

The Health Equity and Accountability Act of 2018

Section-by-Section

TITLE I—DATA COLLECTION AND REPORTING

Overall. Title I focuses on the collection and reporting of data related to disparities associated with the demographic factors of race, ethnicity, sex, primary written and spoken language, disability status, sexual orientation, gender identity, and socioeconomic status. It creates consistency in terminology by replacing “linguistic data” and “primary data” with “primary spoken and written language” throughout the Title.

Section 101. Amendment to the Public Health Service Act (PHSA) to promote data collection, analysis, and reporting of demographic data among federally supported health programs. Requires Department of Health and Human Services (HHS) health-related programs to collect demographic data on the race, ethnicity, sex, primary written and spoken language, disability status, sexual orientation, gender identity, and socioeconomic status of participants. Establishes the requirement that the disclosure of any such data shall be voluntary and optional for participants and prohibits compelled disclosure of any such data as a condition of participating in any HHS program. Broadens levels of government entities with interest in disparities data to include counties and municipalities. Creates a new grants program to provide technical assistance to public and private entities for collecting and reporting disparities data. Requires the National Center for Health Statistics and others to develop an ongoing and sustainable national strategy for oversampling under counted populations, including Asian American, Native Hawaiian or Pacific Islander, in national surveys and to issue a progress report within two years. Requires the HHS Data Council to develop a national plan for the culturally and linguistically appropriate collection of these data through both HHS programs and surveys.

Section 102. Elimination of prerequisite of direct appropriations for data collection and analysis. Under current law, data may not be collected under the PHSA unless funds are directly appropriated for that purpose. Section 102 repeals that language.

Section 103. Collection of demographic data by the Social Security Administration. Requires the Social Security Administration to collect, analyze, and report data on the race, ethnicity, primary written and spoken language, and disability status of applicants for Social Security account numbers or benefits.

Section 104. Revision of HIPAA claims standards. Requires the HHS Secretary, in consultation with the National Coordinator for Health Information Technology, to revise the Health Insurance Portability and Accountability Act (HIPAA) regulations to use appropriate standards for the collection of data on race, ethnicity, primary written and spoken language, sex, disability status, sexual orientation, and gender identity, such as the standards developed under the PHSA Section 3101.

Section 105. National Center for Health Statistics. Extends authorization for appropriations for National Center for Health Statistics (NCHS) activities to 2023.

Section 106. Disparities data collected by the Federal Government. Requires all agencies that have collected data related to race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status during the previous year to submit these data to a centralized electronic repository of government data on the well-being of the U.S. population. Requires HHS to use these data to prepare data sets for public use that relate to disparities in health status, health care access, health care quality, health outcomes, public health, and other areas of health and well-being by factors that include

race, ethnicity, sex, primary language, sexual orientation, disability status, gender identity, and socioeconomic status. Requires HHS to submit a report to Congress on the availability to and use of these data by public stakeholders.

Page 1 of 27

Section 107. Data collection and analysis grants to minority-serving institutions. Establishes grants through the National Institute for Minority Health and Health Disparities and the Office of Minority Health to minority-serving institutions to access and analyze race, ethnicity, and, where possible, other health disparity data.

Section 108. Standards for measuring sexual orientation, gender identity, and socioeconomic status in collection of health data. Amends PHSA Section 3101, regarding the collection of health disparity data by HHS surveys and programs, to include sexual orientation, gender identity, and socioeconomic status.

Section 109. Safety and effectiveness of drugs with respect to racial and ethnic background. Amends the Federal Food, Drug, and Cosmetic Act to require investigation into evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug. Investigation may include both pre-approval and post-market testing. Requires the drug to be labeled accordingly if the existence of such a disparity is found. Requires pre-approval and, in some cases, post-market studies if there is evidence that there may be a disparity in the safety or effectiveness of a drug on the basis of racial or ethnic background.

Section 110. Improving health data regarding Native Hawaiians and Pacific Islanders Requires the National Center for Health Statistics (NCHS) to develop and implement an ongoing and sustainable national strategy for identifying and evaluating the health status and health care needs of Native Hawaiians and Pacific Islanders (NHPI). Requires an NCHS preliminary health survey in order to identify the major areas and regions in which Native Hawaiians and Pacific Islanders reside, a progress report after two years, and a study and report by the National Academies of Science, Engineering, and Medicine.

Section 111. Clarification of simplified administrative reporting requirement. Amends the Food and Nutrition Act of 2008 to establish a simplified administrative reporting requirement for exceptions granted under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

TITLE II—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH AND HEALTH CARE

Overall. Title II focuses on improving access to and the quality of care that is culturally and linguistically appropriate through pilot programs that test interpreting services, federal reimbursement of language access services in Medicaid, CHIP and Medicare, and accountability of federal programs providing federal financial assistance.

Section 201. Definitions and findings. Adds definitions contained in Section 204 to the PHSA.

Section 202. Improving access to services for individuals with limited-English proficiency. Requires Federal agencies providing financial assistance to, or administering, a health program or activity to develop and implement a plan to improve culturally and linguistically appropriate access to their programs or activities for individuals with limited-English proficiency.

Section 203. National standards for culturally and linguistically appropriate services in health care. Sets standards for any health program or activity that receives Federal financial assistance for providing culturally and linguistically appropriate services in health care. This includes through diverse staff and leadership, education and training, offering and providing language assistance, and community collaboration and engagement.

Section 204. Culturally and linguistically appropriate health care services. Establishes through the Agency for Healthcare Research and Quality (AHRQ) the Robert T. Matsui Center for Culturally and Linguistically Appropriate Health Care to provide online resources to link health care providers to

Page 2 of 27

interpreter and translation services. Establishes a grants program to enable the design, implementation, and evaluation of innovative, cost-effective programs to improve culturally and linguistically appropriate access to health care services for individuals with limited-English proficiency. Expands research concerning language access in the provision of health care services.

Section 205. Pilot program for improvement and development of state medical interpreting services. Authorizes competitive grants for states to design, implement, and evaluate statewide programs to provide on-site medical interpreting services under Medicaid. Statewide programs leverage technology for scheduling and payment of in-person interpreter services and ensure better access to interpreter services for small and rural providers.

Section 206. Training tomorrow's doctors for culturally and linguistically appropriate care: Graduate Medical Education. Amends the Direct Graduate Medical Education and Indirect Medical Education programs to include cultural competency training, education, and training in linguistically appropriate service delivery to count in the determination of full-time equivalency.

Section 207. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children's Health Insurance Programs. Establishes a grant program for eligible Medicare service providers to improve communication with Medicare beneficiaries who are English learners, including beneficiaries who live in underserved communities. Includes language assistance services as a rural health clinic service under Medicare. Clarifies the applicability of Title VI and ACA Section 1557 to Medicare Advantage and prescription drug plans. Increases the federal reimbursement rate for language services under Medicaid and CHIP. Funds language assistance services furnished by Medicaid providers that serve high rates of uninsured limited-English proficiency individuals.

Section 208. Increasing understanding of and improving health literacy. Establishes grants to hospitals, health centers or clinics, health plans, or other health entities to improve health care for patient populations that have low functional health literacy.

Section 209. Requirements for health programs or activities receiving Federal funds. Requires health programs or activities that receive Federal assistance to ensure the right of individuals with limited-English proficiency to receive access to quality health by ensuring staff receive ongoing education and training in culturally and linguistically appropriate service delivery, offering language assistance services, and utilizing qualified interpreters except when a patient requests the use of a family member or friend.

Section 210. Report on Federal efforts to provide culturally and linguistically appropriate health care services. Directs HHS to commission a report from the National Academy of Medicine that describes federal efforts to ensure that all individuals with limited-English proficiency have meaningful access to health care and health care-related services that are culturally and linguistically appropriate. The report shall include a description and analysis of best practices, recommendations on the development and implementation of policies and practices by providers for individuals with limited-English proficiency, and a description of the effect of providing language services on quality of health care and access to care.

Section 211. English for speakers of other languages. Establishes Department of Education grants to state or community-based organizations that employ and serve minority populations to develop and implement

a plan for assuring the availability of English as a second language instruction that effectively integrates information about the nature of the United States health care system, how to access care, and any special language skills that may be required for them to access and regularly navigate the system effectively.

Page 3 of 27

Section 212. Implementation. Clarifies that there is no state immunity under the 11th Amendment for failing to provide language access services and a rule of construction clarifying that this measure should not limit other federal financial assistance.

Section 213. Language access services. Adds language access services, including oral interpretation and written translations, as a required category of Essential Health Benefits and employer-sponsored minimum essential coverage under the ACA. Strengthens the regulations governing the processes for internal claims and appeals for health plans to provide oral interpretation and translated notices. Directs the HHS Secretary to modify the single streamlined application to collect the preferred spoken and written language for each household member for those applying for coverage under the ACA and collect an annual report from Federal and State call centers on their implementation of language access services.

TITLE III—HEALTH WORKFORCE DIVERSITY

Overall. Title III recognizes the need to improve the diversity and quality of the nation’s whole health care workforce. It provides grant and loan repayment programs to promote inclusion in a number of different health professions. It focuses on directing funding to underrepresented students who may not otherwise be able to achieve the education needed to participate in the workforce. Title III also provides resources to medical institutions to allow them to better provide growth opportunities for their staff.

Section 301. Amendment to the Public Health Service Act. Establishes:

- A National Working Group on Workforce Diversity to review workforce diversity initiatives, identify successful program and practices, and examine development and implementation challenges;
- A technical clearinghouse for health workforce diversity within HHS;
- Grants to educational institutions or entities that historically produce or train meaningful numbers of underrepresented minority health professionals to expand existing or implement new workforce diversity programs or evaluate existing or new programs;
- Grants to support scientists and researchers and promote the inclusion of underrepresented minorities in health professions;
- Grants to provide career support for non-research health professionals;
- Grants to expand research on the link between health workforce diversity and quality; and
- A health and health care disparities and inequities education program at HHS.

Section 302. Hispanic-serving institutions, Historically Black Colleges and Universities, and Tribal Colleges. Establishes grants to Hispanic-serving health professions schools, Historically Black Colleges & Universities and Tribal Colleges, including Regional community based organizations and national minority medical associations, for scholarships and financial assistance to recruit underrepresented minority individuals to enroll in and graduate from health professions schools.

Section 303. Loan repayment program of Centers for Disease Control and Prevention. Reauthorizes through 2024 a program that permits HHS to repay up to \$50,000 of educational loans for health professionals who agree to conduct prevention activities as employees of CDC and the Agency for Toxic Substances and Disease Registry.

Section 304. Cooperative agreements for online degree programs at schools of public health and schools of allied health. Establishes cooperative agreements between HHS and schools of public health and schools of allied health to design and implement online degree programs with priority to any school of public health or school of allied health that has an established track record of serving medically underserved communities.

Section 305. Sense of Congress on the mission of the National Health Care Workforce Commission. Emphasizes that, in carrying out its duties, the National Health Care Workforce Commission should give attention to the needs of racial and ethnic minorities, individuals with low socioeconomic status, individuals with developmental and physical disabilities, and lesbian, gay, bisexual, and transgender populations, and individuals who are members of multiple minority or special population groups.

Section 306. Scholarship and fellowship programs. Creates:

● David Satcher Public Health and Health Services Corps grants to increase awareness among post-primary and post-secondary students of career opportunities in health professions (with priority given to entities with diverse populations, with experience in health disparity elimination programs that facilitate entry of disadvantaged individuals into higher education institutions, and that provide services to assist disadvantaged individuals in completing postsecondary education);

● Louis Stokes Public Health Scholars program to award scholarships to post-secondary students who seek a career in public health (with priority to students with disadvantaged backgrounds who are admitted to a minority-serving institution and have identified a health professional mentor and an academic advisor);

● Patsy Mink Health and Gender Research Fellowship program that awards 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 (with priority given to applicants that are from disadvantaged backgrounds and who have identified a mentor and academic advisor and secured a research assistant position);

● Paul David Wellstone International Health Fellowship program to award research fellowships to college students or recent graduates to advance their understanding of international health (with priority given to applicants that are from disadvantaged backgrounds and have identified a mentor and advisor);

● Edward R. Roybal Healthcare Scholar program to award grants to eligible entities to expose entering graduate students to the health professions (with priority given to entities that have experience with health disparity elimination programs, facilitate training in specified health professions fields, and provide services to assist individuals in completing postsecondary education); and

● The Leadership Fellowship Program shall award grants to eligible entities to develop leadership fellowship programs for underrepresented health professionals to become future leaders in public health and health care delivery institutions.

Section 307. McNair Postbaccalaureate Achievement Program. Amends the McNair program by requiring the Secretary of Education to coordinate with the Secretary of HHS to ensure collaboration on programs that promote health workforce diversity and encourage participants to consider health profession careers.

Section 308. Rules for determination of full-time equivalent residents for cost reporting periods. Clarifies

that, for the purposes of cost reporting periods, teaching hospitals may count all time residents spend in approved residency programs, including the time residents spend on research, didactic teaching, and training in public health departments. This eliminates regulatory barriers that prevented training programs from placing residents in non-hospital settings.

Section 309. Developing and implementing strategies for local health equity. To better integrate health equity efforts at universities and academic medical centers to increase health equity in their locales, establishes grant programs through a collaborative effort among HHS, the Department of Education, and Department of Labor to:

- Develop capacity at academic institutions to build an evidence base for successful strategies and to serve as national models of driving local health equity;
- Develop strategic partnerships between academic institutions and the communities in which they are situated; and
- Collect data and evaluate the programs' effectiveness and to enable programs to adapt accordingly.

Section 310. Loan forgiveness for mental and behavioral health social workers. Directs the Secretary of Education to cancel the balance of interest and principal due on any eligible Federal Direct Loan not in default for mental health and behavioral health social workers meeting certain loan repayment/service requirements.

Section 311. Health Professions Workforce Fund. Establishes a mandatory Health Professions Workforce Fund to provide for expanded and sustained investments in the health professions and nursing workforce development programs under Title VII and Title VIII of the Public Health Service Act.

Section 312. Findings, sense of Congress related to graduate medical education. Emphasizes that eliminating the freeze on graduate medical education support under the Medicare program is critical to ensuring an appropriate supply of physicians to meet the nation's health care needs, facilitating equitable access to health care, and mitigating disparities and inequities in health and health care. Increased pathway programs for international medical graduates (IMG) would also help make medical education and training more accessible to IMGs, since they already equal 25 percent of the current workforce.

Section 313. Career support for skilled, internationally educated health professionals. Establishes a grant program to:

- provide services to assist unemployed and underemployed internationally-educated health professionals authorized to work in the United States to enter the American health workforce and find employment matching their skill and education;
- assist in the evaluation of foreign credentials;
- reduce barriers for internationally-educated health professionals to enter and advance in the health workforce;
- educate employers on the abilities and capabilities of internationally-educated health professionals;
- assist in the evaluation of foreign credentials; and
- facilitate access to contextualized and accelerated courses on English as a second language.

TITLE IV—IMPROVING HEALTHCARE ACCESS AND QUALITY Overall. Title IV addresses systemic barriers to quality care for disparities-impacted populations through expanding coverage, improving access, innovating in delivery, and creating health empowerment zones. It brings down barriers to coverage for immigrants, people living in U.S. territories, Native Americans, Medicare beneficiaries, and at-risk youth. It improves community health, funding for providers of care, addresses rural health needs, and ensures those enrolled in health insurance can access the providers and benefits they need. It recognizes the ongoing efforts in delivery and payment system reforms and the need to include the impact on health disparities in those efforts.

Subtitle A – Expansion of Coverage

Section 401. Amendment to the Public Health Service Act. Establishes grants for demonstration projects to improve the quality of and access to health care by health entities that provide patients with access to services regardless of their ability to pay and serve patient populations that are composed of uninsured, vulnerable populations, racial and ethnic minorities, or the limited-English proficient. Requires HHS to designate centers of excellence at public hospitals and other health systems serving large numbers of minority patients. Requires HHS to provide direct financial assistance to health providers and centers

in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii.

Section 402. Removing citizenship and immigration barriers to access to affordable health care under ACA. Retains existing eligibility rules for the ACA's insurance affordability programs, such as income and tax filing requirements, and eliminates eligibility criteria based on immigration or citizenship status.

Section 403. Study on the uninsured. Requires HHS to study, in accordance with the standards under section 3101 of the Public Health Service Act, and report on the demographic characteristics of the uninsured and the projected demographic characteristics of the population of individuals who will not have health insurance and/or oral health coverage after the end of open enrollment or any special enrollment period.

Section 404. Medicaid in the territories. Permanently eliminates Medicaid funding limitations for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa and provides parity in FMAP payments for the territories and insular possessions beginning in fiscal year 2019. Permits all five territories to have waiver authority under 1902(j) of the Social Security Act. Adjusts allocation of DSH payments for the territories.

Section 405. Extension of Medicare secondary payer. Establishes a 42-month "coordination period" for patients with end-stage-renal disease and under a group health plan so that the group health plan is the primary payer for 42 months, after which Medicare becomes the primary provider.

Section 406. Border Health Grants. Authorizes a grant program to address priorities and recommendations to improve the health of residents near the United States-Mexico border.

Section 407. Removing Medicare barrier to health care. Makes individuals who are lawfully present in the United States eligible for Medicare.

Section 408. 100 percent FMAP for medical assistance provided by urban Indian Health Centers. Amends section 1905 of the Social Security Act to include medical assistance provided by Indian Health Centers.

Section 409. 100 percent FMAP for medical assistance provided to a Native Hawaiians through a federally qualified health center or a Native Hawaiian health care system under the Medicaid program. Provides 100 percent FMAP for Native Hawaiian treatment or care.

Subtitle B – Expansion of Access

Section 410. Protecting sensitive locations. Codifies existing Department of Homeland Security guidance to protect individuals from immigration enforcement across multiple sensitive locations, including health facilities, schools, early childhood programs, and other places where people access social services and supports.

Section 411. Grants for racial and ethnic approaches to community health. Creates HRSA grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs to reduce or eliminate health disparities experienced by racial and ethnic minorities. Directs HHS to encourage grantees to share best practices, evaluation results, and reports with communities not affiliated with the grantees.

Section 412. Critical Access Hospital improvements. Eliminates the requirement that rural ambulance services be at least 35 miles from one another in order to qualify for Medicare reimbursement; for areas served by a community ambulance where ambulance transport is to or from the critical access hospital (CAH), the community ambulance would receive cost based payment by billing Medicare under arrangement through the hospital. Provides an alternative to the current 25 inpatient bed limit, under which states may elect to count 730 inpatient bed days at a CAH. Under current law, CAHs may have a maximum of 25 acute care inpatient beds (counting any hospital-type bed located in or adjacent to any location where the bed could be used for inpatient care), with exceptions for swing bed agreements, examination or procedure beds, stretchers, operating room tables, and others.

Section 413. Establishment of Rural Community Hospital (RCH) Program. Establishes a rural community hospital program in which HHS can designate hospitals located in a rural area, having fewer than 51 acute care inpatient beds, and that make available 24-hour emergency care services, that can qualify for reimbursement of 101 percent of the reasonable costs of services provided.

Section 414. Medicare remote monitoring pilot projects. Requires HHS to conduct pilot projects to provide incentives to home health agencies to utilize home monitoring and communications technologies that enhance health outcomes for Medicare beneficiaries and reduce expenditures.

Section 415. Rural health quality advisory commission and demonstration projects. Establishes a commission to develop, coordinate, and facilitate implementation of a national plan for rural health quality improvement and five demonstration projects to implement and evaluate methods for improving the quality of health care in rural communities.

Section 416. Rural health care services. Requires HHS to conduct pilot projects to provide incentives to home health agencies to utilize home monitoring and communications technologies that enhance health outcomes for Medicare beneficiaries and reduce expenditures.

Section 417. Community health center collaborative access expansion. Facilitates cooperation between a rural health clinic and a community health center.

Section 418. Facilitating the provision of telehealth services across State lines. Requires HHS to consult with States, physicians, healthcare practitioners, and patient advocates to encourage and facilitate the adoption of telehealth services under the Medicare program with multistate practitioner practice across State lines.

Section 419. Scoring of preventive health savings. Requires the Congressional Budget Office, upon request by the chairman or ranking member of either Budget Committee, to determine if a proposed measure would result in reductions in budget outlays in budgetary outyears through the use of preventive health and preventive health services.

Section 420. Sense of Congress on maintenance of effort provisions regarding children's health. Establishes Sense of Congress that maintenance of effort provisions of the ACA for Medicaid and CHIP are critical for the protection of vulnerable populations, including communities of color, and must be strictly enforced.

Section 421. Repeal of requirement for documentation evidencing citizenship or nationality under the Medicaid program. Repeals provisions of the Deficit Reduction Act of 2005 that require documentation

of U.S. citizenship for Medicaid participants.

Page 8 of 27

Section 422: Protection of the HHS Offices of Minority Health. Maintains that, regardless of any changes in HHS structure, the Offices of Minority Health report to the Secretary of HHS.

Section 423. Office of Minority Health in Veterans Health Administration of Department of Veterans Affairs. Establishes Office of Minority Health in the Veterans Health Administration (VHA) to establish goals and objectives and coordinate all other activities within the VHA that relate to disease prevention, health promotion, health care services delivery, and health care research concerning veterans who are members of a racial or ethnic minority group.

Section 424. Indian defined in the Affordable Care Act. Makes consistent definition of “Indians” under the ACA and Internal Revenue Code of 1986.

Section 425. Study of DSH payments to ensure hospital access for low-income patients. No later than January 1, 2019, the Comptroller General of the United States shall evaluate and examine the continued need for payments to disproportionate share hospitals under section 1886(d)(5)(F) of the Social Security Act and section 1923 of such Act to ensure timely access to health care services for low-income patients after the expansion of coverage under Medicaid programs, as well as how such funding should be allocated among hospital and provide recommendations.

Section 426. Assistant Secretary of the Indian Health Service. Establishes that any reference by law, regulation, document, paper, or other record of the United States to the Director of the Indian Health Service be changed to reference the Assistant Secretary of the Indian Health Service.

Section 427. Reauthorization of the Native Hawaiian Health Care Improvement Act. Amends the Native Hawaiian Health Care Improvement Act to include necessary funding indefinitely.

Section 428. Availability of non-English language speaking providers. Amends Section 1311 of the ACA with respect to the provider’s ability to provide care in a language other than English either through the provider speaking such language or having a trained medical interpreter available. Codifies the standard adopted in section 1557 of the ACA regulations regarding qualified interpreter and translator.

Section 429. Access to essential community providers. Amends Section 1311 of the ACA to increase the percentage of essential community providers and establish data and reporting requirements on essential community providers.

Section 430. Provider network adequacy in communities of color. Amends Section 1311 of the ACA to include network adequacy standards, as established by the Secretary, which may include appointment wait time, transportation data on travel time and distance, extended hours of operation and coverage of services for enrollees through out-of-network providers at no additional cost when in-network providers are unable to comply with adequacy standards.

Section 431. Improving access to dental care. Requires that GAO and HRSA each submit a report to Congress on dental programs, dental shortage areas, and areas lacking Medicaid-participating dentists. Expands coverage for oral health services for federal programs clarifies payment standards.

Subtitle C – Advancing Health Equity through Payment and Delivery Reform

Section 441. Sense of Congress. Establishes Sense of Congress that eliminating health disparities and achieving health equity must be central to efforts to achieve a high value health care system.

Section 442. Centers for Medicare & Medicaid Services Quality Payment Program. Directs CMS to explicitly integrate “achieving health equity” across all measures and activities in the Quality Payment Program. Directs CMS to highly weight providing language services for non-English speakers in the Quality Payment Program. Directs CMS to include stratification of data by disparity variables and implementation of Culturally and Linguistically Accessible Standards as clinical practice improvement activities.

Section 443. Development and testing of disparity reducing delivery and payment models. Directs the Center for Medicare and Medicaid Innovation (CMMI) to establish dedicated funding for identifying, piloting, evaluating, and scaling delivery and payment models that target the reduction of racial and ethnic health disparities through addressing the socially-determined barriers to good health. Requires all CMMI models to include measures that assess and track the model’s impact on health disparities.

Section 444. Supporting safety net and community-based providers to compete in value-based payment systems. Requires all alternative payment models developed and tested by any HHS agency to be assessed for impact on safety net, community-based, and critical access providers, including federally qualified health centers.

Subtitle D – Health Empowerment Zones

Section 451. Short title. The subtitle may be cited as the “Health Empowerment Zone Act of 2018”.

Section 452. Findings.

Section 453. Designation of health empowerment zones. Defines eligibility for and requires HHS to designate at least 110 communities with disproportionate disparities in health status and healthcare as health empowerment zones, with at least one in each state, DC, and territory or possession. Each health empowerment zone is eligible for a grant under section 455. In applying, each entity must set forth goals to be achieved and a strategic plan for achieving those goals.

Section 454. Assistance to those seeking designation. Authorizes HHS to provide technical assistance or grants for entities seeking to apply as a health empowerment zone.

Section 455. Benefits of designation. Authorizes grants for health empowerment zones to implement their strategic plan. HHS will establish metrics for measuring the progress of grantees.

Section 456. Definition of Secretary. HHS shall act through the Administrator of HRSA and the Deputy Assistant Secretary for Minority Health, in cooperation with the Director of the Office of Community Services and the Director of the National Institute on Minority Health and Health Disparities.

Section 457. Authorization of appropriations. To carry out this subtitle, there is authorized to be appropriated \$100,000,000 for fiscal year 2019.

Subtitle E – At Risk Community Coverage

Section 461. Medicaid Coverage for Citizens of Freely Associated States Clarifies that citizens residing in the United States under the Compact of Free Association treaty are eligible for Medicaid.

Section 462. At-Risk Youth Medicaid Protection Requires that incarcerated juveniles' Medicaid is suspended, rather than terminated.

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

Overall: Title V focuses on the research, tools, data based models, programs, workforce, and resources necessary to improve the health and wellbeing of women, adolescents, and families. Seeking to dismantle barriers and disparities in accessing information, education, services, care and coverage, the provisions in Title V address a range of infant, maternal, sexual, and reproductive health needs for marginalized and underserved individuals and communities.

Subtitle A—In General

Section 501. Grants to promote health for underserved communities. Authorizes HHS grant program to promote health for underserved communities, with preference given to projects that benefit racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer or questioning communities, and to strengthen health outreach initiatives in medically underserved communities, including linguistically isolated populations. Grants may be used to support community health workers to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program, Medicare, and Medicaid; to educate about health problems; to target behavioral risk factors; to promote positive health behaviors; to promote community wellness; and to educate and refer target populations for health services.

Section 502. Removing barriers to health care and nutrition assistance for children, pregnant persons, and lawfully residing individuals. Expands coverage of benefits under the Supplemental Nutrition Assistance Program, Medicaid and Children's Health Insurance Program by allowing people who are lawfully present in the United States to be eligible by removing barriers that are based on immigration status or date of entry into the United States. Expands eligibility for Supplemental Nutrition Assistance Program, Medicaid, and the Children's Health Insurance Program for families with children. Ensures proper screening by providing a method that does not require unnecessary information that would restrict welfare and public benefits for aliens.

Section 503. Repeal of denial of benefits. Reinstates food stamp benefits to individuals with drug-related convictions.

Section 504. Birth defects prevention, risk reduction, and awareness. Directs CDC to establish and implement a birth defects prevention and public awareness program that includes a nationwide media campaign to increase awareness among health care providers and at-risk populations about pregnancy and breastfeeding information services. Grants for the provision of, or campaigns to increase awareness about, pregnancy and breastfeeding information services and grants for the conduct or support of surveillance of or research on maternal exposures and maternal health conditions.

Section 505. Preventing maternal deaths. Establishes grants to State departments of health to initiate uniform State maternal mortality review committees on pregnancy-related and pregnancy-associated

deaths. Provides incentives to states to develop a process for

Page 11 of 27

reporting pregnancy related deaths by health care providers and facilities and a reporting process available to family members of the deceased. Establishes research grants for finding, investigating, summarizing and reporting cases of pregnancy related or associated death, severe maternal morbidity, and disparities in the above. Sets out review committee membership and allows for regional review committees. Creates national information clearinghouse at CDC.

Section 506. Eliminating disparities in maternity health outcomes. Requires all relevant agencies within HHS to conduct research into the determinants and distribution of health disparities in maternal health outcomes and improve the infrastructure to measure such disparities. Expands access to maternity services for vulnerable populations. Establishes a demonstration project to compare effective interventions to reduce maternity services disparities and outcomes and implement and assess effective interventions. Requires reporting of demonstration project results.

Section 507. Decreasing the risk factors for sudden unexpected infant death and sudden unexplained death in childhood. Establishes a culturally and linguistically appropriate public health awareness and education campaign at HHS to provide information focused on decreasing the risk factors for sudden unexpected infant death and sudden unexplained death in childhood.

Section 508. Reducing unintended teenage pregnancies. Establishes community grants to equip marginalized young people with medically-accurate, age-appropriate, scientifically-based, and culturally appropriate information and skills to access and obtain sexual health care and related services, promote effective communication regarding sexual health, support better health, educational, and economic opportunities for young parents and their families, and/or provide training for those working with youth to better serve their sexual health and well-being needs. Directs HHS to prioritize these grants seeking to serve young people under age 26 who face structural barriers and systemic inequity in accessing care. Requires an evaluation of effectiveness every two years of either eight programs funded under this subsection or ten percent of funded programs, whichever is greater. Prohibits funding under this subsection from being used for any program that withholds sexual health information, is medically inaccurate or been scientifically show to be ineffective, promotes gender stereotypes, or is insensitive or unresponsive to the needs of young people. Transfers unobligated funds under section 510(d) of the Social Security Act. This is the Youth Access to Sexual Health Services Act (S.1650).

Section 509. Gestational diabetes. Directs CDC to develop a multisite gestational diabetes research project to expand and enhance surveillance data and public health research on gestational diabetes. Directs HHS to expand and intensify public health research on gestational diabetes. Directs CDC to award grants for demonstration projects to reduce the incidence of gestational diabetes, the recurrence of such disease in subsequent pregnancies, and the development of type-2 diabetes in individuals with a history of gestational diabetes. Directs CDC to work with state and Indian tribal- based diabetes prevention and control programs assisted by the CDC to encourage postpartum follow-up after gestational diabetes.

Section 510. Emergency contraception education and information programs. Directs CDC to develop public information on emergency contraception, including, at a minimum, a description of emergency contraception and an explanation of the use, safety, efficacy, affordability, and availability of such contraception. Directs HRSA to develop and disseminate information on emergency contraception to health care providers, including pharmacists.

Section 511. Comprehensive sex education programs. Authorizes HHS in coordination with the

Department of Education to award grants for comprehensive sex education for adolescents, comprehensive sex education provided by institutes of higher education, and training faculty and staff to teach comprehensive sex education to adolescents. Provides limitations on the use of funds.

Page 12 of 27

Requires HHS to enter contract with a nonprofit organization to evaluate and report on the grants. Authorizes \$75 million through FY 2024.

Section 512. Compassionate assistance for rape emergencies. Ensures that no federal funds are provided to a hospital under Medicare or Medicaid unless the hospital provides any person who is a victim of sexual assault, is accompanied by someone who states the person is a victim of assault, or whom hospital personnel have reason to believe is a victim of sexual assault, with medically and factually accurate and unbiased written and oral communication about emergency contraception and post-exposure prophylaxis protocol for the prevention of HIV. Upon request, requires provision of both unless the medical professional determines that further evaluation is required or that the medication will be harmful to the individual's health.

Section 513. Access to birth control duties of pharmacies to ensure provision of FDA-approved contraception. Amends Part B of title II of the Public Health Service Act to ensure that pharmacies that receive FDA-approved drugs or devices in interstate commerce provide customers contraception that is in-stock without delay; locate or refer to a pharmacy of the customer's choice if the contraception is out of stock; and/or order contraception when out of stock. Prohibits pharmacy staff from engaging in intimidating, threatening, harassing, obstructing, or deceiving behavior as related to the request for contraception. Nearly identical to the Access to Birth Control Act (S. 2259).

Section 514. Additional focus area for the Office of Women's Health. Expands access to evidence-based quality maternity care services by adding a focus area for the Office of Women's Health on optimal maternity care; developing an interagency coordinating committee on the promotion of optimal maternity outcomes; directing consumer education campaigns; creating bibliographic database of systemic reviews for care of pregnant individuals and newborns; identifying maternity health professional shortage areas; expanding CDC prevention research centers program to include Centers on Optimal Maternity Outcomes; expanding models to be tested by CMS to include maternity care models; developing interprofessional maternity care educational models and tools; providing interprofessional training; and providing grants to professional organization to increase diversity in maternity care professions.

Section 515. Interagency coordinating committee on the promotion of optimal maternity outcomes. Amends part A of Title II of the Public Health Service Act to establish the Interagency Coordinating Committee on the Promotion of Optimal Maternity Outcomes (ICCPOM). The ICCPOM shall guide policy and program development across the Federal Government with respect to promotion of optimal maternity care. The ICCPOM should work with stakeholder groups and submit an annual report to Congress summarizing federal program policies, and data concerning maternal and infant health.

Section 516. Consumer education campaign. Amends Section 229 of the Public Health Service Act by establishing the development and implementation of a four-year culturally and linguistically appropriate multimedia consumer education campaign that is designed to promote understanding and acceptance of evidence-based maternity practices and models of care.

Section 517. Bibliographic database of systematic reviews for care of childbearing individuals and newborns. Establishes an online bibliographic database identifying systematic reviews for care of childbearing individuals and newborns.

Section 518. Maternity care health professional shortage areas. Amends Section 332 of the Public Health

Service Act to establish designated maternity care health professional shortage areas; urban or rural areas need not to conform to geographic boundaries of political subdivision.

Page 13 of 27

Section 519. Expansion of CDC prevention research centers program to include centers on optimal maternity outcomes. Establishes additional Prevention Research Centers administered by the CDC and be known as a Center for Excellence on Optimal Maternity Outcomes. Each center must incorporate the use of interdisciplinary providers and conduct research in service areas related to mental health, doula labor support, nutrition education, childbirth education, social work, physical and occupational therapy, substance abuse, and home visits.

Section 520. Expanding models allowed to be tested by Center for Medicare and Medicaid Innovation to include maternity care models. Amends Section 1115A of the Social Security Act to include and promote evidence-based models of care that have been associated with reductions in maternal and infant birth disparities.

Section 521. Development of interprofessional maternity care education models and tools. Directs the Secretary and Administrator for HRSA to establish an Interprofessional Maternity Provider Education Commission to develop recommendations for standard physiologic maternity care curriculum, suggestions for multidisciplinary use of the curriculum, strategies to integrate and coordinate education across maternity care disciplines, and pilot demonstrations of interprofessional educational models. The Secretary shall submit a report to Congress containing the recommendations by the Commission and make the report publicly available.

Section 522. Including within inpatient hospital services under Medicare services furnished by certain students, interns, and residents supervised by certified nurse midwives. Amends Sections 1861(b) of the Social Security Act to include services in a hospital or osteopathic hospital furnished by students, interns, and residents supervised by certified nurse midwives.

Section 523. Grants to professional organizations to increase diversity in maternal, reproductive, and sexual health professionals. Requires that the Secretary and Administrator of HRSA establish a grant program for eligible health professional organizations. Planning and implementation grant awards should not exceed \$300,000 and \$500,000, respectively. Grantees must submit a report to the Secretary containing information on the extent and distribution of workforce disparities and reasonable objectives and strategies to address such disparities.

Section 524: Interagency update to the Quality Family Planning Guidelines. Requires the CDC and Office of Population Affairs to expand the 2014 Quality Family Planning (QFP) Guidelines to address health disparities and the importance of patient-directed contraceptive decision-making.

Section 525: Dissemination of the Quality Family Planning Guidelines. Provides grants for publicly funded health centers to implement the QFP.

Subtitle B—Pregnancy Screening

Section 531: Pregnancy intention screening initiative demonstration program. Directs the Secretary, acting through the Director of the CDC, to establish a demonstration program to facilitate clinical adoption of pregnancy intention screening initiatives by health care providers.

TITLE VI—MENTAL HEALTH

Overall. Title VI focuses on eliminating disparities in access to mental health and substance use disorder prevention and treatment. The title address demographic factors such as race, ethnicity, and geographic

location that contribute to mental health disparities. Provisions provide for evaluating promising interventions through

Page 14 of 27

demonstration projects; research to enhance knowledge and understanding of mental health and substance use disparities; strengthening the workforce; and strategies to address unmet needs in underserved populations.

Section 601. Findings.

Section 602. Coverage of marriage and family therapist services, mental health counselor services and substance abuse counselor services under part B of the Medicare program. Expands coverage of marriage and family therapist services, mental health counselor services, and substance abuse counseling services under Medicare Part B to diversify the availability of mental health care services and expands the availability of benefits for rural areas. Similar to the Seniors Mental Health Access Improvement Act (S. 1879) with the addition of substance abuse counselors.

Section 603. Integrated health care demonstration program. Creates grants to provide technical assistance and training regarding effective development and implementation of interprofessional health care teams.

Section 604. Addressing racial and ethnic minority mental health disparities research gaps. Requires a study and report on the existing knowledge of mental and behavioral health disparities in racial and ethnic minority groups and recommendations for its expansion.

Section 605. Health professions competencies to address racial and ethnic minority mental health disparities. Establishes a grant program to national organizations with direct responsibility for the educational development of mental health professionals for the development and dissemination of curricula or core competencies to health professional educational programs addressing mental health disparities among racial and ethnic minority groups. Grants would be used in the training of students in the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, and substance abuse.

Section 606. Geo-Access Study. Directs the Assistant Secretary for Mental Health and Substance Use to conduct a study to determine which geographic areas of the United States have shortages of specialty mental health providers and to assess the preparedness of specialty mental health providers to deliver culturally and linguistically appropriate, affordable, and accessible services.

Section 607. Asian American, Native Hawaiian, and Pacific Islander behavioral and mental health outreach and education strategies. Directs the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and implement an outreach and education strategy to promote behavioral and mental health and reduce stigma associated with mental health conditions and substance abuse among the Asian American, Native Hawaiian, and Pacific Islander populations.

Section 608. Mental Health in Schools. Amends the Public Health Service Act to revise a community children and violence program to assist local communities and schools in applying a public health approach to mental health services, including by: (1) revising eligibility requirements for a grant, contract, or cooperative agreement; and (2) providing for comprehensive school mental health programs that are culturally and linguistically appropriate, trauma-informed, and age appropriate. A comprehensive school mental health program funded under this bill must assist children in dealing with trauma and violence. This is the Mental Health in Schools Act (S. 1370).

TITLE VII—ADDRESSING HIGH IMPACT MINORITY DISEASES

Overall. Title VII proposes targeted approaches for improving awareness, health outcomes, early detection, linkage to care, and treatment for diseases and conditions that significantly impact racial and ethnic minorities, including cancer, viral hepatitis, HIV/AIDS, cardiovascular disease, diabetes, lung disease, sickle cell disease, bone marrow failure diseases, osteoarthritis and musculoskeletal diseases, and sleep disorders. Policy proposals include implementing more focused clinical research, improving and expanding surveillance/data collection and reporting, and authorizing funding – including grant opportunities and cooperative agreements between HHS and state and local health departments – to address the health disparities, cultural and linguistic barriers, and other challenges associated with these diseases.

Subtitle A—Cancer

Section 701. Lung cancer mortality reduction. States the importance of lung cancer mortality reduction as a national public health priority. Requires the implementation of a comprehensive Lung Cancer Mortality Reduction Program to achieve reduction of the mortality rate of lung cancer of at least 25 percent by 2020. Requires HHS to establish a Lung Cancer Advisory Board to monitor the program. Requires the Secretary to establish and implement an early disease research and management program targeted at the high incidence and mortality rates of lung cancer in minority and low- income populations.

Section 702. Expanding prostate cancer research, outreach, screening, testing, access, and treatment effectiveness. Requires the Department of Veterans Affairs, Department of Defense, and HHS to establish an Interagency Prostate Cancer Coordination and Education Task Force to (1) develop a summary of advances in prostate cancer research; (2) consider establishing guidance to enable physicians to screen men over age 74; (3) share and coordinate information on federal research and program activities; (4) develop a comprehensive interagency strategy to evaluate factors that may be related to the etiology of prostate cancer; (5) develop a coordinated message on screening and treatment for prostate cancer for inclusion in federal health program materials; and (6) submit recommendations to Congress. Establishes a program to coordinate and intensify prostate cancer research as needed. Creates four-year telehealth pilot projects to analyze the clinical outcomes and cost-effectiveness associated with telehealth services in different geographic areas that contain high proportions of medically- underserved populations; the results of the pilot are to be submitted to Congress. Requires the Secretary of Veterans Affairs to develop a national education campaign to encourage men to seek prostate cancer screening when appropriate.

Section 703. Improved Medicaid coverage for certain breast and cervical cancer patients in the Territories. Enhances the FMAP for Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for certain breast or cervical cancer patients.

Section 704. Cancer prevention and treatment demonstration for ethnic and racial minorities. Requires the Secretary of HHS to conduct demonstration projects, designed after the evaluation of best practices that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer, and report to Congress no later than two years after the initial demonstration projects are implemented and biannually thereafter.

Section 705. Reducing cancer disparities within Medicare. Requires HHS to enter into an agreement with an entity that specializes in developing quality measures for cancer care. The entity is to develop a

uniform set of measures to evaluate disparities in the quality of cancer care. HHS must specify the classes of Medicare providers of services and suppliers that would be required to publicly report quality measures.

Page 16 of 27

Subtitle B—Viral Hepatitis and Liver Cancer Control and Prevention

Section 711. Viral hepatitis and liver cancer control and prevention. Requires HHS to develop and implement a plan for the prevention, control, and medical management of, and education and research relating to, hepatitis B and hepatitis C. Elements of the program would include education and awareness programs; immunization, prevention, and control programs; epidemiological surveillance; research; and expanded support for underserved and disproportionately affected populations. Authorizes HHS to award grants or enter into contracts or cooperative agreements to carry out program activities. Adds hepatitis to the illnesses for which SAMHSA, in cooperation with the NIH and CDC, is required to develop educational materials and intervention strategies to reduce risks of the illnesses among substance abusers and individuals with mental illness and to develop appropriate mental health services.

Subtitle C—Acquired Bone Marrow Failure Diseases Research and Treatment Act

Section 721. Acquired bone marrow failure diseases. Establishes a registry to identify the incidence and prevalence of and to collect and store data on acquired bone marrow failure disease. Establishes an advisory committee to provide recommendations to the Secretary on the registry. Authorizes HHS grants, contracts, or cooperative agreements for the management, collection, and reporting of registry data. Requires HHS to establish and coordinate outreach and informational programs targeted to minority populations affected by acquired bone marrow failure disease. Requires HHS to enter into cooperative agreements with entities to perform research on acquired bone marrow failure disease. Requires HHS to award grants to improve diagnostic practices and quality of care for patients with acquired bone marrow failure disease.

Subtitle D—Cardiovascular Disease, Chronic Disease, and Other Disease Issues

Section 731. Guidelines for disease screening for minority patients. Requires HHS to convene meetings to develop guidelines for disease screening for minority patient populations with a higher than average risk for many chronic diseases and cancers that are specified in this section.

Section 732. CDC WISEWOMAN Screening Program. Authorizes five years of funding for the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program that provides low-income women with cardiovascular disease screening and lifestyle intervention services.

Section 733. Report on cardiovascular care for women and minorities. Requires HHS to prepare an annual report to Congress on the quality of and access to care for women and minorities with heart disease, stroke, and other cardiovascular diseases.

Section 734. Coverage of comprehensive tobacco cessation services in Medicaid and in private health insurance. Expands comprehensive tobacco cessation coverage, which currently applies only to pregnant women enrolled in Medicaid, to all Medicaid recipients and assures that all available forms of evidence-based tobacco cessation – currently individual, group, and telephone cessation counseling and seven FDA-approved medications – are made available to Medicaid beneficiaries without cost sharing or preauthorization. Provides for states to conduct outreach campaigns to educate providers and Medicaid beneficiaries regarding the benefit and establishes federal reimbursement for such campaigns. Prohibits group and individual health plans from requiring preauthorization for tobacco cessation counseling and cessation drugs that have received an “A” or “B” rating from the U.S. Preventative Services Task Force.

Section 735. Clinical research funding for oral health.

Page 17 of 27

Requires the HHS Secretary to expand support of NIH research activities to improve the population's oral health through prevention and management of oral diseases and conditions.

Section 736. Participation by Medicaid beneficiaries in approved clinical trials Requires coverage of routine patient costs associated with participation in approved clinical trials, consistent with the benefits that would be provided under the State plan if the patient was not enrolled in an approved clinical trial.

Subtitle E—HIV/AIDS

Section 741. Statement of policy. It is the policy of the United States to achieve an AIDS-free generation and to (1) expand access to lifesaving antiretroviral therapy; (2) expand efforts to prevent HIV infection; (3) ensure laws, policies and regulations do not impede access to prevention, treatment and care; (4) accelerate research for more efficacious HIV prevention and treatment tools; and (5) respect the human rights and dignity of persons living with HIV/AIDS.

Section 742. Findings.

Section 743. Additional funding for AIDS Drug Assistance Program Treatments. In addition to funds authorized to carry out this subpart, authorizes such sums as may be necessary to carry out the AIDS Drug Assistance Program Treatments for three years.

Section 744. Enhancing the National HIV Surveillance System. Requires the Secretary of HHS to make grants to States to help integrate public health surveillance systems into electronic health records.

Section 745. Evidence-based strategies for improving linkage to and retention in appropriate care. Requires the Secretary of HHS, in collaboration with other federal Agency heads, to identify evidence-based strategies most effective at addressing the multifaceted issues that impede disease status awareness and linkage to and retention in appropriate care. Requires the Secretary to support the wide-scale implementation of the evidence-based strategies identified, including incorporating such strategies into health care coverage supported by Medicaid, the Ryan White HIV/AIDS Program, and health plans purchased through an ACA exchange. Requires the Secretary to submit a report on the status of these activities not later than one year from date of enactment.

Section 746. Improving entry into and retention in care and antiretroviral adherence for persons with HIV. Expresses the sense of the Congress regarding the benefits of scientific advances in AIDS research. Requires the NIH to expand, intensify, and coordinate operational and translational research and other activities of the NIH regarding methods to: (1) increase adoption of evidence-based adherence strategies within HIV care and treatment programs; (2) to increase HIV testing and case detection rates; (3) to reduce HIV-related health disparities; (4) to ensure that research to improve adherence to HIV care and treatment programs address the unique concerns of women; (5) to integrate HIV/AIDS prevention and care services with mental health and substance use prevention and treatment delivery systems; (6) to increase knowledge on the implementation of pre-exposure prophylaxis (PrEP); and (7) to increase knowledge of Undetectable = Untransmittable.

Section 747. Services to reduce HIV/AIDS in racial and ethnic minority communities. Authorizes the Secretary of HHS to make grants to public health agencies and faith-based organizations to conduct (1) outreach activities related to HIV/AIDS prevention and testing activities; (2) HIV/AIDS prevention activities; and (3) HIV/AIDS testing activities.

Section 748. Minority AIDS Initiative Directs the Secretary of HHS to expand the Minority HIV/AIDS Initiative at HHS.

Section 749. Health care professionals treating individuals with HIV/AIDS Directs HRSA to increase the capacity of the health workforce focusing primarily on HIV/AIDS to meet the demand for culturally competent care. Authorizes grant awards for any of the following: (1) development of curricula for training primary care providers in HIV/AIDS prevention and care, including routine HIV testing; (2) support to expand access to culturally and linguistically accessible benefits counselors, trained peer navigators, and mental and behavioral health professionals with expertise in HIV/AIDS; (3) training health care professionals to provide care to individuals with HIV/AIDS; (4) development of policies for providing culturally relevant and sensitive treatment to individuals with HIV/AIDS, with particular emphasis on treatment to racial and ethnic minorities, men who have sex with men, and women, young people, and children with HIV/AIDS; (5) development and implementation of programs to increase the use of telehealth to respond to HIV/AIDS-specific health care needs in rural and minority communities, with particular emphasis given to medically underserved communities and insular areas; (6) evaluating interdisciplinary medical provider care team models that promote high quality care, with particular emphasis on care to racial and ethnic minorities; (7) training health care professionals to make them aware of the high rates of chronic hepatitis B and chronic hepatitis C in adult racial and ethnic populations, and the importance of prevention, detection, and medical management of hepatitis B and hepatitis C and of liver cancer screening; and (8) development of curricula for training health care providers that HIV/AIDS and tuberculosis are significant mutual comorbidities.

Section 750. HIV/AIDS provider loan repayment program. Authorizes partial provider loan repayment programs for physicians, nurse practitioners, and physician assistants who agree to serve as a medical provider for at least two years in a Ryan White or Title X funded facility with a critical shortage of doctors, or in an area with a high incidence of HIV/AIDS.

Section 751. Dental education loan repayment program. Authorizes HHS to provide dental education loan repayment for dentists who agree to serve for at least two years at a facility with a critical shortage of dentists in an area with a high incidence of HIV/AIDS.

Section 752. Reducing new HIV infections among injecting drug users. Expresses the sense of the Congress that providing sterile syringes and sterilized equipment to injecting drug users substantially reduces risk of HIV infection, increases the probability that they will initiate drug treatment, and does not increase drug use. Authorizes the Secretary to provide grants and technical assistance for the purpose of reducing the rate of HIV infections among injecting drug users through a comprehensive package of services for such users, including the provision of sterile syringes, education and outreach, access to infectious disease testing, overdose prevention, and treatment for drug dependence.

Section 753. Report on impact of HIV/AIDS in vulnerable populations. Requires the Secretary of HHS to submit an annual report to Congress and the President regarding the impact of HIV/AIDS for racial and ethnic minority communities, women, and youth aged 24 and younger.

Section 754. National HIV/AIDS Observance Days. Expresses the sense of the Congress that national observance days should be held to highlight the impact of HIV/AIDS on communities of color.

Section 755. Review of all Federal and State laws, policies and regulations regarding the criminal

prosecution of individuals for HIV-related offenses. Requires the Attorney General, the Secretary of HHS, and Secretary to Defense acting jointly to initiate a national review of Federal and State laws, policies, regulations, and judicial precedents and decisions regarding criminal and related civil commitment cases involving people living with HIV/AIDS, including the Uniform Code of Military Justice. The Attorney General is required to submit a report to Congress to address whether laws place a

unique or additional burden on people living with HIV/AIDS, and to develop best practice recommendations for States.

Section 756. Expanding support for condoms in prisons. Provides authorization to allow community organizations to provide sexually transmitted infection (STI) counseling, STI prevention education, and sexual barrier protection devices in federal correctional facilities. Requires the Attorney General to develop and implement a strategy to reduce the prevalence and spread of STIs in federal and state correctional facilities.

Section 757. Automatic reinstatement or enrollment in Medicaid for people who test positive for HIV before reentering communities. Allows automatic enrollment or reinstatement in Medicaid if an individual is scheduled to be released from a public institution due to the completion of sentence, not less than 30 days prior to the scheduled date of the release; and if an individual is to be released from a public institution on parole or on probation, as soon as possible after the date on which the determination to release such individual was made, and before the date such individual is released.

Section 758. Stop AIDS in prison. Requires the Bureau of Prisons to develop a comprehensive policy to provide HIV testing, treatment, and prevention for inmates within the correctional setting and upon reentry.

Section 759. Support data system review and indicators for monitoring HIV care. Requires the Secretary of HHS to work with other Agency heads to expand and coordinate efforts to align metrics across agencies and modify Federal data systems to incorporate core measures as a way of monitoring the quality of HIV care, mental health, substance abuse, and supportive services.

Section 760. Transfer of funds for implementation of National HIV/AIDS Strategy. Allows the Secretary of HHS to transfer up to 1 percent of discretionary appropriations made to HHS, to the National HIV/AIDS strategy. The Secretary must provide Congress with at least 30 days of notice.

Section 761. Report on the implementation of goal 4 (improved coordination) of the National HIV/AIDS Strategy. Requires the President to submit a report to Congress to document the progress made in achieving Goal 4 (improved coordination) of the National HIV/AIDS Strategy.

Subtitle F— Diabetes

Section 771. Research, treatment, and education. Requires the Director of NIH to provide for (1) ongoing research and other activities with respect to prediabetes and diabetes in minority populations; and (2) inclusion of minority participants in clinical trials. Requires the Diabetes Mellitus Interagency Coordinating Committee to prepare and submit to Congress a report on the federal research and public health activities with respect to prediabetes and diabetes in minority populations as well as a comprehensive federal strategic plan to address prediabetes and diabetes in minority populations. Requires the Director of NIH, through the National Institute on Minority Health and Health Disparities and the National Diabetes Education Program, to provide for (1) health care professionals' mentoring; and (2) minority health professionals' participation in diabetes-focused research programs. Requires the Director to make grants for a pipeline from high school to professional school that will increase minority representation in diabetes-focused health fields.

Section 772. Research, education, and other activities to address diabetes in minority populations. Requires the HHS Secretary, acting through the Director of CDC to: (1) enhance the National Health and

Nutrition Examination Survey to better understand the prevalence of diabetes in certain populations and to

Page 20 of 27

educate the public on the causes and effects of diabetes in minority populations; (2) direct the Division of Diabetes Translation to carry out demonstration projects for diabetes prevention, develop a strategic plan to reduce diabetes in minority populations, support the implementation of the National Diabetes Prevention Program in underserved areas highly impacted by diabetes; (3) educate the public on the causes and effects of diabetes in minority populations; and (4) carry out diabetes health promotion and prevention programs for minority populations.

Section 773. Research, education, and other activities to educate health providers. Directs the HHS Secretary, acting through the Director of HRSA, to educate health professionals on the causes and effects of diabetes in minority populations. Gives priority to diabetes-focused grants and adds minority populations to the list of vulnerable populations under the primary care training and enhancement program. Develops a diabetes focus with the National Health Service Corps Scholarship Program to improve care in underserved areas highly impacted by diabetes.

Section 774. Research, education, and other activities in American Indian populations. Directs the HHS Secretary, acting through the Indian Health Service, to conduct and support research and other activities with respect to diabetes and to coordinate data collection on diabetes treatment and prevention services by health care professionals to the American Indian population.

Section 775. Updated report on health disparities. Requires the HHS Secretary to enter into an arrangement with the National Academy of Medicine to update the landmark 2002 report entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”.

Subtitle G—Lung Disease

Section 776. Expansion of the National Asthma Education and Prevention Program. Requires HHS to convene a working group to develop a report to Congress that catalogs the asthma prevention, management, and surveillance activities of the Federal government and other entities.

Section 777. Asthma-related activities of the Centers for Disease Control and Prevention. Amends the authority for CDC to provide information and education to the public, develop state asthma plans, compile data, and coordinate data collection related to asthma.

Section 778. Influenza and pneumonia vaccination campaign. Enhances the program to increase the number of people vaccinated each year for influenza and pneumonia.

Section 779. Chronic obstructive pulmonary disease action plan. Requires CDC to conduct, support, and expand public health strategies, prevention, diagnosis, surveillance, and public and professional awareness activities regarding chronic obstructive pulmonary disease. Requires the development of a national action plan; public education and awareness activities; grants to reduce the burden of the disease; coordination with HHS, HRSA, and the VA to develop pilot programs; and improve techniques and identify best practices.

Subtitle H—Tuberculosis

Section 781. Elimination of all forms of tuberculosis. States that disparities in tuberculosis (TB) exist and significantly impact minority communities in the United States, with 87 percent of people diagnosed with TB in 2016 having self-identified as racial and ethnic minorities; however, TB is both preventable and curable.

Section 782. Additional funding for states in combating and eliminating tuberculosis. In addition to amounts otherwise authorized to be appropriated to execute this subpart, authorizes such sums as may be necessary to carry out the Advisory Council for the Elimination of Tuberculosis programming for three years.

Section 783. Strengthening clinical research funding for tuberculosis. Requires the Secretary of HHS to expand and intensify support for current and prospective research activities of the NIH, Biomedical Advanced Research and Development Authority, and CDC Division of Tuberculosis Elimination to develop new therapeutics, diagnostics, vaccines and other prevention modalities in addressing all forms of TB.

Subtitle I– Osteoarthritis and Musculoskeletal Diseases

Section 785. Findings.

Section 786. Osteoarthritis and other musculoskeletal health-related activities of the Centers for Disease Control and Prevention. Directs the CDC to educate the public on the causes, ways to prevent, and effects of arthritis and musculoskeletal conditions on minority patient populations and the effects on other comorbidities, including obesity, hypertension, and cardiovascular disease. Authorizes appropriations of “such sums as necessary” for fiscal year 2019 and beyond to carry out this section.

Section 787. Grants for comprehensive osteoarthritis and musculoskeletal disease health education within health professions schools. Authorizes grants for comprehensive arthritis and musculoskeletal health education within health professions schools.

Subtitle J – Sleep and Circadian Rhythm Disorders

Section 791. Short title; findings.

Section 792. Sleep and circadian rhythm disorders research activities of the National Institutes of Health. Encourages the NIH to expand on current research activities addressing sleep health disparities and to implement the ‘NIH Sleep Disorders Research Plan.’ Authorizes appropriations of “such sums as necessary” for fiscal year 2019 and beyond to carry out this section.

Section 793. Sleep and circadian rhythm health disparities-related activities of the Centers for Disease Control and Prevention. Requires the CDC to conduct, support, and expand public health strategies, prevention, diagnosis, surveillance, and public and professional awareness activities regarding sleep and circadian rhythm disorders that are culturally and linguistically appropriate for minority populations. Authorizes appropriations of “such sums as necessary” for fiscal year 2019 and beyond to carry out this section.

Section 794. Grants for comprehensive sleep and circadian health education within health professions schools. Authorizes grants for comprehensive sleep and circadian health education within health professions schools.

Section 795. Report on impact of sleep and circadian health disorders in vulnerable and racial/ethnic populations. Requires the HHS Secretary to submit a report to the Congress and the President on the progress that has been made, as well as the opportunities and challenges that exist, in reducing the impact of sleep and circadian health disorders for racial and ethnic minority communities and other vulnerable populations.

Subtitle K – Sickle Cell Disease Research, Surveillance, Prevention, and Treatment

Section 796. Short Title.

Section 796A. Sickle cell disease research. Requires the Secretary of HHS to conduct or support research to expand the understanding of the cause of, and to find a cure for, sickle cell disease.

Section 796B. Sickle cell disease surveillance. Authorizes grants to (1) conduct surveillance and maintain data on the prevalence and distribution of sickle cell disease and its associated health outcomes, complications, and treatments; (2) conduct public health initiatives with respect to sickle cell disease; and (3) identify and evaluate promising strategies for prevention and treatment of sickle cell disease complications.

Section 796C. Sickle cell disease prevention and treatment. Amends Section 712(c) of the American Jobs Creation Act of 2004 to provide grants to up to 25 eligible entities for each fiscal year in which the program is conducted under this section for the purpose of developing and establishing systemic mechanisms to improve the prevention and treatment of sickle cell disease in populations with a high density of sickle cell disease patients.

Section 796D. Collaboration with community-based entities. Requires collaboration with community-based entities that have five or more years of experience providing services to sickle cell disease patients in order to be eligible for a grant or other assistance under subsection (b) or (c).

TITLE VIII—HEALTH INFORMATION TECHNOLOGY

Overall. Title VIII updates the definition of certified electronic health information technology, requires assessments of and provides funding opportunities for adoption of health information technology in racial and ethnic minority communities, and extends Medicaid electronic health record incentive payments to rehabilitation facilities, long-term care, home health agencies, and physician assistants.

Section 800. Definitions. Defines certified electronic health information technology.

Subtitle A—Reducing Health Disparities Through Health IT

Section 801. HRSA assistance to health centers for promotion of health IT. Expands and intensifies HRSA's programs and activities to provide technical assistance and resources to health centers to adopt and meaningfully use certified electronic health information technology for the management of chronic disease and health conditions and reduction of health disparities.

Section 802. Assessment of impact of health IT on racial and ethnic minority communities; outreach and adoption of health IT in such communities. Requires the Office of the National Coordinator of Health Information Technology (ONC) to assess and report on the level of use and accessibility of certified health information technology in racial and ethnic minority communities, and by providers participating in Medicare and Medicaid programs. Requires the National Center for Health Statistics to provide to Congress more detailed data about the adoption of certified health information technology. Requires HHS to collect the races and ethnicities of providers attesting to the Medicare and Medicaid EHR Incentive Program and the Medicare Merit-based Incentive Payment System, (MIPS). Requires the ONC to

assess the impact of health IT on communities with a high proportion of individuals from racial and ethnic minority groups, including people with disabilities in those groups.

Subtitle B—Modifications to achieve parity in existing programs

Section 811. Extending funding to strengthen the health IT infrastructure in racial and ethnic minority communities. Extends funding for health IT in communities with a high proportion of individuals from racial and ethnic minority groups; requires ONC to report on activities and expenditures.

Section 812. Extending competitive grants for the development of loan programs to facilitate adoption of certified electronic health record technology by providers serving racial and ethnic minority groups. Extends competitive grants for loan programs to facilitate adoption of certified health information technology by providers serving communities with a high proportion of individuals from racial and ethnic minority groups.

Section 813. Authorization of appropriations. Authorizes appropriations from fiscal years 2019 through 2024.

Subtitle C—Additional Research and Studies

Section 821. Data collection and assessments conducted in coordination with minority-serving institutions. Requires the ONC to develop and implement a health IT impact assessment program in coordination with a minority-serving institution (such as an historically Black college or university, a Hispanic-serving institution, a tribal college or university, or an Asian American, Native American and Pacific Islander-serving institution with an accredited public health, health policy or health services research program) to measure the effects of adoption and use of health IT in minority communities, and report to Congress with respect to this assessment program on an annual basis.

Section 822. Study of health information technology in medically underserved communities. Requires HHS to enter into agreement with the National Academies of Sciences, Engineering to conduct a study and report to Congress on the development, implementation, and effectiveness of health IT within medically underserved areas. The study shall identify barriers to implementation, examine the impact on providing quality care and reducing the cost of care, examine the impact of health IT on improving health care-related decisions by both patients and providers, identify best practices for provision of physical accessibility and reasonable policy accommodations to individuals with disabilities, assess the feasibility and costs associated with health IT, evaluate whether adoption of health IT is effective in reducing health disparities, identify providers not electing to adopt health IT and determine what barriers prevent those providers from adopting, and examine urban and rural health systems to determine the impact that health IT may have on the capacity of primary care providers in those systems.

Subtitle D—Closing Gaps in Funding to Adopt Certified EHRs

Section 831. Extending Medicaid EHR incentive payments to rehabilitation facilities, long-term care facilities, and home health agencies. Extends Medicaid EHR incentive payments to rehabilitation facilities, long-term care facilities, and home health agencies.

Section 832. Extending physician assistant eligibility for Medicaid electronic health record incentive payments. Extends eligibility for Medicaid EHR payments for the adoption and meaningful use of certified electronic health records to physician assistants who are primary care providers.

TITLE IX—ACCOUNTABILITY AND EVALUATION

Overall. Title IX ensures the federal government is responsive and responsible for addressing health disparities. It expands civil rights protections for anyone operating with Federal financial assistance, ensures populations in correctional facilities receive care, and ensures that there is transparency in how protections are enforced. Requires a number of reports on how the government is addressing disparities.

Section 901. Prohibition on discrimination in Federal assisted health care services and research programs on the basis of sex, race, color, national origin, marital status, familial status, sexual orientation, gender identity, or disability status. Establishes that no health care service or research program or activity receiving Federal financial assistance shall discriminate against individuals based on sex, race, color, national origin, sexual orientation, gender identity, or disability status.

Section 902. Treatment of the Medicare payments under title VI of the Civil Rights Act of 1964. Clarifies that a payment under Medicare Section B is to be considered a grant, and not a contract of insurance or guaranty.

Section 903. Accountability and transparency within the Department of Health and Human Services. Establishes an Office of Health Disparities to ensure that the health programs, activities, and operations of health entities that receive federal financial assistance are abiding by the prohibition on discrimination. Requires HHS to establish civil rights compliance officers in each agency that administers health programs. Adds “sexual orientation and gender identity” to the list of attributes (already including age, race, language, sex, etc.) that all recipients of Federal financial assistance under federal health programs must serve without discrimination.

Section 904. United States Commission on Civil Rights. Requires the Department of Justice and HHS to coordinate activities carried out in health care and correctional facilities toward eliminating health disparities between the general population and racial and ethnic minorities.

Section 905. Sense of Congress concerning full funding of activities to eliminate racial and ethnic health disparities. Expresses the sense of Congress that adequate funding should be allocated for health disparity elimination programs because:

- The health status of the American populace is declining;
- Racial and ethnic minority communities have the poorest health status and face substantial barriers to health care;
- LGBT populations experience significant personal and structural barriers to obtaining quality health care;
- Efforts to improve this situation have been limited by inadequate resources; and
- Public health legislation, policy and planning includes language and directives that either fail to articulate clear criteria and have vague or incomplete standards that limit health equity.

Section 906. GAO and NIH Reports. Requires GAO to study the racial and ethnic diversity of all those involved in grant-making (applicants, grantees, and grant-makers) of NIH grants. Requires NIH to report on the progress of expanded planning, coordination, review and evaluation authority of the National Institute on Minority Health and Health Disparities. Requires a GAO report on the recipients of ACA funding looking at how funds have gone to community based organizations working on enrollment by

racial and ethnic diversity and the impact of such community based organizations enrollment efforts on the insurance status of their communities. Requires an annual report from the Director of the National Institute on Minority Health and Health Disparities on the progress made by NIH to reduce health disparities.

Page 25 of 27

TITLE X—ADDRESSING SOCIAL DETERMINANTS AND IMPROVING ENVIRONMENTAL JUSTICE

Overall. Title X defines social determinants of health, and the role they play in creating health inequities. The title also describes the relationship between built environments and health, and how health income assessments and the implementation of evidence-based programs can remediate environmental hazards in communities. Section 1005 specifically calls for the creation of a CDC grant program to address these root causes. Title X also includes language on environmental justice, specifically in regard to clean air rules, lead and radon exposure, gun violence research and the impact of the Deepwater Horizon oil rig explosion in the Gulf Coast.

Section 1001. Definitions. Defines social determinants of health as “the circumstances in which people are born, grow up, live, work, and age, as well as systems put in place to deal with illness” and distinguishes “social determinants” from other determinants of health.

Section 1002. Findings. Provides specific examples illustrating the nexus between the unequal distribution of the social determinants of health and health inequities across four categories prioritized by Healthy People 2020: (1) neighborhoods and the built environment including lead exposure; (2) social and community context; (3) education; and (4) economic stability. These findings are intended to capture pressing health disparities affecting minority communities that are caused by or correlated with non-traditional health factors. African American, Asian American, Native American, lesbian, gay, bisexual, and transgender individuals, and low-income children are among the particular populations covered in this section.

Section 1003. Health Impact Assessments. Establishes a program at the CDC in collaboration with the Department of Housing and Urban Development, Department of Transportation, and the Department of Agriculture to administer grants to implement evidence-based programs aimed at decreasing disparities that result from the built environment. Criteria are provided with which to evaluate how proposed activities affect health outcomes.

Section 1004. Implementation of recommendations by Environmental Protection Agency. Requires the Environmental Protection Agency to follow the Inspector General’s recommendations related to environmental justice reviews of its programs, policies, and activities. These recommendations include devoting more attention to environmental justice when developing clean air rules, implementing a federal action plan reducing exposure to radon, and developing a federal action plan to prevent childhood lead poisoning, particularly within low-income and minority families.

Section 1005. Grant program to conduct environmental health improvement activities and to improve social determinants of health. Establishes a new grant program at the CDC for state and local coalitions, including public health departments, health care providers, academic institutions, and child-serving institutions, to conduct environmental health improvement activities. These activities are intended to address the root causes of chronic diseases disproportionately affecting racial and ethnic minorities and improve the built environment of communities.

Section 1006. Additional research on the relationship between the built environment and the health of community residents. Establishes a new grant program to conduct and coordinate research on the built environment and its influence on individual and population-based health.

Section 1007. Environment and public health restoration. Describes changes to law and regulations since 2001 that have negatively impacted public health and environment. Sets forth a partnership between the Federal government and other authorities in order to “act as a steward of the environment for the benefit of public health, to maintain air quality and water quality, to sustain the diversity of plant and animal species, to combat global climate change, and to protect the environment for future generations to enjoy.” Requires the National Academy of Sciences to complete a report on the impact on public health, air quality, water quality, wildlife, and the environment of specified regulations, laws, and proposed laws.

Section 1008. GAO report on health effects of Deepwater Horizon oil rig explosion in the Gulf Coast. Requires GAO to conduct a study on the type and scope of health care services administered through the Department of HHS addressing the provision of health care to racial and ethnic minorities affected by the explosion of the mobile offshore drilling unit Deepwater Horizon that occurred on April 20, 2010. Requires that GAO report on the type, size, and scope of programs administered by HHS that focus on provision of health care to communities in the Gulf Coast, identify the merits and disadvantages associated with each program, perform an analysis of the costs and benefits of the programs, and determine whether there is any duplication of programs. Requires that GAO report no later than 180 days after the enactment of this Act to report its findings and recommendations to Congress for improving access to health care for racial and ethnic minorities.

Subtitle B—Gun Violence

Section 1011. Findings

Section 1012. Reaffirming research authority of the Centers for Disease Control and Prevention. Clarifies that the CDC may conduct research into gun violence (repeals the “Dickey Amendment”) while affirming it may not advocate for gun control.

Section 1013. National violent death reporting system. Requests CDC work to improve by expanding, on a voluntary basis, participation in the National Violent Death Reporting System.

Section 1014. Report on effects of gun violence on public health. Requires a Surgeon General report on the impact of gun violence on public health.

Section 1015. Report on effects of gun violence on mental health in minority communities. Requires an Office of Minority Health Report on the impact of gun violence on public health, particularly on the mental health of minority communities.