a) EPIDEMIOLOGY CENTERS.—
“(1) ESTABLISHMENT.—
“(A) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this title, (including those centers for which funding is currently being provided through funding agreements under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in subparagraph
(B). Any centers established under the preceding sentence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

“(B) FUNCTIONS.—In consultation with and upon the request of Indian tribes, tribal organizations and urban Indian organizations, each area epidemiology center established under this subsection shall, with respect to such area shall—

“(i) collect data related to the health status objective described in section 3(b) of the Indian Health Care Improvement Act, and monitor the progress that the Service, Indian tribes, tribal organizations, and urban Indian organizations have made in meeting such health status objective;

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

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

“(iv) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities;

“(v) make recommendations to improve healthcare delivery systems for Indians and urban Indians;

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

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

“(C) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.
“(2) FUNDING.—The Secretary may make funding available to Indian tribes, tribal organizations, and eligible intertribal consortia or urban Indian organizations to conduct epidemiological studies of Indian communities.

“(b) DEFINITIONS.—For purposes of this section, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.”.

SEC. 502. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

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

“SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

“(a) REQUIREMENT.—The Commissioner of the Social Security Administration in consultation with the Administrator of the Centers for Medicare and Medicaid Services shall—

“(1) require the collection of data on the race, ethnicity, and primary language of all applicants for social security numbers, social security income, social security disability, and medicare—

“(A) using, at a minimum, the categories for race and ethnicity described in the 1997 Of-
Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available language standards; and

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

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

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

“(B) the primary language of the parent or legal guardian of such an applicant or recipient be used;

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

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

“(5) ensure transmission to the Centers for Medicare and Medicaid Services and other Federal health agencies;
“(6) provide such data to the Secretary on at
least an annual basis; and

“(7) ensure that the provision of assistance to
an applicant is not denied or otherwise adversely af-
fected because of the failure of the applicant to pro-
vide race, ethnicity, and primary language data.

“(b) PROTECTION OF DATA.—The Commissioner of
Social Security shall ensure (through the promulgation of
regulations or otherwise) that all data collected pursuant
subsection (a) is protected—

“(1) under the same privacy protections as the
Secretary applies to other health data under the reg-
ulations promulgated under section 264(c) of the
Health Insurance Portability and Accountability Act
of 1996 (Public Law 104–191; 110 Stat. 2033) re-
lating to the privacy of individually identifiable
health information and other protections; and

“(2) from all inappropriate internal use by any
entity that collects, stores, or receives the data, in-
cluding use of such data in determinations of eligi-
bility (or continued eligibility) in health plans, and
from other inappropriate uses, as defined by the
Secretary.

“(c) NATIONAL EDUCATION PROGRAM.—Not later
than 18 months after the date of enactment of this sec-
tion, the Secretary, acting through the Director of the Of-

cice of Minority Health and in collaboration with the Com-

missioner of the Social Security Administration, shall de-

velop and implement a program to educate all populations

about the purpose and uses of racial, ethnic, and primary

language health data collection.

“(d) RULE OF CONSTRUCTION.—Nothing in this sec-

tion shall be construed to permit the use of information

collected under this section in a manner that would ad-

versely affect any individual providing any such informa-

tion.

“(e) TECHNICAL ASSISTANCE.—The Secretary may,

either directly or by grant or contract, provide technical

assistance to enable any health entity to comply with the

requirements of this section.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There

is authorized to be appropriated to carry out this section,
such sums as may be necessary for each of fiscal years

2005 through 2010.”.

SEC. 503. 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.), as added by the Health Insurance
Portability and Accountability Act of 1996 (Public Law 104–191), relating to the collection of data on race, ethnicity, and primary language in a health-related transaction to require—

(1) the use, at a minimum, of the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

(2) the establishment of a new data code set for primary language; and

(3) the designation of the racial, ethnic, and primary language code sets as “required” for claims and enrollment data.

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

(c) COMPLIANCE.—The Secretary of Health and Human Services shall require that health entities comply with the new standards developed under subsection (a) not later than 2 years after the final promulgation of such standards.
SEC. 504. 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 “2010”;

(2) in paragraph (2), in the first sentence, by striking “2003” and inserting “2010”; and

(3) in paragraph (3), by striking “2002” and inserting “2010”.

Subtitle B—Minority Health and Genomics Commission

SEC. 511. SHORT TITLE.

This subtitle may be cited as the “Minority Health and Genomics Act of 2003”.

SEC. 512. MINORITY HEALTH AND GENOMICS COMMISSION.

(a) ESTABLISHMENT.—There is established a commission to be known as the Minority Health and Genomics Commission (in this subtitle referred to as the “Commission”).

(b) DUTIES.—

(1) STUDY.—The Commission shall conduct a thorough study of, and develop recommendations on, issues relating to genomic research as applied to minority groups and, under section 516, submit a report to the appropriate committees of Congress that recommends policies that the Commission finds will
ultimately improve healthcare and promote the elimination of health disparities.

(2) ISSUES.—The study under paragraph (1) shall address specific issues and the needs of each minority group described in subparagraph (A) in addition to issues involving genomic research that affect the groups as a whole. In conducting such study the Commission shall carry out the following:

(A) Establish standards in genomic research and services that will promote the improvement of health and health-related services for the following groups: American Indians and Alaska Natives, African Americans, Asian Americans, Hispanics, and Native Hawaiians and other Pacific Islanders.

(B) Recommend minimum requirements and standards for the equitable use of genetics research in patient care and public health services for racial and ethnic minority patients.

(C) Examine the accessibility, effectiveness, availability, and cost efficiency of genomic research, genetic testing, genetic counseling, and genetic screening to minority populations.

(D) Determine and recommend procedures and policies to address the need for cultural,
linguistic, and religious sensitivity training for

genetic counselors and researchers who work

with minority groups.

(E) Evaluate whether minority persons are

provided with informed consent that is cul-
turally and linguistically appropriate to allow a
fully informed decision about their healthcare,
availability of treatments or options, or partici-
pation in any clinical trial involving the collec-
tion of genetic material.

(F) Recommend how population sampling

studies of genetic information can be improved
to aid in the elimination of health disparities
and improve healthcare for minority commu-
nities.

(G) Examine how genetic material or in-
formation derived from individual minorities is
used the help minority groups with the use of
highly specific drug therapies.

(H) Identify the accessibility, effectiveness,
availability, privacy, and benefit of genetic data-
bases and depositories to minority communities.

(I) Identify the accessibility, effectiveness,
and affordability of reproductive technologies to
minority groups.
(J) Recommend an incentives program for genomic researchers that will encourage the study of disease and genetic ailments that disproportionately affect minority communities.

SEC. 513. REPORT.

Not later than 2 years after the date of the enactment of this Act, the Commission shall prepare and submit to the appropriate committees of Congress, the President, and the general public a report containing a detailed statement of the findings and conclusions of the Commission with respect to matters described in section 512(b)(2), together with such recommendations as the Commission considers appropriate that may be specific to each minority group.

SEC. 514. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members to be appointed as follows:

(1) Four members shall be appointed by the Speaker of the House of Representatives.

(2) Four members shall be appointed by the minority leader of the House of Representatives.

(3) Four members shall be appointed by the majority leader of the Senate.
(4) Four members shall be appointed by the minority leader of the Senate.

(5) One member shall be appointed by the President.

(b) PERSONS ELIGIBLE.—

(1) IN GENERAL.—The members of the Commission shall be individuals who have knowledge or expertise, whether by experience or training, in matters to be studied by the Commission. The members may be from the public or private sector, and may include employees of the Federal Government or of State, territory, tribal, or local governments, members of academia, legal scholars and practitioners, tribal leaders, representatives of nonprofit organizations, or other interested individuals who demonstrate a dedication to the use of genomics to improve minority healthcare and the elimination of health disparities among minorities.

(2) DIVERSITY.—It is the intent of Congress that individuals appointed to the Commission represent diverse interests, ethnicities, various professional backgrounds, and are from different regions of the United States.

(c) CONSULTATION AND APPOINTMENT.—
(1) IN GENERAL.—The President, Speaker of the House of Representatives, minority leader of the House of Representatives, majority leader of the Senate, and minority leader of the Senate shall consult among themselves before appointing the members of the Commission in order to achieve, to the maximum extent practicable, fair and equitable representation of various points of view with respect to matters studied by the Commission.

(2) DATE OF APPOINTMENT.—The appointments of the members of the Commission shall be made not later than 90 days after the date of enactment of this Act.

(d) TERMS.—

(1) IN GENERAL.—Each member of the Commission shall be appointed for the life of the Commission.

(2) VACANCIES.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(e) BASIC PAY.—Members of the Commission shall serve without pay.

(f) TRAVEL EXPENSES.—Each member of the Commission shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provi-
visions under subchapter I of chapter 57 of title 5, United States Code.

(g) CHAIRPERSON AND VICE CHAIRPERSON.—The members of the Commission shall elect a Chairperson and Vice Chairperson of the Commission from among the members.

(h) MEETINGS.—

(1) IN GENERAL.—The Commission shall meet at the call of the Chairperson or a majority of its members.

(2) INITIAL MEETING.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

SEC. 515. POWERS OF COMMISSION.

(a) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this subtitle, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate to carry out this subtitle.

(b) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action that the Commission is authorized to take by this section.
(c) Obtaining Official Data.—Notwithstanding sections 552 and 552a of title 5, United States Code, the Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this subtitle. Upon request of the Commission, the head of that department or agency shall furnish that information to the Commission.

(d) Postal Services.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(e) Website.—For purposes of conducting the study under section 512(b)(1), the Commission shall establish and maintain a website to facilitate public comment and participation.

(f) Staff of Federal Agencies.—Upon request of the Commission, the head of any Federal department or agency may detail, on a nonreimbursable basis, any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this subtitle.

(g) Administrative Support Services.—Upon the request of the Commission, the Administrator of General Services may provide to the Commission, on a non-reimbursable basis, the administrative support services
necessary for the Commission to carry out its responsibilities under this subtitle.

SEC. 516. TERMINATION.

The Commission shall terminate 1 year after submitting its final report pursuant to section 513.

TITLE VI—ACCOUNTABILITY

SEC. 601. REPORT ON WORKFORCE DIVERSITY.

(a) IN GENERAL.—Not later than July 1, 2005, and annually thereafter, the Secretary, acting through the director of each entity within the Department of Health and Human Services, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on healthcare workforce diversity.

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

(1) The response of the entity involved to the upcoming 2004 Institute of Medicine report on workforce diversity, the 2002 Institute of Medicine report entitled The Future of the Public Health in the 21st Century, and the Healthy People 2010 initiative.
(2) A description of the personnel in each such entity who are responsible for overseeing workforce diversity initiatives.

(3) The level of workforce diversity achieved within each such entity, including absolute numbers and percentages of minority employees as well as the rank of such employees.

(4) A description of any grant support that is provided by each entity for workforce diversity initiatives, including the amount of the grants and the percentage of grant funds as compared to overall entity funding;

(e) Public Availability.—The report under subsection (a) shall be made available for public review and comment.

SEC. 602. FEDERAL AGENCY PLAN TO ELIMINATE DISPARITIES AND IMPROVE THE HEALTH OF MINORITY POPULATIONS.

(a) In General.—Not later than September 1, 2005, each Federal health agency shall develop and implement a national strategic action plan to eliminate disparities on the basis of race, ethnicity, and primary language and improve the health and healthcare of minority populations, through programs relevant to the mission of the agency.
(b) Publication.—Each action plan described in paragraph (1) shall—

(1) be publicly reported in draft form for public review and comment;

(2) include a response to the review and comment described in paragraph (1) in the final plan;

(3) include the agency response to the 2002 Institute of Medicine report, Unequal Treatment—Confronting Racial and Ethnic Disparities in Healthcare;

(4) demonstrate progress in meeting the Healthy People 2010 objectives; and

(5) be updated, including progress reports, for inclusion in an annual report to Congress.

SEC. 603. ACCOUNTABILITY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Title XXIX of the Public Health Service Act, as amended by section 502(b), is further amended by adding at the end the following:

“Subtitle F—Accountability

“SEC. 2961. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.

“(a) In General.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.
“(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities which receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin. The activities of the Office shall include the following:

“(1) The development and implementation of an action plan to address racial and ethnic healthcare disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled ‘Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity’ (September, 1999). This plan shall be publicly disclosed for review and comment and the final plan shall address any comments or concerns that are received by the Office.

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

“(3) The review of racial, ethnic, and primary language health data collected by Federal health agencies to assess healthcare disparities related to
intentional discrimination and policies and practices that have a disparate impact on minorities.

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

“(5) The provision of technical assistance for health entities to facilitate compliance with title VI of the Civil Rights Act.

“(6) Coordination and oversight of activities of the civil rights compliance offices established under section 2962.

“(7) Ensuring compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race, Ethnicity and the available language standards.

“(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

“(1) adequate funding to enable the Office to carry out its duties under this section; and

“(2) staff with expertise in—

“(A) epidemiology;

“(B) statistics;

“(C) health quality assurance;
“(D) minority health and health disparities; and

“(E) civil rights.

“(d) REPORT.—Not later than December 31, 2005, and annually thereafter, the Secretary, in collaboration with the Director of the Office for Civil Rights, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

“(1) the number of cases filed, broken down by category;

“(2) the number of cases investigated and closed by the office;

“(3) the outcomes of cases investigated; and

“(4) the staffing levels of the office including staff credentials.

“(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 2005 through 2010.
“SEC. 2962. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL HEALTH AND HUMAN SERVICES AGENCIES.

“(a) IN GENERAL.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

“(b) PURPOSE OF OFFICES.—Each office established under subsection (a) shall ensure that recipients of Federal financial assistance under Federal health programs administer their programs, services, and activities in a manner that—

“(1) does not discriminate, either intentionally or in effect, on the basis of race, national origin, language, ethnicity, sex, age, or disability; and

“(2) promotes the reduction and elimination of disparities in health and healthcare based on race, national origin, language, ethnicity, sex, age, and disability.

“(c) POWERS AND DUTIES.—The offices established in subsection (a) shall have the following powers and duties:

“(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program administered by an agency within the Department of
Health and Human Services including the establishment of disparity reduction standards to encompass disparities in health and healthcare related to race, national origin, language, ethnicity, sex, age, and disability.

“(2) The development and implementation of program-specific guidelines that interpret and apply Department of Health and Human Services guidance under title VI of the Civil Rights Act of 1964 to each Federal health program administered by the agency.

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

“(4) Oversight of data collection, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency, and compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and the available language standards.
“(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as 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 healthcare through the Federal programs administered by the agency.

“(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF JUSTICE.—

“(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Office for Civil Rights in the Department of Health and Human Services shall provide standard-setting and compliance review investigation support services to the Civil Rights Compliance Office for each agency.

“(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights in the Department of Justice shall continue to maintain the power to institute formal proceedings when an agency Office for Civil Rights
determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the agency.

“(e) DEFINITION.—In this section, the term ‘Federal health programs’ mean programs—

“(1) under the Social Security Act (42 U.S.C. 301 et seq.) that pay for healthcare and services; and

“(2) under this Act that provide Federal financial assistance for healthcare, biomedical research, health services research, and programs designed to improve the public’s health.”.

SEC. 604. OFFICE OF MINORITY HEALTH.

Section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(1) by striking the section heading and inserting the following:

“OFFICE OF MINORITY HEALTH AND RACIAL, ETHNIC, AND PRIMARY LANGUAGE HEALTH DISPARITY ELIMINATION”;

(2) by striking “Office of Minority Health” each place that such appears and inserting “Office of Minority Health and Racial, Ethnic, and Primary Language Health Disparities Elimination”; and

(3) by striking subsection (b) and inserting the following:

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“(b) DUTIES.—With respect to improving the health of racial and ethnic minority groups, the Secretary, acting through the Deputy Assistant Secretary for Minority Health and Racial, Ethnic, and Primary Language Health Disparities Elimination (in this section referred to as the ‘Deputy Assistant Secretary’), shall carry out the following:

“(1) Establish, implement, monitor, and evaluate short-range and long-range goals and objectives and oversee all other activities within the Public Health Service that relate to disease prevention, health promotion, service delivery, and research concerning minority groups. The heads of each of the agencies of the Service shall consult with the Deputy Assistant Secretary to ensure the coordination of such activities.

“(2) Oversee all activities within the Department of Health and Human Services that relate to reducing or eliminating disparities in health and healthcare in racial and ethnic minority populations, including coordinating—

“(A) the design of programs, support for programs, and the evaluation of programs;

“(B) the monitoring of trends in health and healthcare;
“(C) research efforts;
“(D) the training of health providers; and
“(E) information and education programs and campaigns.
“(3) Enter into interagency and intra-agency agreements with other agencies of the Public Health Service.
“(4) Ensure that the Federal health agencies and the National Center for Health Statistics collect data on the health status and healthcare of each minority group, using at a minimum the categories specified in the 1997 OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity as required under subtitle B and available language standards.
“(5) Provide technical assistance to States, local agencies, territories, Indian tribes, and entities for activities relating to the elimination of racial and ethnic disparities in health and healthcare.
“(6) Support a national minority health resource center to carry out the following:
“(A) Facilitate the exchange of information regarding matters relating to health information, health promotion and wellness, preven-
tive health services, and education in the approp-
riate use of health services.

“(B) Facilitate timely access to culturally
and linguistically appropriate information.

“(C) Assist in the analysis of such infor-
mation.

“(D) Provide technical assistance with re-
spect to the exchange of such information (in-
cluding facilitating the development of materials
for such technical assistance).

“(7) Carry out programs to improve access to
healthcare services for individuals with limited
English proficiency, including developing and car-
ying out programs to provide bilingual or interper-
tive services through the development and support of
a National Center for Cultural and Linguistic Com-
petence in Healthcare as provided for in section
2903.

“(8) Carry out programs to improve access to
healthcare services and to improve the quality of
healthcare services for individuals with low func-
tional health literacy. As used in the preceding sen-
tence, the term ‘functional health literacy’ means the
ability to obtain, process, and understand basic
health information and services needed to make appropriate health decisions.

“(9) Advise in matters related to the development, implementation, and evaluation of health professions education on decreasing disparities in healthcare outcomes, with focus on cultural competency as a method of eliminating disparities in health and healthcare in racial and ethnic minority populations.

“(10) Assist healthcare professionals, community and advocacy organizations, academic centers and public health departments in the design and implementation of programs that will improve the quality of health outcomes by strengthening the provider-patient relationship.”.

(2) by redesignating subsections (c) through (f) and subsections (g) and (h) as subsections (d) through (g) and subsections (j) and (k), respectively;

(3) by inserting after subsection (b), the following:

“(c) NATIONAL PLAN TO ELIMINATE RACIAL AND ETHNIC HEALTH AND HEALTHCARE DISPARITIES.—

“(1) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary, shall—
“(A) not later than 1 year after the date of enactment of the Healthcare Equality and Accountability Act, establish and implement a comprehensive plan to achieve the goal of Healthy People 2010 to eliminate health disparities in the United States;

“(B) establish the plan referred to in subparagraph (A) in consultation with—

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

“(ii) the Director of the National Institutes of Health;

“(iii) the Director of the National Center on Minority Health and Health Disparities;

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

“(v) the Administrator of the Health Resources and Services Administration;

“(vi) the Administrator of the Centers for Medicare and Medicaid Services;

“(vii) the Director of the Office for Civil Rights;
“(viii) the Administrator of the Substance Abuse and Mental Health Services Administration;

“(ix) the Commissioner of the Food and Drug Administration; and

“(x) the heads of other appropriate public and private entities;

“(C) ensure that the plan includes measurable objectives, describes the means for achieving such objectives, and designates a date by which such objectives are expected to be achieved;

“(D) ensure that all amounts appropriated for such activities are expended in accordance with the plan;

“(E) review the plan on at least an annual basis and revise the plan as appropriate;

“(F) ensure that the plan will serve as a binding statement of policy with respect to the agencies’ activities related to disparities in health and healthcare; and

“(G) not later than March 1 of each year, submit the plan (or any revisions to the plan), to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee
on Energy and Commerce of the House of Rep-
resentatives.

“(2) COMPONENTS OF THE PLAN.—The Deputy
Assistant Secretary shall ensure that the compre-
hensive plan established under paragraph (1) address-
es—

“(A) the recommendations of the 2002 In-
stitute of Medicine report (Unequal Treatment)
with respect to racial and ethnic disparities in
healthcare;

“(B) health and disease prevention edu-
cation for racial, ethnic, and primary language
health disparity populations;

“(C) research to identify sources of health
and healthcare disparities in minority groups;

“(D) the implementation and assessment
of promising intervention strategies;

“(E) data collection and the monitoring of
the healthcare and health status of health dis-
parity populations;

“(F) care of individuals who lack pro-
ficiency with the English language;

“(G) care of individuals with low func-
tional health literacy;
“(H) the training, recruitment, and retention of minority health professionals;

“(I) programs to expand and facilitate access to healthcare services, including the use of telemedicine, National Health Service Scholars, community health workers, and case managers;

“(J) public and health provider awareness of racial and ethnic disparities in healthcare;

“(K) methods to evaluate and measure progress toward the goal of eliminating disparities in health and healthcare in racial and ethnic minority populations;

“(L) the promotion of interagency and intra-agency coordination and collaboration and public-private and community partnerships; and

“(M) the preparedness of health professionals to care for racially, ethnically, and linguistically diverse populations and low functional health literacy populations including evaluations as required under section 606 of the Healthcare Equality and Accountability Act.”;

(4) in subsection (d) (as so redesignated)—

(A) in paragraph (1), by inserting “and Racial, Ethnic, and Primary Language Health
Disparities Elimination” after “Minority Health”; and

(B) in paragraph (2)—

(i) by striking “Deputy Assistant”; and

(ii) by striking “(10) of subsection (b)” and inserting “(9) of subsection (e)”;

(5) in subsection (e)(1) (as so redesignated)—

(A) in subparagraph (A), by striking “subsection (b)(9)” and inserting “subsection (b)(7)”;

and

(B) in subparagraph (B), by striking “subsection (b)(10)” and inserting “subsection (b)(8)”;

(6) in subsection (f)(3) (as so redesignated), by striking “subsection (f)” and inserting “subsection (g)”;

(7) in subsection (g)(1) (as so redesignated)—

(A) by striking “1999 and each second” and inserting “2004 and each”; and

(B) by striking “Labor and Human Resources” and inserting “Health, Education, Labor, and Pensions”;

(C) by striking “2 fiscal years” and inserting “fiscal year”; and
(D) by inserting after “improving the health of racial and ethnic minority groups” the following: “reducing and eliminating disparities in health and healthcare in racial and ethnic minority populations, in accordance with the national plan specified under subsection (c) and the goals of Healthy People 2010”;

(8) by inserting after subsection (g) (as so redesignated) the following:

“(h) FEDERAL PARTNERSHIP WITH ACCREDITATION ENTITIES.—

“(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Healthcare Equality and Accountability Act, the Secretary, in collaboration with the Director of the Agency for Healthcare Research and Quality, the Administrator of the Centers for Medicare and Medicaid Services, the Director of the Office for Minority Health, and the heads of appropriate State agencies, shall convene a working group with members of accreditation organizations and other quality standard setting organizations to develop guidelines to evaluate and report on the health and healthcare of minority populations served by health centers, health plans, hospitals, and other federally funded health entities.
“(2) REPORT.—Not later than 6 months after
the convening of the working group under paragraph
(1), the working group shall submit a report to the
Secretary at such time, in such manner, and con-
taining such information as the Secretary may re-
quire, including guidelines and recommendations on
how each accreditation body will work with con-
stituent members to ensure the adoption of such
guidelines.

“(3) DEMONSTRATION PROJECTS.—The Sec-
retary, acting through the Administrator of the Cen-
ters for Medicare and Medicaid Services, shall award
grants for the establishment of demonstration
projects to assess the impact of providing financial
incentives for the reporting and analysis of the qual-
ity of minority healthcare by hospitals, health plans,
health centers, and other healthcare entities.

“(4) AUTHORIZATION OF APPROPRIATIONS.—
There are authorized to be appropriated to carry out
this subsection, such sums as may be necessary for
each of fiscal years 2005 through 2010.

“(i) PREPARATION OF HEALTH PROFESSIONALS TO
PROVIDE HEALTHCARE TO MINORITY POPULATIONS.—
The Secretary, in collaboration with the Director of the
Bureau of Health Professions and the Director of the Of-
Office of Minority Health, shall require that health professional schools that receive Federal funds train future health professionals to provide culturally and linguistically appropriate healthcare to diverse populations.”; and

(9) by striking subsection (k) (as so redesignated) and inserting the following:

“(k) Authorization of Appropriations.—For the purpose of carrying out this section (other than subsection (h)), there is authorized to be appropriated $100,000,000 for fiscal year 2004, and such sums as may be necessary for each of fiscal years 2005 through 2010.”.

SEC. 605. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

(a) Establishment.—

(1) In general.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide healthcare services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service.

(2) Assistant Secretary of Indian Health.—The Service shall be administered by an
Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

(3) all health programs under which healthcare is provided to Indians based upon their status as In-
dians which are administered by the Secretary, including programs under—

(A) the Indian Health Care Improvement Act;

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.);

(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

(F) title XXIX of the Public Health Service Act; and

(4) all scholarship and loan functions carried out under title I of the Indian Health Care Improvement Act.

(d) Authority.—

(1) In general.—The Secretary, acting through the Assistant Secretary, shall have the authority—

(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;
(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

(e) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking the following: “Assistant Secretaries of Health and Human Services (6).” and inserting “Assistant Secretaries of Health and Human Services (7).”.

(2) POSITIONS AT LEVEL V.—Section 5316 of such title is amended by striking the following: “Director, Indian Health Service, Department of Health and Human Services.”.

(f) DUTIES OF ASSISTANT SECRETARY FOR INDIAN HEALTH.—Section 601 of the Indian Health Care Im-
provement Act (25 U.S.C. 1661) is amended in subsection

(a)—

(1) by inserting “(1)” after “(a)”;

(2) in the second sentence of paragraph (1), as

so designated, by striking “a Director,” and insert-

ing “the Assistant Secretary for Indian Health,”;

(3) by striking the third sentence of paragraph

(1), as so designated, and all that follows through

the end of the subsection (a) of such section and in-

serting the following: “The Assistant Secretary for

Indian Health shall carry out the duties specified in

paragraph (2).”; and

(4) by adding after paragraph (1) the following:

“(2) The Assistant Secretary for Indian Health

shall—

“(A) report directly to the secretary con-

cerning all policy and budget-related matters

affecting Indian health;

“(B) collaborate with the Assistant Sec-

retary for Health concerning appropriate mat-

ters of Indian health that affect the agencies of

the Public Health Service;

“(C) advise each Assistant Secretary of the

Department of Health and Human Services

concerning matters of Indian health with re-
pect to which that Assistant Secretary has au-
thetaity and responsibility;

“(D) advise the heads of other agencies
and programs of the Department of Health and
Human Services concerning matters of Indian
health with respect to which those heads have
authority and responsibility; and

“(E) coordinate the activities of the De-
partment of Health and Human Services con-
cerning matters of Indian health.”.

(g) CONTINUED SERVICE BY INCUMBENT.—The indi-
vidual serving in the position of Director of the Indian
Health Service on the date preceding the date of enact-
ment of this Act may serve as Assistant Secretary for In-
dian Health, at the pleasure of the President after the
date of enactment of this Act.

(h) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO INDIAN HEALTH CARE IM-
PROVEMENT ACT.—The Indian Health Care Im-
provement Act (25 U.S.C. 1601 et seq.) is amend-
ed—

(A) in section 601—

(i) in subsection (e), by striking “Di-
rector of the Indian Health Service” both
places it appears and inserting “Assistant Secretary for Indian Health”; and

(ii) in subsection (d), by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”; and

(B) in section 816(e)(1), by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(2) Amendments to Other Provisions of Law.—The following provisions are each amended by striking “Director of the Indian Health Service” each place it appears and inserting “Assistant Secretary for Indian Health”:

(A) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 761b(a)(1)).

(B) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)).

(C) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)).

(i) References.—Reference in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document of or relating to the Director
of the Indian Health Service shall be deemed to refer to the Assistant Secretary for Indian Health.

(j) DEFINITIONS.—For purposes of this section, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.

SEC. 606. OFFICE OF MINORITY HEALTH AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish within the Centers for Medicare and Medicaid Services an Office of Minority Health (referred to in this section as the “Office”).

(b) DUTIES.—The Office shall be responsible for the coordination and facilitation of activities of the Centers for Medicare and Medicaid Services to improve minority health and healthcare and to reduce racial and ethnic disparities in health and healthcare, which shall include—

(1) creating a strategic plan, which shall be made available for public review, to improve the health and healthcare of Medicare, Medicaid, and SCHIP beneficiaries;

(2) promoting agency-wide policies relating to healthcare delivery and financing that could have a beneficial impact on the health and healthcare of minority populations;
(3) assisting health plans, hospitals, and other health entities in providing culturally and linguistically appropriate healthcare services;

(4) increasing awareness and outreach activities for minority healthcare consumers and providers about the causes and remedies for health and healthcare disparities;

(5) developing grant programs and demonstration projects to identify, implement and evaluate innovative approaches to improving the health and healthcare of minority beneficiaries in the Medicare, Medicaid, and SCHIP programs;

(6) considering incentive programs relating to reimbursement that would reward health entities for providing quality healthcare for minority populations using established benchmarks for quality of care;

(7) collaborating with the compliance office to ensure compliance with the anti-discrimination provisions under title VI of the Civil Rights Act of 1964;

(8) identifying barriers to enrollment in public programs under the jurisdiction of the Centers for Medicare and Medicaid Services;

(9) monitoring and evaluating on a regular basis the success of minority health programs and initiatives;
(10) publishing an annual report about the ac-
tivities of the Centers for Medicare and Medicaid
Services relating to minority health improvement;
and

(11) other activities determined appropriate by
the Secretary of Health and Human Services.

(c) STAFF.—The staff at the Office shall include—

(1) one or more individuals with expertise in
minority health and racial and ethnic health dispari-
ties; and

(2) one or more individuals with expertise in
healthcare financing and delivery in underserved
communities.

(d) COORDINATION.—In carrying out its duties under
this section, the Office shall coordinate with—

(1) the Office of Minority Health in the Office
of the Secretary of Health and Human Services;

(2) the National Centers for Minority Health
and Health Disparities in the National Institutes of
Health; and

(3) the Office of Minority Health in the Centers
for Disease Control and Prevention.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the
purpose of carrying out this section, there are authorized
to be appropriated $10,000,000 for fiscal year 2004, and
such sums may be necessary for each of fiscal years 2005 through 2010.

Sec. 607. Office of Minority Affairs at the Food and Drug Administration.

Chapter IX of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

“Sec. 908. Office of Minority Affairs.

“(a) In General.—Not later than 60 days after the date of enactment of this section, the Secretary shall establish within the Office of the Commissioner of the Food and Drug Administration an Office of Minority Affairs (referred to in this section as the ‘Office’).

“(b) Duties.—The Office shall be responsible for the coordination and facilitation of activities of the Food and Drug Administration to improve minority health and healthcare and to reduce racial and ethnic disparities in health and healthcare, which shall include—

“(1) promoting policies in the development and review of medical products that reduce racial and ethnic disparities in health and healthcare;

“(2) encouraging appropriate data collection, analysis, and dissemination of racial and ethnic differences using, at a minimum, the categories described in the 1997 Office of Management and
Budget standards, in response to different therapies in both adult and pediatric populations;

“(3) providing, in coordination with other appropriate government agencies, education, training, and support to increase participation of minority patients and physicians in clinical trials;

“(4) collecting and analyzing data using, at a minimum, the categories described in the 1997 Office of Management and Budget standards, on the number of participants from minority racial and ethnic backgrounds in clinical trials used to support medical product approvals;

“(5) the identification of methods to reduce language and literacy barriers; and

“(6) publishing an annual report about the activities of the Food and Drug Administration pertaining to minority health.

“(c) STAFF.—The staff of the Office shall include—

“(1) one or more individuals with expertise in the design and conduct of clinical trials of drugs, biological products, and medical devices; and

“(2) one or more individuals with expertise in therapeutic classes or disease states for which medical evidence suggests a difference based on race or ethnicity.
“(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—

“(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

“(2) the National Center for Minority Health and Health Disparities in the National Institutes of Health; and

“(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

“(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2005 through 2010.”.

SEC. 608. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

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

“SEC. 505C. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

“(a) PRE-APPROVAL STUDIES.—If there is evidence that there may be a disparity on the basis of racial or
ethnic background as to the safety or effectiveness of a
drug, then—

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

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

“(2) if the investigations confirm that there is
a disparity, the labeling of the drug shall include ap-
propriate information about the disparity.

“(b) POST-MARKET STUDIES.—

“(1) IN GENERAL.—If there is evidence that
there may be a disparity on the basis of racial or
ethnic background as to the safety or effectiveness
of a drug for which there is an approved application
under section 505 or a license under section 351 of
the Public Health Service Act, the Secretary may by
order require the holder of the approved application
or license to conduct, by a date specified by the Sec-
retary, post-marketing studies to investigate the dis-
parity.
“(2) LABELING.—If the Secretary determines that the post-market studies confirm that there is a disparity described in paragraph (1), the labeling of the drug shall include appropriate information about the disparity.

“(3) STUDY DESIGN.—The Secretary may specify all aspects of study design, including the number of studies and study participants, in the order requiring post-market studies of the drug.

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

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

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

“(1) evidence that there is a disparity on the basis of racial or ethnic background as to safety or effectiveness of a drug in the same chemical class as the drug;
“(2) evidence that there is a disparity on the basis of racial or ethnic background in the way the drug is metabolized; and

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

“(d) Applications Under Section 505(b)(2) and 505(j).—

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

“(2) LABELING.—Notwithstanding clauses (iii) and (iv) of section 505(j)(5)(D), the Secretary may require that the labeling of a drug approved under section 505(j) that omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug include
a statement of any appropriate contraindications, warnings, or precautions related to the disparity that the Secretary considers necessary.”.

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

“(w)(1) If it is a drug and the holder of the approved application under section 505 or license under section 351 of the Public Health Service Act for the drug has failed to complete the investigations or studies, or comply with any other requirement, of section 505C.”.

(c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h) is amended by adding after “required” the following: “,

including supplements required under section 505C of the Act”.

SEC. 609. UNITED STATES COMMISSION ON CIVIL RIGHTS.

(a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a) is amended—

(1) in paragraph (1)(B), by striking “and” at the end;
(2) in paragraph (2), in the matter after and
below subparagraph (D), by striking the period and
inserting “; and”; and

(3) by adding at the end the following:

“(3) shall, with respect to activities carried out
in healthcare and correctional facilities toward the
goal of eliminating health disparities between the
general population and members of racial or ethnic
minority groups, coordinate such activities of—

“(A) the Office for Civil Rights within the
Department of Justice;

“(B) the Office of Justice Programs within
the Department of Justice;

“(C) the Office for Civil Rights within the
Department of Health and Human Services;

and

“(D) the Office of Minority Health within
the Department of Health and Human Services
(headed by the Deputy Assistant Secretary for
Minority Health).”.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section
5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
1975e) 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 2005, and such sums as may be necessary for each of the fiscal years 2006 through 2010.’’

SEC. 610. SENSE OF CONGRESS CONCERNING FULL FUNDING OF ACTIVITIES TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES.

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

(1) The health status of the American populace is declining and the United States currently ranks below most industrialized nations in health status measured by longevity, sickness, and mortality.

(2) Within the spectrum of declining health, racial and ethnic minority populations tend to be in the poorest of health and face substantial cultural, social, and economic barriers to obtaining quality healthcare.

(3) The problems affecting minority health have been exacerbated by the fact that adequate resources (funding, staffing, stewardship, and accountability) have not been devoted to initiatives designed to examine and eliminate racial and ethnic disparities in health.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—
(1) funding should be doubled by fiscal year 2005 for the National Center for Minority Health Disparities, the Office of Civil Rights in the Department of Health and Human Services, the National Institute of Nursing Research, and the Office of Minority Health;

(2) adequate funding by fiscal year 2005, and subsequent funding increases, should be provided for health professions training programs, the Racial and Ethnic Approaches to Community Health (REACH) at the Center for Disease Control and Prevention, the Minority HIV/AIDS Initiative, and the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) Program at the Agency for Healthcare Research and Quality;

(3) 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 2005; and

(4) stewardship and accountability should be provided by Congress and the President for health disparity elimination.
TITLE VII—STRENGTHENING HEALTH INSTITUTIONS THAT PROVIDE HEALTHCARE TO MINORITY POPULATIONS

SEC. 701. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXIX of the Public Health Service Act, as amended by section 602, is further amended by adding at the end the following:

“Subtitle G—Strengthening Health Institutions That Provide Healthcare to Minority Populations

“CHAPTER 1—GENERAL PROGRAMS

“SEC. 2971. 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 and Medicaid Services, shall award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to healthcare.
“(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

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

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

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

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

“(ii) that—

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

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

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

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

“(1) demonstrate an intent to operate as part of a healthcare 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 healthcare quality improvement, including—

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

“(B) innovative collaborative or similar processes;

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

“(D) case management services;
“(E) physician or patient reminder systems;

“(F) educational interventions; or

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

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

“(1) with respect to healthcare systems, activities relating to improving—

“(A) patient safety;

“(B) timeliness of care;

“(C) effectiveness of care;

“(D) efficiency of care; and

“(E) patient centeredness; and

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

“(A) staying healthy;

“(B) getting well;

“(C) living with illness or disability; and

“(D) coping with end of life issues.

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

“(f) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

“SEC. 2971A. 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 2971(b)(1);

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

“(3) demonstrate excellence in reducing disparities in health and healthcare.

“(b) Requirements.—A hospital or health system that serves as a Center of Excellence under subsection (a) shall—

“(1) design, implement, and evaluate programs and policies relating to the delivery of care in racially, ethnically, and linguistically diverse populations;
“(2) provide training and technical assistance to other hospitals and health systems relating to the provision of quality healthcare 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 is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2005 through 2010.

“SEC. 2971B. CONSULTATION, CONSTRUCTION AND RENOVATION OF AMERICAN INDIAN AND ALASKA NATIVE FACILITIES; REPORTS.

“(a) Consultation.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

“(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location,
type, and other characteristics of any facility on
which such expenditure is to be made; and

“(2) ensure, whenever practicable, that such fa-
cility meets the construction standards of any na-
tionally recognized accrediting body by not later
than 1 year after the date on which the construction
or renovation of such facility is completed.

“(b) CLOSURE OF FACILITIES.—

“(1) IN GENERAL.—Notwithstanding any provi-
sion of law other than this subsection, no Service
hospital or outpatient healthcare facility or any inpa-
tient service or special care facility operated by the
Service, may be closed if the Secretary has not sub-
mitted to the Congress at least 1 year prior to the
date such proposed closure an evaluation of the im-
pact of such proposed closure which specifies, in ad-
dition to other considerations—

“(A) the accessibility of alternative
healthcare resources for the population served
by such hospital or facility;

“(B) the cost effectiveness of such closure;

“(C) the quality of healthcare to be pro-
pvided to the population served by such hospital
or facility after such closure;
“(D) the availability of contract healthcare funds to maintain existing levels of service;

“(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

“(F) the level of utilization of such hospital or facility by all eligible Indians; and

“(G) the distance between such hospital or facility and the nearest operating Service hospital.

“(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

“(c) PRIORITY SYSTEM.—

“(1) ESTABLISHMENT.—The Secretary shall establish a healthcare facility priority system, that shall—

“(A) be developed with Indian tribes and tribal organizations through negotiated rulemaking;

“(B) give the needs of Indian tribes the highest priority, with additional priority being given to those service areas where the health status of Indians within the area, as measured
by life expectancy based upon the most recent
data available, is significantly lower than the
average health status for Indians in all service
areas; and

“(C) at a minimum, include the lists re-
quired in paragraph (2)(B) and the method-
ology required in paragraph (2)(E);

except that the priority of any project established
under the construction priority system in effect on
the date of this Act shall not be affected by any
change in the construction priority system taking
place thereafter if the project was identified as one
of the top 10 priority inpatient projects or one of the
top 10 outpatient projects in the Indian Health
Service budget justification for fiscal year 2004, or
if the project had completed both Phase I and Phase
II of the construction priority system in effect on
the date of this title.

“(2) REPORT.—The Secretary shall submit to
the President and Congress a report that includes—

“(A) a description of the healthcare facility
priority system of the Service, as established
under paragraph (1);

“(B) healthcare facility lists, including—
“(i) the total healthcare facility planning, design, construction and renovation needs for Indians;

“(ii) the 10 top-priority inpatient care facilities;

“(iii) the 10 top-priority outpatient care facilities;

“(iv) the 10 top-priority specialized care facilities (such as long-term care and alcohol and drug abuse treatment); and

“(v) any staff quarters associated with such prioritized facilities;

“(C) the justification for the order of priority among facilities;

“(D) the projected cost of the projects involved; and

“(E) the methodology adopted by the Service in establishing priorities under its healthcare facility priority system.

“(3) CONSULTATION.—In preparing each report required under paragraph (2) (other than the initial report) the Secretary shall annually—

“(A) consult with, and obtain information on all healthcare facilities needs from, Indian tribes and tribal organizations including those
tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act; and

“(B) review the total unmet needs of all tribes and tribal organizations for healthcare facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

“(4) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

“(5) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities, operated under funding agreements in accordance with the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the healthcare facility priority system.
“(d) Review of Need for Facilities.—

“(1) Report.—Beginning in 2005, the Secretary shall annually submit to the President and Congress a report which sets forth the needs of the Service and all Indian tribes and tribal organizations, including urban Indian organizations, for inpatient, outpatient and specialized care facilities, including the needs for renovation and expansion of existing facilities.

“(2) Consultation.—In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

“(3) Criteria.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evalu-
ating the needs of facilities operated directly by the Service.

“(4) **Equitable Integration.**—The Secretary shall ensure that the planning, design, construction, and renovation needs of facilities operated under funding agreements, in accordance with the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the development of the health facility priority system.

“(5) **Annual Nominations.**—Each year the Secretary shall provide an opportunity for the nomination of planning, design, and construction projects by the Service and all Indian tribes and tribal organizations for consideration under the healthcare facility priority system.

“(e) **Inclusion of Certain Programs.**—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act.

“(f) **Innovative Approaches.**—The Secretary shall consult and cooperate with Indian tribes, tribal organizations and urban Indian organizations in developing inno-
vative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

“(g) LOCATION OF FACILITIES.—

“(1) PRIORITY.—The Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

“(2) DEFINITION.—In this subsection, the term ‘Indian lands’ means—

“(A) all lands within the exterior boundaries of any Indian reservation;

“(B) any lands title to which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to
restriction by the United States against alienation and over which an Indian tribe exercises governmental power; and

“(C) all lands in Alaska owned by any Alaska Native village, or any village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

“(h) DEFINITIONS.—For purposes of this section, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.

“SEC. 2971C. 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 healthcare providers and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving health care facilities and services.

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

“(1) is owned or operated by—

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

“(B) a nonprofit organization; and

“(2)(A) provides care or treatment for a substantial number of patients who are uninsured, receiving assistance under a State program under a title XVIII of the Social Security Act, or a State program under title XIX of such Act, or who are members of a vulnerable population, as determined by the Secretary; or

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

“(c) REPORT.—Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary shall submit to the Congress and the President a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, and 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 healthcare facilities needs from the entities described in subsection (b); and

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

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

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

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

“CHAPTER 2—NATIONAL HEALTH SAFETY NET INFRASTRUCTURE.

“Subchapter A—General Provisions

“SEC. 2972. PAYMENTS TO HEALTHCARE FACILITIES.

“(a) IN GENERAL.—The Secretary, with the approval of the Health Safety Net Infrastructure Trust Fund Board of Trustees described in section 2972C(d) (hereafter in this subtitle referred to as the ‘Trust Fund Board’), shall make payments, from amounts in the
Health Safety Net Infrastructure Trust Fund established under section 2972C(a) (hereafter in this subtitle referred to as the ‘Trust Fund’), for capital financing assistance to eligible healthcare facilities whose applications for assistance have been approved under this subtitle.

“(b) General Eligibility Requirements for Assistance.—

“(1) Eligible healthcare facilities described.—

“(A) In general.—A healthcare facility shall be generally eligible for capital financing assistance under this subtitle if the healthcare facility—

“(i) receives an additional payment under section 1886(d)(5)(F) of the Social Security Act and is described in clause (i)(II) or clause (vii)(I) of such section, or is deemed a disproportionate share hospital under a State plan for medical assistance under title XIX of the Social Security Act on the basis described in section 1923(b)(1) of such Act;

“(ii) is a hospital which meets the criteria for designation by the Secretary as an essential access community hospital.
under section 1820(i)(1) of such Act or a rural primary care hospital under section 1820(i)(2) of such Act (whether or not such hospital is actually designated under such section);

“(iii) is a Federally qualified health center (as defined in section 1905(l)(2)(B) of such Act);

“(iv) is a hospital which—

“(I) is a sole community provider; or

“(II) has closed within the preceding 12 months;

“(v) is a facility which—

“(I) provides service to ill or injured individuals prior to the transportation of such individuals to a hospital or provides inpatient care to individuals needing such care for a period not longer than 96 hours;

“(II) is located in a county (or equivalent unit of local government) with fewer than 6 residents per square mile or is located more than
35 road miles from the nearest hospital;

“(III) permits a physician assistant or nurse practitioner to admit and treat patients under the supervision of a physician not present in such facility; and

“(IV) has obtained a waiver from the Secretary permitting the facility to participate in the medicare program under title XVIII of the Social Security Act; or

“(vi) is a hospital that the Secretary otherwise determines to be an appropriate recipient of assistance under this subtitle on the basis of the existence of a patient care operating deficit, a demonstrated inability to secure or repay financing for a qualifying project on reasonable terms, or such other criteria as the Secretary considers appropriate.

“(B) Development of Criteria.—For purposes of subparagraph (A)(vi), with respect to rural hospitals which are at risk or critical to healthcare access, the Prospective Payment
Review Commission, not later than January 1, 1994, shall develop criteria to assist the Secretary in deciding if such hospitals deserve assistance, after considering, at a minimum, the following factors:

“(i) AT-RISK RURAL HOSPITALS.—In the case of rural hospitals the closure of which within the next year is imminent or the continued operation of which over a 2- to 5-year period is questionable, such factors as the level of health resources available in a community as measured by physician supply, the population base of the area served by the hospital and utilization of services by such population as measured by service area population, and financial indicators predictive of closure.

“(ii) RURAL HOSPITALS CRITICAL TO HEALTHCARE ACCESS.—In the case of rural hospitals which provide access to essential health services within a service area where no other provider of such essential services exists, such factors as the market share of the hospital for an area or population, the number of outpatient visits, the
proximity of the next closest provider of such services, and the degree to which the area population is medically underserved.

“(2) OWNERSHIP REQUIREMENTS.—In order to be eligible for assistance under this subtitle, a healthcare facility (other than a healthcare facility described in clauses (ii) and (v) of paragraph (1)) must—

“(A) be owned or operated by a unit of State or local government;

“(B) be a quasi-public corporation, defined as a private, nonprofit corporation or public benefit corporation which is formally granted one or more governmental powers by legislative action through (or is otherwise partially funded by) the State legislature, city or county council;

“(C) be a private nonprofit healthcare facility which has contracted with, or is otherwise funded by, a governmental agency to provide healthcare services to low income individuals not eligible for assistance under title XVIII or title XIX of the Social Security Act, where revenue from such contracts constitute at least 10 percent of the facility’s operating revenues over the prior 3 fiscal years; or
“(D) be a nonprofit small rural healthcare facility (as determined by the Secretary).

“(3) PRIORITY.—In making payments under this section, the Secretary shall give priority to eligible healthcare entities that are federally qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act), or other similar entities at least 50 percent of the patients of which are minority or low-income individuals.

“(c) MEETING ADDITIONAL SPECIFIC CRITERIA.—Healthcare facilities that are generally eligible for assistance under this subtitle under subsection (b) may apply for the specific programs described in this subtitle and must meet any additional criteria for participation in such programs.

“(d) ASSISTANCE AVAILABLE.—Capital financing assistance available under this subtitle shall include loan guarantees, interest rate subsidies, matching loans and direct grants. Healthcare facilities determined to be generally eligible for assistance under this subtitle may apply for and receive more than one type of assistance under this subtitle.
“SEC. 2972A. APPLICATION FOR ASSISTANCE.

“(a) In General.—No healthcare facilities may receive assistance for a qualifying project under this subtitle unless the healthcare facility—

“(1) has filed with the Secretary, in a form and manner specified by the Secretary, with the advice and approval of the Trust Fund Board (as described in section 2972C(d)), an application for assistance under this subtitle;

“(2) establishes in its application (for its most recent cost reporting period) that it meets the criteria for general eligibility under this subtitle;

“(3) includes a description of the project, including the community in which it is located, and describes utilization and services characteristics of the project and the healthcare facility, and the patient population that is to be served;

“(4) describes the extent to which the project will include the financial participation of State and local governments if assistance is granted under this subtitle, and all other sources of financing sought for the project; and

“(5) establishes, to the satisfaction of the Secretary and the Trust Fund Board, that the project meets the additional criteria for each type of capital financing assistance for which it is applying.
“(b) CRITERIA FOR APPROVAL.—The Secretary, with the approval of the Trust Fund Board, shall determine for each application for assistance under this subtitle—

“(1) whether the healthcare facility meets the general eligibility criteria under section 2972(b);

“(2) whether the healthcare facility meets the specific eligibility criteria of each type of assistance for which it has applied, including whether the healthcare facility meets any criteria for priority consideration for the type of assistance for which it has applied;

“(3) whether the capital project for which assistance is being requested is a qualifying project under this subtitle; and

“(4) whether funds are available, pursuant to the limitations of each program, to fully fund the request for assistance.

“(c) PRIORITY OF APPLICATIONS.—In addition to meeting the criteria otherwise described in this subtitle, at the discretion of the Trust Fund Board, the Secretary shall give preference to those applications for qualifying projects that—

“(1)(A) are necessary to bring existing safety net healthcare facilities into compliance with accreditation standards of fire and life safety, seismic, or
other related Federal, State or local regulatory standards;

“(B) improve the provision of essential services such as emergency medical and trauma services, AIDS and infectious disease, perinatal, burn, primary care, and other services which the Trust Fund Board may designate; or

“(C) provide access to otherwise unavailable essential health services to the indigent and other needy persons within the healthcare facility’s territorial area;

“(2) include specific State or local governmental or other non-Federal assurances of financial support if assistance for a qualifying project is granted under this subtitle; and

“(3) are unlikely to be financed without assistance granted under this subtitle.

“(d) Submission of Applications.—Applications under this subtitle shall be submitted to the Secretary through the Trust Fund Board. If two or more healthcare facilities join in the project, the application shall be submitted by all participating healthcare facilities jointly. Such applications shall set forth all of the descriptions, plans, specifications, and assurances as required by this
subtitle and contain other such information as the Trust Fund Board shall require.

“(e) OPPORTUNITY FOR APPEAL.—The Trust Fund Board shall afford a healthcare facility applying for a loan guarantee under this section an opportunity for a hearing if the guarantee is denied.

“(f) APPLICATIONS FOR AMENDMENTS.—Amendment of an approved application shall be subject to approval in the same manner as an original application.

“SEC. 2972B. PUBLIC SERVICE RESPONSIBILITIES.

“(a) IN GENERAL.—Any healthcare facility accepting capital financing assistance under this subtitle shall agree—

“(1) to make the services of the facility or portion thereof to be constructed, acquired, or modernized available to all persons; and

“(2) to provide a significant volume of services to persons unable to pay therefore, consistent with other provisions of this Act and the amount of assistance received under this subtitle.

“(b) ENFORCEMENT.—The Director of the Office for Civil Rights of the Department of Health and Human Services shall be given the power to enforce the public service responsibilities described in this section.
SEC. 2972C. HEALTH SAFETY NET INFRASTRUCTURE TRUST FUND.

“(a) Creation of Trust Fund.—There is established in the Treasury of the United States a trust fund to be known as the Health Safety Net Infrastructure Trust Fund, consisting of such amounts as may be transferred, appropriated, or credited to such Trust Fund as provided in this subtitle.

“(b) Authorization of Appropriations to Trust Fund.—There are authorized to be appropriated to the Trust Fund such sums as may be necessary to carry out the purposes of this subtitle.

“(c) Expenditures From Trust Fund.—Amounts in the Trust Fund shall be available, pursuant to appropriations Acts, only for making expenditures to carry out the purposes of this subtitle.

“(d) Board of Trustees; Composition; Meetings; Duties.—

“(1) In general.—There shall be created a Health Safety Net Infrastructure Trust Fund Board of Trustees composed of the Secretary of Health and Human Services, the Secretary of the Treasury, the Assistant Secretary for Health, the Director of the Office of Minority Health, and the Administrator of the Centers for Medicare and Medicaid Services (all serving in their ex officio capacities), and 5 public
members who shall be appointed for 4 year terms by
the President, from the following categories—

“(A) one chief health officer from a State;

“(B) one chief executive officer of a
healthcare facility that meets the general eligi-
bility criteria of this subtitle;

“(C) one representative of the financial
community; and

“(D) two additional public or consumer
representatives.

“(2) DUTIES.—The Board of Trustees shall
meet no less than quarterly and shall have the re-
sponsibility to approve implementing regulations, to
establish criteria, and to recommend and approve ex-
penditures by the Secretary under the programs set
forth in this subtitle.

“(3) MANAGING TRUSTEE.—The Secretary of
the Treasury shall serve as the Managing Trustee of
the Trust Fund, and shall be responsible for the in-
vestment of funds. The provisions of subsections (b)
through (e) of section 1817 of the Social Security
Act shall apply to the Trust Fund and the Managing
Trustee of the Trust Fund in the same manner as
they apply to the Federal Hospital Insurance Trust
Fund and the Managing Trustee of that Trust Fund.

“SEC. 2972D. ADMINISTRATION.

“(a) IN GENERAL.—The Administrator of the Centers for Medicare and Medicaid Services shall serve as Secretary of the Board of Trustees and shall administer the programs under this subtitle.

“(b) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the funds annually appropriated to the Trust Fund may be available for administration of the Trust Fund or programs under this subtitle.

“Subchapter B—Loan Guarantees

“SEC. 2973. PROVISION OF LOAN GUARANTEES TO SAFETY NET HEALTHCARE FACILITIES.

“(a) IN GENERAL.—The Safety Net Infrastructure Trust Fund will provide a Federal guarantee of loan repayment, including guarantees of repayment of refinancing loans, to non-Federal lenders making loans to eligible healthcare facilities for healthcare facility replacement (either by construction or acquisition), modernization and renovation projects, and capital equipment acquisition.

“(b) PURPOSES.—The loan guarantee program shall be designed by the Trust Fund Board with the goal of rebuilding and maintaining the essential health services of
healthcare facilities eligible for assistance under this subtitle.

“SEC. 2973A. ELIGIBLE LOANS.

“(a) IN GENERAL.—Loan guarantees under this chapter are available for loans made to eligible healthcare facilities for replacement facilities (either newly constructed or acquired), modernization and renovation of existing facilities, and for capital equipment acquisition.

“(b) LOAN GUARANTEE MUST BE ESSENTIAL TO BOND FINANCING.—Eligible healthcare facilities must demonstrate that a Federal loan guarantee is essential to obtaining bond financing from non-Federal lenders at a reasonably affordable rate of interest.

“(c) ADDITIONAL ELIGIBILITY CRITERIA FOR LOAN GUARANTEES.—In order to be eligible for assistance under this chapter, a healthcare facility must demonstrate that the following criteria are met:

“(1) The healthcare facility has evidence of an ability to meet debt service.

“(2) The assistance, when considered with other resources available to the project, is necessary and will restore, improve, or maintain the financial or physical soundness of the healthcare facility.

“(3) The applicant agrees to assume the public service responsibilities described in section 2972B.
“(4) The project is being, or will be, operated and managed in accordance with a management-improvement-and-operating plan which is designed to reduce the operating costs of the project, which has been approved by the Trust Fund Board, and which includes—

“(A) a detailed maintenance schedule;

“(B) a schedule for correcting past deficiencies in maintenance, repairs, and replacements;

“(C) a plan to upgrade the project to meet cost-effective energy efficiency standards prescribed by the Trust Fund Board;

“(D) a plan to improve financial and management control systems;

“(E) a detailed annual operating budget taking into account such standards for operating costs in the area as may be determined by the Trust Fund Board; and

“(F) such other requirements as the Trust Fund Board may determine.

“(5) The application includes stringent provisions for continued State or local support of the program, both with respect to operating and financial capital.
“(6) The terms, conditions, maturity, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable and in accord with regulation, including a determination that the rate of interest does not exceed such annual percentage on the principal obligation outstanding as the Trust Fund Board determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States.

“(7) The healthcare facility must meet such other additional criteria as the Secretary may impose.

“(e) STATE OR LOCAL PARTICIPATION.—Projects in which State or local governmental entities participate in the form of first guarantees of part or all of the total loan value shall be given a preference for loan guarantees under this chapter.

“SEC. 2973B. GUARANTEE ALLOTMENTS.

“(a) IN GENERAL.—$150,000,000 shall be annually allocated within the Trust Fund to the loan guarantee program established by this chapter in order to create a cumulative reserve in support of loan guarantees.
“(b) Loan Guarantees for Rural Healthcare Facilities.—At least 20 percent of the dollar value of loan guarantees made under this program during any given year shall be allocated for eligible rural healthcare facilities, to the extent a sufficient number of applications are made by such healthcare facilities.

“(c) Guarantees for Small Loans.—At least $200,000,000 of the annual dollar value of loan guarantees made under the program shall be reserved for loans of under $50,000,000, if there are a sufficient number of applicants for loans of that size.

“(d) Special Rule for Refinancing Loans.—Not more than 20 percent of the amount allocated each year to the loan guarantee program established by this chapter may be allocated to guarantee refinancing loans during the year.

“SEC. 2973C. TERMS AND CONDITIONS OF LOAN GUARANTEES.

“(a) In General.—The principal amount of the guaranteed loan, when added to any Federal grant assistance made under this subtitle, may not exceed 95 percent of the total value of the project, including land.

“(b) Guarantees Provided May Not Supplant Other Funds.—Guarantees provided under this chapter
may not be used to supplant other forms of State or local support.

“(c) Right To Recover Funds.—The United States shall be entitled to recover from any applicant healthcare facility the amount of payments made pursuant to any loan guarantee under this chapter, unless the Trust Fund Board for good cause waives its right of recovery, and the United States shall, upon making any such payment pursuant to any such loan guarantee be subrogated to all of the rights of the recipients of the payments.

“(d) Modification of Terms.—Loan guarantees made under this chapter shall be subject to further terms and conditions as the Trust Fund Board determines to be necessary to assure that the purposes of this Act will be achieved, and any such terms and conditions may be modified by the Trust Fund Board to the extent that it determines such modifications to be consistent with the financial interest of the United States.

“(e) Terms Are Incontestable Absent Fraud or Misrepresentation.—Any loan guarantee made by the Trust Fund Board pursuant to this chapter shall be incontestable in the hands of an applicant on whose behalf such guarantee is made, and as to any person who makes or contracts to make a loan to such applicant in reliance
thereon, except for fraud or misrepresentation on the part
of such applicant or other person.

“SEC. 2973D. PREMIUMS FOR LOAN GUARANTEES.

“(a) IN GENERAL.—The Trust Fund Board shall de-
termine a reasonable loan insurance premium which shall
be charged for loan guarantees under this chapter, taking
into account the availability of the reserves created under
section 2973B. Premium charges shall be payable in cash
to the Trust Fund Board, either in full upon issuance,
or annually in advance. In addition to the premium charge
herein provided for, the Trust Fund Board is authorized
to charge and collect such amount as it may deem reason-
able for the appraisal of a property or project offered for
insurance and for the inspection of such property or
project.

“(b) PAYMENT IN ADVANCE.—In the event that the
principal obligation of any loan accepted for insurance
under this chapter is paid in full prior to the maturity
date, the Trust Fund Board is authorized in its discretion
to require the payment by the borrower of an adjusted
premium charge in such amount as the Board determines
to be equitable, but not in excess of the aggregate amount
of the premium charges that the healthcare facility would
otherwise have been required to pay if the loan had contin-
ued to be insured until maturity date.
``(c) Trust Fund Board May Waive Premiums.—

The Trust Fund Board may in its discretion partially or totally waive premiums charged for loan insurance under this section for financially distressed healthcare facilities (as described by the Secretary).

``SEC. 2973E. PROCEDURES IN THE EVENT OF LOAN DEFAULT.

``(a) In General.—Failure of the borrower to make payments due under or provided by the terms of a loan accepted for insurance under this chapter shall constitute a default.

``(b) Assignment of Defaulted Loans.—If a default continues for 30 days, then, upon the lender’s transfer to the Trust Fund Board of all its rights and interests arising under the defaulted loan or in connection with the loan transaction, the lender shall be entitled to debentures which, together with a certificate of claim, are equal in value to the amount the lender would have received if, on the date of transfer, the borrower had repaid the loan in full, together with the amount of necessary expenses incurred by the lender in connection with the default.

``(c) Foreclosure by Lender.—Subject to the approval of the Trust Fund Board, or as provided in regulations, the lender may foreclose on the property securing the defaulted loan.
“(d) Foreclosure by Trust Fund Board.—The Trust Fund Board is authorized to—

“(1) acquire possession of and title to any property securing a defaulted loan by voluntary conveyance in extinguishment of the indebtedness, or

“(2) institute proceedings for foreclosure on the property securing any such defaulted loan and prosecute such proceedings to conclusion.

“(e) Handling and Disposal of Property; Settlement of Claims.—

“(1) Payment for certain expenses.—Notwithstanding any other provision of law relating to the acquisition, handling, or disposal of real and other property by the United States, the Trust Fund Board shall also have power, for the protection of the interests of the Trust Fund, to pay out of the Trust Fund all expenses or charges in connection with, and to deal with, complete, reconstruct, rent, renovate, modernize, insure, make contracts for the management of, or establish suitable agencies for the management of, or sell for cash or credit or lease in its discretion, any property acquired by the Trust Fund under this section.

“(2) Settlement of claims.—Notwithstanding any other provision of law, the Trust Fund
Board shall also have the power to pursue to final
collection by way of compromise or otherwise all
claims assigned and transferred to the Trust Fund
in connection with the assignment, transfer, and de-
delivery provided for in this section, and at any time,
upon default, to foreclose or refrain from foreclosing
on any property secured by any defaulted loan as-
signed and transferred to or held by the Trust
Fund.

“(3) LIMITATIONS ON AUTHORITY.—Sub-
sections (a) and (b) shall not be construed to apply
to any contract for hazard insurance, or to any pur-
chase or contract for services or supplies on account
of such property if the amount thereof does not ex-
ceed $1,000.

“(f) REGULATIONS.—The Trust Fund Board shall
propose and the Secretary shall promulgate regulations
governing procedures in the event of a default on a loan
accepted for insurance under this chapter.

“Subchapter C—Grants for Urgent Capital
Needs

“SEC. 2976. PROVISION OF GRANTS.

“(a) IN GENERAL.—The Trust Fund Board shall
make available $400,000,000 in direct grants annually.
The Secretary, with the approval of the Trust Fund
Board, shall make direct grants to eligible healthcare facilities with urgent capital needs.

“(b) PURPOSES.—Direct grants shall be available to eligible healthcare facilities for 3 types of projects:

“(1) Emergency certification and licensure grants would be available to eligible healthcare facilities that are threatened with closure or loss of accreditation or certification of a facility or of essential services as a result of life or safety code violations or similar facility or equipment failures. Such grants would provide limited funding for repair and renovation where failure to fund would disrupt the provision of essential public health services such as emergency care.

“(2) Emergency grants would be available for capital renovation, expansion, or replacement necessary to the maintenance or expansion of essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care and preventive health services.

“(3) Planning grants would be available to eligible healthcare facilities who require pre-approval assistance to meet regulatory requirements related to management and finance in order to apply for
loans, loan guarantees, and interest subsidies under this subtitle.

“(c) Priority to Financially Distressed Healthcare Facilities.—Priority for direct grants under this section would be given to financially distressed healthcare facilities (as described by the Secretary).

“(d) Application Process.—The Secretary, with the approval of the Trust Fund Board, shall create an expedited application process for direct grants.

“SEC. 2976B. Eligible Projects.

“(a) Matching Grants.—

“(1) Limitation on Amount.—Grants for capital expenditures by eligible healthcare facilities will be limited to $25,000,000.

“(2) Matching Requirement.—At least half of the projects funded in a year must receive at least 50 percent of their funding from State or local sources. The remaining projects funded during the year could be financed up to 90 percent with a combination of Federal grants and loans.

“(3) Reservation for Rural Healthcare Facilities.—No less than 20 percent of the grant funds in any given year would be reserved for rural healthcare facilities, provided that a sufficient number of applications are approved.
“(b) Planning Grants.—Applicants who can demonstrate general qualification for the direct matching loan, loan guarantee, or interest subsidy programs under this subtitle or eligibility for mortgage insurance under section 242 of the National Housing Act will be eligible for a grant of up to $500,000 to assist in implementation of key budgetary and financial systems as well as management and governance restructuring.”.

TITLE VIII—MISCELLANEOUS PROVISIONS

SEC. 801. DEFINITIONS.

For purposes of this Act (including the amendments made by this Act other than the amendments made by subtitles A through G of title I):

(1) Appropriate Healthcare Services.— The term “appropriate healthcare services” includes services or treatments to address physical, mental, and behavioral diseases, conditions, or syndromes. The definition contained in this paragraph shall not apply for purposes of sections 206 and 606.

(2) Hispanic.—The term “Hispanic” means individuals whose origin is Mexican, Puerto Rican, Cuban, Central or South American, or any other Spanish-speaking country.
(3) INDIAN.—The term “Indian”, unless otherwise designated, means any person who is a member of an Indian tribe.

(4) INDIAN TRIBE.—The term “Indian tribe” means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(5) LIMITED ENGLISH PROFICIENT.—The term “limited English proficient” with respect to an individual means an individual who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with clinical or nonclinical staff at a healthcare organization.

(6) 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.

(7) Minority group.—The term “minority group” has the meaning given the term “racial and ethnic minority group”.

(8) Racial and ethnic minority group.—The term “racial and ethnic minority group” means American Indians and Alaska Natives, African Americans (including Blacks), Asian Americans, Hispanics (including Latinos), and Native Hawaiians and other Pacific Islanders.

(9) Secretary.—The term “Secretary” means the Secretary of Health and Human Services.

(10) State.—The term “State” means each of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Indian tribes, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(11) Tribal organization.—The term “tribal organization” means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the
Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(12) UNDERREPRESENTED MINORITY.—The terms “underrepresented minority” and “underrepresented minorities” refer to individuals who are members of racial or ethnic minority groups that are underrepresented in the health professions relative to their numbers in the general population.

(13) UNDERSERVED POPULATIONS.—The term “underserved population” means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

SEC. 802. DAVIS-BACON ACT.

All laborers and mechanics employed by contractors or subcontractors in the performance of construction work financed in whole or in part with assistance under this Act (or an amendment made by this Act), including capital financing assistance, or grants or loan guarantees from the Safety Net Infrastructure Trust Fund (established under section 2972C of the Public Health Service Act), shall be paid wages at rates not less than those prevailing on similar work in the locality involved as deter-
mined by the Secretary of Labor in accordance with sub-
chapter IV of chapter 31 of title 40, United States Code
(commonly referred to as the Davis-Bacon Act). The Sec-
retary of Labor shall have, with respect to such labor
standards, the authority and functions set forth in Reor-
ganization Plan Numbered 14 of 1950 (15 F.R. 3176; 64
Stat 1267) and section 3145 of title 40, United States
Code.