

110TH CONGRESS
1ST SESSION

H. R. 3014

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

IN THE HOUSE OF REPRESENTATIVES

JULY 12, 2007

Ms. SOLIS (for herself, Mr. ABERCROMBIE, Mr. BACA, Mr. BECERRA, Mr. BISHOP of Georgia, Ms. BORDALLO, Ms. CORRINE BROWN of Florida, Mr. BUTTERFIELD, Mr. CARDOZA, Ms. CARSON, Ms. CASTOR, Mrs. CHRISTENSEN, Ms. CLARKE, Mr. CLAY, Mr. CLEAVER, Mr. CLYBURN, Mr. CONYERS, Mr. COSTA, Mr. CROWLEY, Mr. CUELLAR, Mr. CUMMINGS, Mr. DAVIS of Alabama, Mr. DAVIS of Illinois, Mr. ELLISON, Mr. JOHNSON of Georgia, Mrs. JONES of Ohio, Mr. KILDEE, Ms. KILPATRICK, Ms. LEE, Ms. JACKSON-LEE of Texas, Mr. LEWIS of Georgia, Ms. MATSUI, Mr. MEEK of Florida, Mr. MEEKS of New York, Ms. MOORE of Wisconsin, Mrs. NAPOLITANO, Ms. NORTON, Mr. ORTIZ, Mr. PASTOR, Mr. PAYNE, Mr. RANGEL, Mr. REYES, Mr. RUSH, Mr. RODRIGUEZ, Ms. ROSLEHTINEN, Ms. ROYBAL-ALLARD, Mr. SALAZAR, Mr. FATTAH, Mr. FORTUÑO, Mr. GONZALEZ, Mr. AL GREEN of Texas, Mr. GENE GREEN of Texas, Mr. GRJALVA, Mr. HASTINGS of Florida, Mr. HINOJOSA, Mr. HONDA, Mr. HOYER, Mr. JACKSON of Illinois, Mr. JEFFERSON, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. SCOTT of Georgia, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SIREN, Mr. THOMPSON of Mississippi, Mr. TOWNS, Ms. VELÁZQUEZ, Ms. WATERS, Ms. WATSON, Mr. WATT, and Mr. WYNN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Natural Resources, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Equity and
 5 Accountability Act of 2007”.

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

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

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

TITLE I—CULTURALLY AND LINGUISTICALLY APPROPRIATE
HEALTH CARE

- Sec. 101. Amendment to the Public Health Service Act.
- Sec. 102. Standards for language access services.
- Sec. 103. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid and State Children’s Health Insurance Program.
- Sec. 104. Increasing understanding of and improving health literacy.
- Sec. 105. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
- Sec. 106. Definitions.
- Sec. 107. Treatment of the Medicare part B program under title VI of the Civil Rights Act of 1964.

TITLE II—HEALTH WORKFORCE DIVERSITY

- Sec. 201. Amendment to the Public Health Service Act.
- Sec. 202. Health Careers Opportunity Program.
- Sec. 203. Program of Excellence in Health Professions Education for Underrepresented Minorities.
- Sec. 204. Minority-Serving Institutions and Hispanic-serving health professions schools.
- Sec. 205. Health Professions Student Loan fund; authorizations of appropriations regarding students from underrepresented minority communities.
- Sec. 206. National Health Service Corps; training programs.
- Sec. 207. Loan Repayment Program of the Centers for Disease Control and Prevention.
- Sec. 208. Strengthening and expanding rural health provider networks.
- Sec. 209. McNair Postbaccalaureate Achievement program.
- Sec. 210. Ensuring proportional representation of interests of rural areas on MedPAC.

TITLE III—DATA COLLECTION AND REPORTING

- Sec. 301. Amendment to the Public Health Service Act.

- Sec. 302. Collection of race and ethnicity data by the Social Security Administration.
- Sec. 303. Revision of HIPAA claims standards.
- Sec. 304. National Center for Health Statistics.
- Sec. 305. Geo-access study.
- Sec. 306. Racial, ethnic, and linguistic data collected by the Federal Government.
- Sec. 307. Health information technology grants.
- Sec. 308. Study of health information technology in medically underserved communities.
- Sec. 309. Health information technology in medically underserved communities.
- Sec. 310. Data collection and analysis grants to minority-serving institutions.
- Sec. 311. Health information technology grants for rural health care providers.

TITLE IV—ACCOUNTABILITY AND EVALUATION

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- Sec. 401. Federal agency plan to eliminate disparities and improve the health of minority populations.
- Sec. 402. Accountability within the Department of Health and Human Services.
- Sec. 403. Office of Minority Health.
- Sec. 404. Establishment of the Indian Health Service as an agency of the Public Health Service.
- Sec. 405. Establishment of individual offices of minority health within agencies of the Public Health Service.
- Sec. 406. Office of Minority Health at the Centers for Medicare & Medicaid Services.
- Sec. 407. Office of Minority Affairs at the Food and Drug Administration.
- Sec. 408. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 409. United States Commission on Civil Rights.
- Sec. 410. Sense of Congress concerning full funding of activities to eliminate racial and ethnic health disparities.
- Sec. 411. Guidelines for disease screening for minority patients.
- Sec. 412. National center for minority health and health disparities reauthorization.

Subtitle B—Improving Environmental Justice

- Sec. 421. Codification of executive order 12898.
- Sec. 422. Implementation of recommendations by environmental protection agency.
- Sec. 423. Grant program.
- Sec. 424. Additional research on the relationship between the built environment and the health of community residents.

TITLE V—IMPROVEMENT OF HEALTH CARE SERVICES

- Sec. 501. Health empowerment zones.
- Sec. 502. Amendment to the Public Health Service Act.
- Sec. 503. Optional coverage of legal immigrants under the Medicaid program and SCHIP.
- Sec. 504. Border health grants.
- Sec. 505. Cancer prevention and treatment demonstration for ethnic and racial minorities.
- Sec. 506. Grants to promote positive health behaviors in women and children.

- Sec. 507. Exception for citizens of freely associated States.
 Sec. 508. Medicare graduate medical education.
 Sec. 509. HIV/AIDS reduction in racial and ethnic minority communities.
 Sec. 510. Grants for racial and ethnic approaches to community health.
 Sec. 511. Critical access hospital improvements.
 Sec. 512. Coverage of marriage and family therapist services and mental health
 counselor services under part B of the Medicare program.
 Sec. 513. Establishment of rural community hospital (RCH) program.
 Sec. 514. Medicare remote monitoring pilot projects.
 Sec. 515. Rural health quality advisory commission and demonstration projects.
 Sec. 516. Rural health care services.
 Sec. 517. Community health center collaborative access expansion.
 Sec. 518. Facilitating the provision of telehealth services across State lines.

1 **TITLE I—CULTURALLY AND LIN-**
 2 **GUISTICALLY APPROPRIATE**
 3 **HEALTH CARE**

4 **SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
 5 **ACT.**

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

8 **“TITLE XXX—CULTURALLY AND**
 9 **LINGUISTICALLY APPRO-**
 10 **PRIATE HEALTH CARE**

11 **“SEC. 3000. DEFINITIONS.**

12 “In this title:

13 “(1) APPROPRIATE HEALTH CARE SERVICES.—

14 The term ‘appropriate health care services’ includes
 15 services or treatments to address prevention and
 16 care of physical, mental, oral, and behavioral dis-
 17 orders or syndromes.

18 “(2) INDIAN TRIBE.—The term ‘Indian tribe’
 19 means any Indian tribe, band, nation, or other orga-

1 nized group or community, including any Alaska Na-
2 tive village or group or regional or village corpora-
3 tion as defined in or established pursuant to the
4 Alaska Native Claims Settlement Act (85 Stat. 688)
5 (43 U.S.C. 1601 et seq.), which is recognized as eli-
6 gible for the special programs and services provided
7 by the United States to Indians because of their sta-
8 tus as Indians.

9 “(3) LIMITED ENGLISH PROFICIENT.—The
10 term ‘limited English proficient’ with respect to an
11 individual means an individual who speaks a primary
12 language other than English and cannot speak, read,
13 write, or understand the English language at a level
14 that permits them to effectively communicate with
15 clinical or nonclinical staff at a health care organiza-
16 tion.

17 “(4) MINORITY.—

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

21 “(B) POPULATIONS.—The term ‘minority’,
22 with respect to populations, refers to racial and
23 ethnic minority groups.

1 “(5) MINORITY GROUP.—The term ‘minority
2 group’ has the meaning given the term ‘racial and
3 ethnic minority group’.

4 “(6) RACIAL AND ETHNIC MINORITY GROUP.—
5 The term ‘racial and ethnic minority group’ means
6 American Indians and Alaska Natives, African
7 Americans (including Caribbean Blacks, Africans
8 and other Blacks), Asian Americans, Hispanics (in-
9 cluding Latinos), and Native Hawaiians and other
10 Pacific Islanders.

11 “(7) STATE.—The term ‘State’ means each of
12 the several states, the District of Columbia, the
13 Commonwealth of Puerto Rico, the Indian tribes,
14 the Virgin Islands, Guam, American Samoa, and the
15 Commonwealth of the Northern Mariana Islands.

16 **“SEC. 3001. IMPROVING ACCESS TO SERVICES FOR INDIVID-**
17 **UALS WITH LIMITED ENGLISH PROFICIENCY.**

18 “(a) PURPOSE.—As provided in Executive Order
19 13166, it is the purpose of this section—

20 “(1) to improve access to federally conducted
21 and federally assisted programs and activities for in-
22 dividuals who are limited in their English pro-
23 ficiency;

24 “(2) to require each Federal agency to examine
25 the services it provides and develop and implement

1 a system by which limited English proficient individ-
2 uals can obtain meaningful access to those services
3 consistent with, and without substantially burdening,
4 the fundamental mission of the agency;

5 “(3) to require each Federal agency to ensure
6 that recipients of Federal financial assistance pro-
7 vide meaningful access to their limited English pro-
8 ficient applicants and beneficiaries;

9 “(4) to ensure that recipients of Federal finan-
10 cial assistance take reasonable steps, consistent with
11 the guidelines set forth in the Limited English Pro-
12 ficient Guidance of the Department of Justice (as
13 issued on June 12, 2002), to ensure meaningful ac-
14 cess to their programs and activities by limited
15 English proficient individuals; and

16 “(5) to ensure compliance with title VI of the
17 Civil Rights Act of 1964 and that health care pro-
18 viders and organizations do not discriminate in the
19 provision of services.

20 “(b) **FEDERALLY CONDUCTED PROGRAMS AND AC-**
21 **TIVITIES.—**

22 “(1) **IN GENERAL.—**Not later than 120 days
23 after the date of enactment of this title, each Fed-
24 eral agency that carries out health care-related ac-
25 tivities shall prepare a plan to improve access to the

1 federally conducted health care-related programs
2 and activities of the agency by limited English pro-
3 ficient individuals.

4 “(2) PLAN REQUIREMENT.—Each plan under
5 paragraph (1) shall be consistent with the standards
6 set forth in section 102 of the Health Equity and
7 Accountability Act of 2007, and shall include the
8 steps the agency will take to ensure that limited
9 English proficient individuals have access to the
10 agency’s health care-related programs and activities.
11 Each agency shall send a copy of such plan to the
12 Department of Justice, which shall serve as the cen-
13 tral repository of the agencies’ plans.

14 “(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVI-
15 TIES.—

16 “(1) IN GENERAL.—Not later than 120 days
17 after the date of enactment of this title, each Fed-
18 eral agency providing health care-related Federal fi-
19 nancial assistance shall ensure that the guidance for
20 recipients of Federal financial assistance developed
21 by the agency to ensure compliance with title VI of
22 the Civil Rights Act of 1964 (42 U.S.C. 2000d et
23 seq.) is specifically tailored to the recipients of such
24 assistance and is consistent with the standards de-
25 scribed in section 102 of the Health Equity and Ac-

1 countability Act of 2007. Each agency shall send a
2 copy of such guidance to the Department of Justice
3 which shall serve as the central repository of the
4 agencies' plans. After approval by the Department of
5 Justice, each agency shall publish its guidance docu-
6 ment in the Federal Register for public comment.

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

9 “(A) detail how the general standards es-
10 tablished under section 102 of the Health Eq-
11 uity and Accountability Act of 2007 will be ap-
12 plied to the agency's recipients; and

13 “(B) take into account the types of health
14 care services provided by the recipients, the in-
15 dividuals served by the recipients, and other
16 factors set out in such standards.

17 “(3) EXISTING GUIDANCES.—A Federal agency
18 that has developed a guidance for purposes of title
19 VI of the Civil Rights Act of 1964 that the Depart-
20 ment of Justice determines is consistent with the
21 standards described in section 102 of the Health Eq-
22 uity and Accountability Act of 2007 shall examine
23 such existing guidance, as well as the programs and
24 activities to which such guidance applies, to deter-

1 mine if modification of such guidance is necessary to
2 comply with this subsection.

3 “(4) CONSULTATION.—Each Federal agency
4 shall consult with the Department of Justice in es-
5 tablishing the guidances under this subsection.

6 “(d) CONSULTATIONS.—

7 “(1) IN GENERAL.—In carrying out this sec-
8 tion, each Federal agency that carries out health
9 care-related activities shall ensure that stakeholders,
10 such as limited English proficient individuals and
11 their representative organizations, recipients of Fed-
12 eral assistance, and other appropriate individuals or
13 entities, have an adequate and comparable oppor-
14 tunity to provide input with respect to the actions of
15 the agency.

16 “(2) EVALUATION.—Each Federal agency de-
17 scribed in paragraph (1) shall evaluate the—

18 “(A) particular needs of the limited
19 English proficient individuals served by the
20 agency, and by a recipient of assistance pro-
21 vided by the agency;

22 “(B) burdens of compliance with the agen-
23 cy guidance and its recipients of the require-
24 ments of this section; and

25 “(C) outcomes or effectiveness of services.

1 **“SEC. 3002. NATIONAL STANDARDS FOR CULTURALLY AND**
2 **LINGUISTICALLY APPROPRIATE SERVICES IN**
3 **HEALTH CARE.**

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

11 “(1) implement strategies to recruit, retain, and
12 promote individuals at all levels of the organization
13 to maintain a diverse staff and leadership that can
14 provide culturally and linguistically appropriate
15 health care to patient populations of the service area
16 of the organization;

17 “(2) ensure that staff at all levels and across all
18 disciplines of the organization receive ongoing edu-
19 cation and training in culturally and linguistically
20 appropriate service delivery;

21 “(3) offer and provide language assistance serv-
22 ices, including trained bilingual staff and interpreter
23 services, at no cost to each patient with limited
24 English proficiency at all points of contact, in a
25 timely manner during all hours of operation;

1 “(4) notify patients of their right to receive lan-
2 guage assistance services in their primary language;

3 “(5) ensure the competence of language assist-
4 ance provided to limited English proficient patients
5 by interpreters and bilingual staff, and ensure that
6 family, particularly minor children, and friends are
7 not used to provide interpretation services—

8 “(A) except in case of emergency; or

9 “(B) except on request of the patient, who
10 has been informed in his or her preferred lan-
11 guage of the availability of free interpretation
12 services;

13 “(6) make available easily understood patient-
14 related materials, if such materials exist for non-lim-
15 ited English proficient patients, including informa-
16 tion or notices about termination of benefits and
17 post signage in the languages of the commonly en-
18 countered groups or groups represented in the serv-
19 ice area of the organization;

20 “(7) develop and implement clear goals, poli-
21 cies, operational plans, and management account-
22 ability and oversight mechanisms to provide cul-
23 turally and linguistically appropriate services;

24 “(8) conduct initial and ongoing organizational
25 assessments of culturally and linguistically appro-

1 appropriate services-related activities and integrate valid
2 linguistic competence-related measures into the in-
3 ternal audits, performance improvement programs,
4 patient satisfaction assessments, and outcomes-based
5 evaluations of the organization;

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

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

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

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

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

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

12 “(13) regularly make available to the public in-
13 formation about their progress and successful inno-
14 vations in implementing the standards under this
15 section and provide public notice in their commu-
16 nities about the availability of this information; and

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

1 **“SEC. 3003. ROBERT T. MATSUI CENTER FOR CULTURAL**
2 **AND LINGUISTIC COMPETENCE IN HEALTH**
3 **CARE.**

4 “(a) ESTABLISHMENT.—The Secretary, acting
5 through the Director of the Office of Minority Health Dis-
6 parity Elimination, shall establish and support a center
7 to be known as the ‘Robert T. Matsui Center for Cultural
8 and Linguistic Competence in Health Care’ (referred to
9 in this section as the ‘Center’) to carry out the following
10 activities:

11 “(1) REMOTE MEDICAL INTERPRETING.—The
12 Center shall provide remote medical interpreting, di-
13 rectly or through contracts, to health care providers
14 who otherwise would be unable to provide language
15 interpreting services, at reasonable or no cost as de-
16 termined appropriate by the Director of the Center.
17 Methods of interpretation may include remote, si-
18 multaneous or consecutive interpreting through tele-
19 phonic systems, video conferencing, and other meth-
20 ods determined appropriate by the Secretary for pa-
21 tients with limited English proficiency. The quality
22 of such interpreting shall be monitored and reported
23 publicly. Nothing in this paragraph shall be con-
24 strued to limit the ability of health care providers or
25 organizations to provide medical interpreting serv-
26 ices directly and obtain reimbursement for such

1 services as provided for under the Medicare, Med-
2 icaid, or SCHIP programs under titles XVIII, XIX,
3 or XXI of the Social Security Act.

4 “(2) MODEL LANGUAGE ASSISTANCE PRO-
5 GRAMS.—The Center shall provide for the collection
6 and dissemination of information on current model
7 language assistance programs and strategies to im-
8 prove language access to health care for individuals
9 with limited English proficiency, including case stud-
10 ies using de-identified patient information, program
11 summaries, and program evaluations.

12 “(3) INTERNET HEALTH CLEARINGHOUSE.—
13 The Center shall develop and maintain an Internet
14 clearinghouse to reduce medical errors and improve
15 medical outcomes and reduce health care costs
16 caused by miscommunication with individuals with
17 limited English proficiency or low functional health
18 literacy and reduce or eliminate the duplication of
19 effort to translate materials by—

20 “(A) developing and making available tem-
21 plates for standard documents that are nec-
22 essary for patients and consumers to access and
23 make educated decisions about their health
24 care, including—

1 “(i) administrative and legal docu-
2 ments such as informed consent, advanced
3 directives, and waivers of rights;

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

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

11 “(iv) additional health or health care-
12 related materials as determined appro-
13 priate by the Director of the Center;

14 “(B) ensuring that the documents posted
15 in English and non-English languages are cul-
16 turally appropriate;

17 “(C) allowing public review of the docu-
18 ments before dissemination in order to ensure
19 that the documents are understandable and cul-
20 turally appropriate for the target populations;

21 “(D) allowing health care providers to cus-
22 tomize the documents for their use;

23 “(E) facilitating access to these docu-
24 ments;

1 “(F) providing technical assistance with
2 respect to the access and use of such informa-
3 tion; and

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

7 “(4) PROVISION OF INFORMATION.—The Cen-
8 ter shall provide information relating to culturally
9 and linguistically competent health care for minority
10 populations residing in the United States to all
11 health care providers and health care organizations
12 at no cost. Such information shall include—

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

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

17 “(C) cultural and linguistic competence
18 training tools;

19 “(D) strategic plans to increase cultural
20 and linguistic competence in different types of
21 health care organizations, including regional
22 collaborations among health care organizations;
23 and

1 “(E) resources for cultural and linguistic
2 competence information for educators, practi-
3 tioners and researchers.

4 “(b) DIRECTOR.—The Center shall be headed by a
5 Director who shall be appointed by, and who shall report
6 to, the Deputy Assistant Secretary for Minority Health.

7 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
8 rector shall collaborate with all agencies within the De-
9 partment of Health and Human Services to notify health
10 care providers and health care organizations about the
11 availability of language access services by the Center.

12 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section
14 such sums as may be necessary for each of fiscal years
15 2008 through 2012.

16 **“SEC. 3004. INNOVATIONS IN CULTURAL AND LINGUISTIC**
17 **COMPETENCE GRANTS.**

18 “(a) IN GENERAL.—The Secretary, acting through
19 the Administrator of the Centers for Medicare & Medicaid
20 Services, the Administrator of the Health Resources and
21 Services Administration, the Secretary of Education, and
22 the Deputy Assistant Secretary for Minority Health, shall
23 award grants to eligible entities to enable such entities to
24 design, implement, and evaluate innovative, cost-effective
25 programs to improve cultural and linguistic competence in

1 health care for individuals with limited English pro-
2 ficiency.

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

5 “(1) be a city, county, Indian tribe, State, terri-
6 tory, community-based and other nonprofit organiza-
7 tion, health center or community clinic, university,
8 college, or other entity designated by the Secretary;
9 and

10 “(2) prepare and submit to the Secretary an
11 application, at such time, in such manner, and ac-
12 companied by such additional information as the
13 Secretary may require.

14 “(c) USE OF FUNDS.—An entity shall use funds re-
15 ceived under a grant under this section to—

16 “(1) develop, implement, and evaluate models of
17 providing real-time cultural competence and inter-
18 pretation services through in-person interpretation,
19 communications, and computer technology, including
20 the Internet, teleconferencing, or video conferencing;

21 “(2) develop short-term medical interpretation
22 training courses and incentives for bilingual health
23 care staff who are asked to interpret in the work-
24 place;

1 “(3) develop formal training programs for indi-
2 viduals interested in becoming dedicated health care
3 interpreters and culturally competent providers;

4 “(4) provide staff language training instruction
5 which shall include information on the practical limi-
6 tations of such instruction for non-native speakers;
7 and

8 “(5) develop other language assistance services
9 as determined appropriate by the Secretary.

10 “(d) PRIORITY.—In awarding grants under this sec-
11 tion, the Secretary shall give priority to entities that have
12 developed partnerships with organizations or agencies with
13 experience in culturally competent and language access
14 services.

15 “(e) EVALUATION.—An entity that receives a grant
16 under this section shall submit to the Secretary an evalua-
17 tion that describes the activities carried out with funds
18 received under the grant, and how such activities improved
19 access to health care services and the quality of health
20 care for individuals with limited English proficiency. Such
21 evaluation shall be collected and disseminated through the
22 Robert T. Matsui Center for Cultural and Linguistic Com-
23 petence in Health Care established under section 3003.

1 “(6) optimal approaches for delivering language
2 access.

3 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2008 through 2012.

7 **“SEC. 3006. INFORMATION ABOUT FEDERAL HEALTH PRO-**
8 **GRAMS FOR LIMITED ENGLISH PROFICIENT**
9 **POPULATIONS.**

10 “The Secretary shall provide for a means by which
11 limited English proficient individuals who are seeking in-
12 formation about, or assistance with, Federal health care
13 programs may obtain such information or assistance.”.

14 **SEC. 102. STANDARDS FOR LANGUAGE ACCESS SERVICES.**

15 Not later than 120 days after the date of enactment
16 of this Act, the head of each Federal agency that carries
17 out health care-related activities shall develop and adopt
18 a guidance on language services for those with limited
19 English proficiency who attempt to have access to or par-
20 ticipate in such activities that provides at the minimum
21 the factors and principles set forth in the Department of
22 Justice guidance published on June 12, 2002.

1 **SEC. 103. FEDERAL REIMBURSEMENT FOR CULTURALLY**
2 **AND LINGUISTICALLY APPROPRIATE SERV-**
3 **ICES UNDER THE MEDICARE, MEDICAID AND**
4 **STATE CHILDREN'S HEALTH INSURANCE**
5 **PROGRAM.**

6 (a) DEMONSTRATION PROJECT PROMOTING ACCESS
7 FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH
8 PROFICIENCY.—

9 (1) IN GENERAL.—The Secretary shall conduct
10 a demonstration project (in this subsection referred
11 to as the “project”) to demonstrate the impact on
12 costs and health outcomes of providing reimburse-
13 ment for interpreter services to certain Medicare
14 beneficiaries who are limited English proficient in
15 urban and rural areas.

16 (2) SCOPE.—The Secretary shall carry out the
17 project in not less than 30 States or territories
18 through contracts with—

19 (A) MA plans (under part C of title XVIII
20 of the Social Security Act);

21 (B) small providers;

22 (C) hospitals; and

23 (D) community-based clinics.

24 (3) DURATION.—Each contract entered into
25 under the project shall extend over a period of not
26 longer than 2 years.

1 (4) REPORT.—Upon completion of the project,
2 the Secretary shall submit a report to Congress on
3 the project which shall include recommendations re-
4 garding the extension of such project to the entire
5 Medicare program.

6 (5) EVALUATION.—The Director of the Agency
7 for Healthcare Research and Quality, in consultation
8 with the Office of Minority Health and the National
9 Center on Minority Health and Health Disparities,
10 shall award grants to public and private nonprofit
11 entities that demonstrate experience and capability
12 with respect to cultural and linguistic competence,
13 including Historically Black Colleges and Univer-
14 sities, Hispanic-serving institutions, and other enti-
15 ties directed by and serving representatives of racial
16 and ethnic minority groups, for the evaluation of the
17 project. Such evaluations shall focus on access, utili-
18 zation, efficiency, cost-effectiveness, patient satisfac-
19 tion, and select health outcomes.

20 (b) MEDICAID.—Section 1903(a)(3) of the Social Se-
21 curity Act (42 U.S.C. 1396b(a)(3)) is amended—

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

24 (2) by adding at the end the following:

1 improve health care for patient populations that have low
2 functional health literacy.

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

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

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

12 (c) USE OF FUNDS.—

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

17 (A) to define and increase the under-
18 standing of health literacy;

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

21 (C) to clarify which aspects of health lit-
22 eracy have an effect on health outcomes; and

23 (D) for any other activity determined ap-
24 propriate by the Director of the Agency.

1 (2) HEALTH RESOURCES AND SERVICES ADMIN-
2 ISTRATION.—Grants awarded under subsection (a)
3 through the Health Resources and Services Adminis-
4 tration shall be used to conduct demonstration
5 projects for interventions for patients with low
6 health literacy that may include—

7 (A) the development of new disease man-
8 agement programs for patients with low health
9 literacy;

10 (B) the tailoring of existing disease man-
11 agement programs addressing mental, physical,
12 oral, and behavioral health conditions for pa-
13 tients with low health literacy;

14 (C) the translation of written health mate-
15 rials for patients with low health literacy;

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

18 (E) the conduct of educational campaigns
19 for patients and providers about low health lit-
20 eracy; and

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

24 (d) DEFINITIONS.—In this section, the term “low
25 health literacy” means the inability of an individual to ob-

1 tain, process, and understand basic health information
2 and services needed to make appropriate health decisions.

3 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section,
5 such sums as may be necessary for each of fiscal years
6 2008 through 2012.

7 **SEC. 105. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
8 **TURALLY AND LINGUISTICALLY APPRO-**
9 **PRIATE HEALTH CARE SERVICES.**

10 Not later than 1 year after the date of enactment
11 of this Act and annually thereafter, the Secretary of
12 Health and Human Services shall enter into a contract
13 with the Institute of Medicine for the preparation and
14 publication of a report that describes Federal efforts to
15 ensure that all individuals have meaningful access to cul-
16 turally and linguistically appropriate health care services.
17 Such report shall include—

18 (1) a description and evaluation of the activities
19 carried out under this Act;

20 (2) a description of best practices, model pro-
21 grams, guidelines, and other effective strategies for
22 providing access to culturally and linguistically ap-
23 propriate health care services; and

24 (3) an assessment of the implementation of the
25 Department of Health and Human Services National

1 Standards on Culturally and Linguistically Appro-
2 priate Services (CLAS) in Health Care, in particular
3 the implementation of CLAS mandates by recipients
4 of Federal funds.

5 **SEC. 106. DEFINITIONS.**

6 In this title:

7 (1) INCORPORATED DEFINITIONS.—The defini-
8 tions contained in section 3000 of the Public Health
9 Service Act, as added by section 101, shall apply.

10 (2) SECRETARY.—The term “Secretary” means
11 the Secretary of Health and Human Services.

12 **SEC. 107. TREATMENT OF THE MEDICARE PART B PRO-**
13 **GRAM UNDER TITLE VI OF THE CIVIL RIGHTS**
14 **ACT OF 1964.**

15 A payment provider of services or physician or other
16 supplier under part B of title XVIII of the Social Security
17 Act shall be deemed a grant, and not a contract of insur-
18 ance or guaranty, for the purposes of title VI of the Civil
19 Rights Act of 1964.

1 **TITLE II—HEALTH WORKFORCE**
2 **DIVERSITY**

3 **SEC. 201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
4 **ACT.**

5 Title XXX of the Public Health Service Act, as added
6 by section 101, is amended by adding at the end the fol-
7 lowing:

8 **“Subtitle A—Diversifying the**
9 **Health Care Workplace**

10 **“SEC. 3011. REPORT ON WORKFORCE DIVERSITY.**

11 “(a) IN GENERAL.—Not later than July 1, 2008, and
12 biannually thereafter, the Secretary, acting through the
13 director of each entity within the Department of Health
14 and Human Services, shall prepare and submit to the
15 Committee on Health, Education, Labor, and Pensions of
16 the Senate and the Committee on Energy and Commerce
17 of the House of Representatives a report on health work-
18 force diversity.

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

21 “(1) A description of any grant support that is
22 provided by each entity for workforce diversity ini-
23 tiatives with the following information—

24 “(A) the number of grants made;

25 “(B) the purpose of the grants;

1 “(C) the populations served through the
2 grants;

3 “(D) the organizations and institutions re-
4 ceiving the grants, including specification of the
5 number of Hispanic health professions schools
6 and minority-serving institutions; and

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

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

12 “(A) the number of underrepresented mi-
13 nority health professionals that will be needed
14 in various disciplines over the next 10 years to
15 achieve population parity;

16 “(B) the level of funding needed to fully
17 expand and adequately support health profes-
18 sions pipeline programs;

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

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

1 “(b) INFORMATION AND SERVICES.—The clearing-
2 house established under subsection (a) shall offer the fol-
3 lowing information and services:

4 “(1) Information on the importance of health
5 workforce diversity.

6 “(2) Statistical information relating to under-
7 represented minority representation in health and al-
8 lied health professions and occupations.

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

11 “(4) Admissions policies that promote health
12 workforce diversity and are in compliance with Fed-
13 eral and State laws.

14 “(5) Lists of scholarship, loan repayment, and
15 loan cancellation grants as well as fellowship infor-
16 mation for underserved populations for health pro-
17 fessions schools.

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

20 “(c) CONSULTATION.—In carrying out this section,
21 the Secretary shall consult with non-Federal entities,
22 which shall include minority health professional associa-
23 tions to help ensure thoroughness and accuracy of infor-
24 mation.

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

4 “(c) USE OF FUNDS.—Amounts awarded under a
5 grant under subsection (a) shall be used to support the
6 following evaluation activities:

7 “(1) Determinations of measures of health
8 workforce diversity success.

9 “(2) Assessments of the effects of health work-
10 force diversity on quality, including—

11 “(A) language access;

12 “(B) cultural competence;

13 “(C) patient satisfaction;

14 “(D) timeliness of care;

15 “(E) safety of care;

16 “(F) effectiveness of care;

17 “(G) efficiency of care;

18 “(H) patient outcomes;

19 “(I) community engagement;

20 “(J) resource allocation;

21 “(K) organizational structure; and

22 “(L) other topics determined appropriate
23 by the Secretary.

24 “(3) The short- and long-term tracking of par-
25 ticipants in health workforce diversity pipeline pro-

1 grams funded by the Department of Health and
2 Human Services.

3 “(4) Assessments of partnerships formed
4 through activities to increase health workforce diver-
5 sity.

6 “(5) Assessments of barriers to health work-
7 force diversity.

8 “(6) Assessments of policy changes at the Fed-
9 eral, State, and local levels.

10 “(7) Assessments of coordination within and be-
11 tween Federal agencies and other institutions.

12 “(8) Other activities determined appropriate by
13 the Secretary.

14 “(d) REPORT.—Not later than 1 year after the date
15 of enactment of this title, the Bureau of Health Profes-
16 sions within the Health Resources and Services Adminis-
17 tration shall prepare and make available for public com-
18 ment a report that summarizes the findings made by enti-
19 ties under grants under this section.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section,
22 such sums as may be necessary for each of fiscal years
23 2008 through 2013.

1 **“SEC. 3014. DATA COLLECTION AND REPORTING BY**
2 **HEALTH PROFESSIONAL SCHOOLS.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Bureau of Health Professions of the Health Resources
5 and Services Administration and the Office of Minority
6 Health, shall establish an aggregated database on health
7 professional students.

8 “(b) REQUIREMENT TO COLLECT DATA.—Each
9 health professional school (including medical, dental, and
10 nursing schools) and allied health profession school and
11 program that receives Federal funds shall collect race, eth-
12 nicity, and language proficiency data concerning those stu-
13 dents enrolled at such schools or in such programs. In col-
14 lecting such data, a school or program shall—

15 “(1) at a minimum, use the categories for race
16 and ethnicity described in the 1997 Office of Man-
17 agement and Budget Standards for Maintaining,
18 Collecting, and Presenting Federal Data on Race
19 and Ethnicity and available language standards; and

20 “(2) if practicable, collect data on additional
21 population groups if such data can be aggregated
22 into the minimum race and ethnicity data categories.

23 “(c) USE OF DATA.—Data on race, ethnicity, and
24 primary language collected under this section shall be re-
25 ported to the database established under subsection (a)

1 on an annual basis. Such data shall be available for public
2 use.

3 “(d) PRIVACY.—The Secretary shall ensure that all
4 data collected under this section is protected from inap-
5 propriate internal and external use by any entity that col-
6 lects, stores, or receives the data and that such data is
7 collected without personally identifiable information.

8 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
9 is authorized to be appropriated to carry out this section,
10 such sums as may be necessary for each of fiscal years
11 2008 through 2013.

12 **“SEC. 3015. SUPPORT FOR INSTITUTIONS COMMITTED TO**
13 **WORKFORCE DIVERSITY.**

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

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

20 “(1) be an educational institution or entity that
21 historically produces or trains meaningful numbers
22 of underrepresented minority health professionals,
23 including—

24 “(A) Historically Black Colleges and Uni-
25 versities;

1 “(B) Hispanic-serving health professions
2 schools;

3 “(C) Hispanic-serving institutions;

4 “(D) Tribal Colleges and Universities;

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

7 “(F) institutions that have programs to re-
8 cruit and retain underrepresented minority
9 health professionals, in which a significant
10 number of the enrolled participants are under-
11 represented minorities;

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

15 “(H) institutions—

16 “(i) located in communities with pre-
17 dominantly underrepresented minority pop-
18 ulations;

19 “(ii) with whom partnerships have
20 been formed for the purpose of increasing
21 workforce diversity; and

22 “(iii) in which at least 20 percent of
23 the enrolled participants are underrep-
24 resented minorities; and

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

4 “(c) USE OF FUNDS.—Amounts received under a
5 grant under subsection (a) shall be used to expand existing
6 workforce diversity programs, implement new workforce
7 diversity programs, or evaluate existing or new workforce
8 diversity programs, including with respect to mental as
9 well as oral health care professions. Such programs shall
10 enhance diversity by considering minority status as part
11 of an individualized consideration of qualifications. Pos-
12 sible activities may include—

13 “(1) educational outreach programs relating to
14 opportunities in the health professions;

15 “(2) scholarship, fellowship, grant, and loan re-
16 payment programs;

17 “(3) post-baccalaureate programs;

18 “(4) academic enrichment programs, particu-
19 larly targeting those who would not be competitive
20 for health professions schools;

21 “(5) kindergarten through 12th grade and
22 other health pipeline programs;

23 “(6) mentoring programs;

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

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

6 “(9) leadership training.

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

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

15 “(1) that are eligible institutions under section
16 312(b) of the Higher Education Act of 1965; and

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

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section
23 \$100,000,000 for each of fiscal years 2008 through 2013.

1 **“SEC. 3016. CAREER DEVELOPMENT FOR SCIENTISTS AND**
2 **RESEARCHERS.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the National Institutes of Health, the Di-
5 rector of the Centers for Disease Control and Prevention,
6 the Commissioner of Food and Drugs, and the Director
7 of the Agency for Healthcare Research and Quality, shall
8 award grants that expand existing opportunities for sci-
9 entists and researchers and promote the inclusion of
10 underrepresented minorities in the health professions.

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

20 “(c) DATA COLLECTION.—The head of each entity
21 within the Department of Health and Human Services
22 shall collect data on the number (expressed as an absolute
23 number and a percentage) of underrepresented minority
24 and nonminority applicants who receive and are denied
25 agency funding at every stage of review. Such data shall

1 be reported annually to the Secretary and the appropriate
2 committees of Congress.

3 “(d) **STUDENT LOAN REIMBURSEMENT.**—The Sec-
4 retary shall establish a student loan reimbursement pro-
5 gram to provide student loan reimbursement assistance to
6 researchers who focus on racial and ethnic disparities in
7 health. The Secretary shall promulgate regulations to de-
8 fine the scope and procedures for the program under this
9 subsection.

10 **“SEC. 3017. CAREER SUPPORT FOR NON-RESEARCH**
11 **HEALTH PROFESSIONALS.**

12 “(a) **IN GENERAL.**—The Secretary, acting through
13 the Director of the Centers for Disease Control and Pre-
14 vention, the Administrator of the Substance Abuse and
15 Mental Health Services Administration, the Administrator
16 of the Health Resources and Services Administration, and
17 the Administrator of the Centers for Medicare & Medicaid
18 Services shall establish a program to award grants to eligi-
19 ble individuals for career support, including leadership
20 training, in non-research-related health care.

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

23 “(1) be a student in a health professions school,
24 a graduate of such a school who is working in a

1 health profession, or a faculty member of such a
2 school; and

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

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

8 “(1) support the individual’s health activities or
9 projects that involve underserved communities, in-
10 cluding rural communities and racial and ethnic mi-
11 nority communities;

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

14 “(3) to pay, or as reimbursement for payments
15 of, student loans for individuals who are health pro-
16 fessionals and are focused on health issues affecting
17 underserved communities, including rural commu-
18 nities and racial and ethnic minority communities.

19 “(d) DEFINITION.—In this section, the term ‘career
20 in non-research-related health care’ means employment or
21 intended employment in the field of public health, health
22 policy, health management, health administration, medi-
23 cine, nursing, pharmacy, allied health, community health,
24 or other fields determined appropriate by the Secretary,
25 other than in a position that involves research.

1 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section,
3 such sums as may be necessary for each of fiscal years
4 2008 through 2013.

5 **“SEC. 3018. CULTURAL COMPETENCE TRAINING FOR**
6 **HEALTH CARE PROFESSIONALS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Administrator of the Health Resources and Services
9 Administration, the Deputy Assistant Secretary for Mi-
10 nority Health, and the Director of the National Center
11 for Minority Health and Health Disparities, shall award
12 grants to eligible entities to test, implement, and evaluate
13 models of cultural competence training, including con-
14 tinuing education, for health care providers.

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

17 “(1) be an academic medical center, a health
18 center or clinic, a hospital, a health plan, a health
19 system, or a health care professional guild (including
20 a mental health care professional guild);

21 “(2) partner with a minority-serving institution,
22 minority health professional association, or commu-
23 nity-based organization representing minority popu-
24 lations, in addition to a research institution to carry
25 out activities under this grant; and

1 “(1) recruitment of minority students and fac-
2 ulty; and

3 “(2) development of curriculum on minority
4 health for health professions students, allied health
5 students, and other health professionals.

6 “(c) ELIGIBILITY.—To be eligible to receive a cooper-
7 ative agreement under subsection (a), a minority commu-
8 nity-based organization, school district, or profession orga-
9 nization must be recognized for its demonstrated ability
10 to engage minority community involvement in health care
11 programs.

12 “(d) PRIORITY.—In awarding cooperative agreements
13 under subsection (a), the Office of Minority Health shall
14 give priority to entities that—

15 “(1) will use the agreement in a geographic
16 area that has a large medically underserved minority
17 population; and

18 “(2) will use a regional approach through part-
19 nerships with other health professions schools, pri-
20 vate sector entities, school districts, and community-
21 based organizations that serve the area.”.

22 **SEC. 202. HEALTH CAREERS OPPORTUNITY PROGRAM.**

23 (a) PURPOSE.—It is the purpose of this section to
24 diversify the health care workforce by increasing the num-
25 ber of individuals from disadvantaged backgrounds in the

1 health and allied health professions by enhancing the aca-
2 demic skills of students from disadvantaged backgrounds
3 and supporting them in successfully competing, entering,
4 and graduating from health professions training pro-
5 grams.

6 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
7 740(c) of the Public Health Service Act (42 U.S.C.
8 293d(c)) is amended by striking “\$29,400,000” and all
9 that follows through “2002” and inserting “\$50,000,000
10 for fiscal year 2008, and such sums as may be necessary
11 for each of fiscal years 2009 through 2013”.

12 **SEC. 203. PROGRAM OF EXCELLENCE IN HEALTH PROFES-**
13 **SIONS EDUCATION FOR UNDERREP-**
14 **RESENTED MINORITIES.**

15 (a) PURPOSE.—It is the purpose of this section to
16 diversify the health care workforce by supporting pro-
17 grams of excellence in designated health professions
18 schools with a demonstrated set of effective policies, cri-
19 teria, programs, performance standards, and measures
20 that document commitment and capacity to underrep-
21 resented minority populations with a focus on minority
22 health issues, cultural and linguistic competence, and
23 eliminating racial and ethnic disparities in health and
24 health care.

1 (b) AUTHORIZATION OF APPROPRIATION.—Section
2 736(h)(1) of the Public Health Service Act (42 U.S.C.
3 293(h)(1)) is amended to read as follows:

4 “(1) AUTHORIZATION OF APPROPRIATIONS.—
5 For the purpose of making grants under subsection
6 (a), there are authorized to be appropriated
7 \$50,000,000 for fiscal year 2008, and such sums as
8 may be necessary for each of the fiscal years 2009
9 through 2013.”.

10 **SEC. 204. MINORITY-SERVING INSTITUTIONS AND HIS-**
11 **PANIC-SERVING HEALTH PROFESSIONS**
12 **SCHOOLS.**

13 Part B of title VII of the Public Health Service Act
14 (42 U.S.C. 293 et seq.) is amended by adding at the end
15 the following:

16 **“SEC. 742. MINORITY-SERVING INSTITUTIONS AND HIS-**
17 **PANIC-SERVING HEALTH PROFESSIONS**
18 **SCHOOLS.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Administrator of the Health Resources and Services
21 Administration, shall award grants to minority-serving in-
22 stitutions and Hispanic-serving health professions schools
23 for the purpose of carrying out programs to recruit under-
24 represented individuals to enroll in and graduate from

1 such schools, which may include providing scholarships
2 and other financial assistance as appropriate.

3 “(b) DEFINITIONS.—In this section:

4 “(1) The term ‘Hispanic-serving health profes-
5 sions school’ means an entity that—

6 “(A) is a school or program under section
7 799B;

8 “(B) has an enrollment of full-time equiva-
9 lent students that is made up of at least 9 per-
10 cent Hispanic students;

11 “(C) has been effective in carrying out pro-
12 grams to recruit Hispanic individuals to enroll
13 in and graduate from the school;

14 “(D) has been effective in recruiting and
15 retaining Hispanic faculty members; and

16 “(E) has a significant number of graduates
17 who are providing health services to medically
18 underserved populations or to individuals in
19 health professional shortage areas.

20 “(2) The term ‘historically Black college or uni-
21 versity’ means a part B institution (as defined in
22 section 322(2) of the Higher Education Act of
23 1965).

24 “(3) The term ‘minority-serving institution’
25 means an entity that is—

1 “(A) an historically Black college or uni-
2 versity;

3 “(B) an Hispanic-serving institution (as
4 defined in section 502(a)(5) of the Higher Edu-
5 cation Act of 1965);

6 “(C) a tribally controlled college or univer-
7 sity (as defined in section 2(a)(4) of the Trib-
8 ally Controlled College or University Assistance
9 Act of 1978);

10 “(D) an Alaska Native-serving institution
11 (as defined in section 317(b)(2) of the Higher
12 Education Act of 1965); or

13 “(E) a Native Hawaiian-serving institution
14 (as defined in section 317(b)(4) of the Higher
15 Education Act of 1965).”.

16 **SEC. 205. HEALTH PROFESSIONS STUDENT LOAN FUND; AU-**
17 **THORIZATIONS OF APPROPRIATIONS RE-**
18 **GARDING STUDENTS FROM UNDERREP-**
19 **RESENTED MINORITY COMMUNITIES.**

20 Section 724(f) of the Public Health Service Act (42
21 U.S.C. 292t(f)) is amended by inserting before paragraph
22 (2) the following:

23 “(1) IN GENERAL.—With respect to making
24 Federal capital contributions to student loan funds
25 for purposes of subsection (a), there is authorized to

1 be appropriated \$50,000,000 for fiscal year 2008,
2 and such sums as may be necessary for each of the
3 fiscal years 2009 through 2013.”.

4 **SEC. 206. NATIONAL HEALTH SERVICE CORPS; TRAINING**
5 **PROGRAMS.**

6 (a) IN GENERAL.—Section 331(b) of the Public
7 Health Service Act (42 U.S.C. 254d(b)) is amended by
8 adding at the end the following:

9 “(3) The Secretary shall ensure that the individuals
10 with respect to whom activities under paragraphs (1) and
11 (2) are carried out include individuals from disadvantaged
12 backgrounds, including activities carried out to provide
13 health professions students with information on the Schol-
14 arship and Repayment Programs.”.

15 (b) ASSIGNMENT OF CORPS PERSONNEL.—

16 (1) IN GENERAL.—Section 333(a)(3) of the
17 Public Health Service Corps (42 U.S.C. 254f(a)(3))
18 is amended to read as follows:

19 “(3)(A) In approving applications for assign-
20 ment of members of the Corps the Secretary shall
21 not discriminate against application from entities
22 which are not receiving Federal financial assistance
23 under this Act.

24 “(B) In approving such applications, the Sec-
25 retary shall—

1 “(i) give preference to applications in
2 which a nonprofit entity or public entity shall
3 provide a site to which Corps members may be
4 assigned; and

5 “(ii) give highest preference to applica-
6 tions—

7 “(I) from entities described in clause
8 (i) that are federally qualified health cen-
9 ters as defined in section 1905(l)(2)(B) of
10 the Social Security Act; and

11 “(II) from entities described in clause
12 (i) that primarily serve rural communities,
13 racial and ethnic minorities, and other
14 health disparity populations with annual
15 incomes at or below twice those set forth
16 in the most recent poverty guidelines
17 issued by the Secretary pursuant to section
18 673(2) of the Community Services Block
19 Grant Act (42 U.S.C. 9902(2)).”.

20 (2) PRIORITIES IN ASSIGNMENT OF CORPS PER-
21 SONNEL.—Section 333A of the Public Health Serv-
22 ice Act (42 U.S.C. 254f-1) is amended—

23 (A) in subsection (a)—

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

4 (ii) by striking “shall—” and insert-
5 ing “shall—

6 “(1) give preference to applications as set forth
7 in subsection (a)(3) of section 333;”;

8 (B) in subsection (b)(1), by striking “sub-
9 section (a)(1)(A)” and inserting “subsection
10 (a)(2)(A)”; and

11 (C) by striking “subsection (a)(1)” each
12 place it appears and inserting “subsection
13 (a)(2)”.

14 (3) CONFORMING AMENDMENT.—Section
15 338I(c)(3)(B)(ii) of the Public Health Service Act
16 (42 U.S.C. 254q-1(c)(3)(B)(ii)) is amended by strik-
17 ing “section 333A(a)(1)” and inserting “section
18 333A(a)(2)”.

19 (c) REAUTHORIZATION OF NATIONAL HEALTH SERV-
20 ICE CORPS SCHOLARSHIP PROGRAM AND LOAN REPAY-
21 MENT PROGRAM.—

22 (1) REAUTHORIZATION OF APPROPRIATIONS.—
23 Section 338H(a) of the Public Health Service Act
24 (42 U.S.C. 254q(a)) is amended by striking
25 “\$146,250,000” and all that follows through the pe-

1 riod and inserting “\$300,000,000 for each of fiscal
2 years 2008 through 2012.”.

3 (2) SCHOLARSHIPS FOR MEDICAL STUDENTS.—

4 Section 338H of such Act is further amended by
5 adding at the end the following:

6 “(d) SCHOLARSHIPS FOR MEDICAL STUDENTS.—For
7 contracts for scholarships under this subpart to individ-
8 uals who are accepted for enrollment, or enrolled, in a
9 course of study or program described in section
10 338A(b)(1)(B) that leads to a degree in medicine, osteo-
11 pathic medicine, dentistry, or mental health services, the
12 Secretary shall, of the amounts appropriated under sub-
13 section (a) for a fiscal year, obligate the greater of 10 per-
14 cent or such amount as necessary to fund ongoing activi-
15 ties related to such contracts.”.

16 (d) REAUTHORIZATION OF CERTAIN PROGRAMS PRO-
17 VIDING GRANTS FOR HEALTH PROFESSIONS TRAINING
18 FOR DIVERSITY.—

19 (1) GRANTS FOR CENTERS OF EXCELLENCE.—

20 Section 736(h)(1) of the Public Health Service Act
21 (42 U.S.C. 293(h)(1)) is amended by striking
22 “\$26,000,000” and all that follows through “2002”
23 and inserting “\$50,000,000 for each of fiscal years
24 2008 through 2012”.

1 (2) EDUCATIONAL ASSISTANCE FOR INDIVID-
 2 UALS FROM DISADVANTAGED BACKGROUNDS.—Sec-
 3 tion 740(c) of such Act (42 U.S.C. 293d(c)) is
 4 amended by striking “\$29,400,000” and all that fol-
 5 lows through “1999 through 2002.” and inserting
 6 “\$50,000,000 for each of fiscal years 2008 through
 7 2012.”.

8 (e) EXPANSION OF RESIDENCY TRAINING PROGRAMS
 9 AND PRIMARY CARE SERVICES OFFERED BY COMMUNITY
 10 HEALTH CENTERS.—Part C of title VII of the Public
 11 Health Service Act (42 U.S.C. 293k et seq.) is amended—

12 (1) by adding before section 747 the following:

13 **“Subpart I—In General”; and**

14 (2) by adding after section 748 the following:

15 **“Subpart II—Additional Programs**

16 **“SEC. 749. GRANTS TO EXPAND MEDICAL RESIDENCY**
 17 **TRAINING PROGRAMS AT COMMUNITY**
 18 **HEALTH CENTERS.**

19 “(a) PROGRAM AUTHORIZED.—The Secretary may
 20 make grants to community health centers—

21 “(1) to establish, at the centers, new or alter-
 22 native-campus accredited medical residency training
 23 programs affiliated with a hospital or other health
 24 care facility; or

1 “(2) to fund new residency positions within ex-
2 isting accredited medical residency training pro-
3 grams at the centers and their affiliated partners.

4 “(b) USE OF FUNDS.—Amounts from a grant under
5 this section shall be used to cover the costs of establishing
6 or expanding a medical residency training program de-
7 scribed in subsection (a), including costs associated with—

8 “(1) curriculum development;

9 “(2) equipment acquisition;

10 “(3) recruitment, training, and retention of
11 residents and faculty; and

12 “(4) residency stipends.

13 “(c) APPLICATIONS.—A community health center
14 seeking a grant under this section shall submit an applica-
15 tion to the Secretary at such time, in such manner, and
16 containing such information as the Secretary may require.

17 “(d) PREFERENCE.—In selecting recipients for a
18 grant under this section, the Secretary shall give pref-
19 erence to funding medical residency training programs fo-
20 cusing on primary health care.

21 “(e) DEFINITIONS.—In this section:

22 “(1) The term ‘accredited’, as applied to a new
23 or alternative-campus medical residency training
24 program, means a program that is accredited by a
25 recognized body or bodies approved for such purpose

1 by the Accreditation Council for Graduate Medical
2 Education, except that a new medical residency
3 training program that, by reason of an insufficient
4 period of operation, is not eligible for accreditation
5 on or before the date of submission of an application
6 under subsection (c) shall be deemed accredited if
7 the Accreditation Council for Graduate Medical
8 Education finds, after consultation with the appro-
9 priate accreditation body or bodies, that there is rea-
10 sonable assurance that the program will meet the ac-
11 creditation standards of such body or bodies prior to
12 the date of graduation of the first entering class in
13 that program.

14 “(2) The term ‘community health center’ means
15 a health center as defined in section 330.

16 **“SEC. 749A. GRANTS TO IMPROVE DELIVERY OF PRIMARY**
17 **CARE SERVICES IN COMMUNITY HEALTH**
18 **CENTERS.**

19 “(a) PRIMARY CARE ACCESS GRANTS.—

20 “(1) PROGRAM AUTHORIZED.—The Secretary,
21 acting through the Administrator of the Health Re-
22 sources and Services Administration, may make
23 grants to community health centers for the purpose
24 of increasing the number of medical service pro-
25 viders associated with such centers.

1 “(2) GRANTS.—A recipient of a grant under
2 this subsection shall be eligible to receive such
3 grants for a total of 5 fiscal years.

4 “(3) USE OF FUNDS.—A recipient of a grant
5 under this subsection shall use amounts from the
6 grant for one or more of the following activities:

7 “(A) To recruit residents for medical resi-
8 dency training programs at the community
9 health center.

10 “(B) To establish a multi-community phy-
11 sician mentoring program to encourage upper
12 level residents to remain in the State or Terri-
13 tory in which the community health center and
14 medical residency training program are located.

15 “(C) To enter into contracts for technical
16 assistance for the purpose of recruiting or re-
17 taining primary health care staff.

18 “(D) To enter into contracts for technical
19 assistance in preparing contracts with local pro-
20 viders of primary health care to provide services
21 for medically underserved communities.

22 “(E) To enter into contracts for the devel-
23 opment and implementation of strategies to
24 identify and retain health care professionals
25 and specialists, including oral and mental

1 health providers, who are willing and able to
2 provide direct actual service to the community
3 health center on a referral basis.

4 “(4) APPLICATION.—A community health cen-
5 ter seeking a grant under this subsection shall sub-
6 mit an application to the Secretary at such time, in
7 such manner, and containing such information as
8 the Secretary may require.

9 “(b) GRANTS FOR PRIMARY CARE FACILITY CAPITAL
10 EXPENDITURES.—

11 “(1) PROGRAM AUTHORIZED.—The Secretary,
12 acting through the Administrator of the Health Re-
13 sources and Services Administration, may make
14 grants to community health centers for the purpose
15 of increasing primary health care capabilities
16 through the construction, expansion, or renovation
17 of facilities.

18 “(2) GRANTS.—A recipient of a grant under
19 this subsection shall be eligible to receive such
20 grants for a total of 5 fiscal years.

21 “(3) USE OF FUNDS.—A recipient of a grant
22 under this subsection shall use amounts from the
23 grant for one or more of the following activities:

24 “(A) To acquire or lease facilities.

25 “(B) To construct new facilities.

1 “(C) To repair or modernize existing facili-
2 ties.

3 “(D) To purchase or lease medical equip-
4 ment.

5 “(c) DEFINITION.—The term ‘community health cen-
6 ter’ means a health center as defined in section 330.

7 **“SEC. 749B. AUTHORIZATION OF APPROPRIATIONS.**

8 “There is authorized to be appropriated
9 \$200,000,000 for fiscal year 2008 and such sums as may
10 be necessary for each fiscal year thereafter to carry out
11 this subpart.”.

12 (f) INTERDISCIPLINARY, COMMUNITY-BASED PRO-
13 GRAMS.—

14 (1) AREA HEALTH EDUCATION CENTERS.—Sec-
15 tion 751(a) of the Public Health Service Act (42
16 U.S.C. 294a(a)) is amended—

17 (A) in paragraph (1)(A)—

18 (i) in clause (i), by inserting at the
19 end before the semicolon the following: “,
20 with an emphasis on such personnel who
21 focus on primary care”;

22 (ii) by redesignating clauses (ii)
23 through (vii) as clauses (iii) through (viii),
24 respectively; and

1 (iii) by inserting after clause (i) the
2 following:

3 “(ii) foster and provide community-
4 based training and education for health
5 professions students in underserved com-
6 munities and among underserved popu-
7 lations, including but not limited to the
8 National Health Service Corps, community
9 and migrant health centers, rural health
10 clinics, critical access hospitals, tribal
11 health clinics, and public health depart-
12 ments;” and

13 (B) by adding at the end the following:

14 “(3) POINT OF SERVICE ENHANCEMENT
15 GRANTS.—

16 “(A) IN GENERAL.—The Secretary may
17 award grants to entities receiving an award
18 under paragraph (1) or (2) to improve the ef-
19 fectiveness of the programs operated by such
20 entities or to enable the entities to respond to
21 changes affecting such entities arising since the
22 date of the receipt of the award under para-
23 graph (1) or (2).

24 “(B) APPLICATION.—To receive an award
25 under this paragraph, an entity described under

1 subparagraph (A) shall submit to the Secretary
2 an application at such time, in such manner,
3 and containing such information as the Sec-
4 retary may require, including an explanation of
5 the changes affecting such entity arising since
6 the date of the receipt by the entity of the
7 award under paragraph (1) or (2), such as
8 changes in the demographics of the area served,
9 the needs of the population served, and the sit-
10 uations encountered by such population and
11 such entity.”.

12 (2) AUTHORIZATION OF APPROPRIATIONS.—
13 Section 757 of the Public Health Service Act (42
14 U.S.C. 294g) is amended—

15 (A) in subsection (a), by striking
16 “\$55,600,000” and all that follows through
17 “2002” and inserting “\$125,000,000 for fiscal
18 year 2008 and such sums as may be necessary
19 for each of fiscal years 2009 through 2012”;

20 (B) by striking subsection (b) and insert-
21 ing the following:

22 “(b) ALLOCATION.—

23 “(1) IN GENERAL.—Of the amounts appro-
24 priated under subsection (a) that the Secretary

1 makes available for each fiscal year to carry out sec-
2 tion 751, the Secretary shall obligate—

3 “(A) for awards under paragraph (1) of
4 section 751(a), not more than 25 percent of
5 such amounts in each fiscal year; and

6 “(B) for awards under paragraphs (2) and
7 (3) of section 751(a), not less than 60 percent
8 of such amounts in each fiscal year.”; and

9 (C) in subsection (c), by—

10 (i) striking the subsection designation
11 and heading and inserting the following:

12 “(c) SENSE OF THE CONGRESS.—It is the sense of
13 the Congress that—”.

14 (ii) striking paragraph (1); and

15 (iii) in paragraph (2), by—

16 (I) striking the paragraph des-
17 ignation and all that follows through
18 “Congress that—”; and

19 (II) redesignating subparagraphs
20 (A) and (B) as paragraphs (1) and
21 (2) and indenting appropriately.

22 **SEC. 207. LOAN REPAYMENT PROGRAM OF THE CENTERS**
23 **FOR DISEASE CONTROL AND PREVENTION.**

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

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

2 (2) by inserting before the period the following:

3 “\$750,000 for fiscal year 2008, and such sums as
4 may be necessary for each of the fiscal years 2009
5 through 2013.”.

6 **SEC. 208. STRENGTHENING AND EXPANDING RURAL**
7 **HEALTH PROVIDER NETWORKS.**

8 Section 330A of the Public Health Service Act (42
9 U.S.C. 254e) is amended—

10 (1) in subsection (h), by adding at the end the
11 following:

12 “(4) RURAL MINORITY, BORDER, AND INDIAN
13 POPULATIONS.—In making grants under this sec-
14 tion, the Director of the Office of Rural Health Pol-
15 icy of the Health Resources and Services Adminis-
16 tration, in coordination with the Director of the In-
17 dian Health Service and the Deputy Assistant Sec-
18 retary for Minority Health, shall make grants to en-
19 tities that serve rural minority, border, and Indian
20 populations.

21 “(5) DIVERSITY HEALTH TRAINING PRO-
22 GRAMS.—The Director of the Office of Rural Health
23 Policy of the Health Resources and Services Admin-
24 istration, in coordination with the Director of the In-
25 dian Health Service and the Deputy Assistant Sec-

1 retary for Minority Health, shall coordinate the
2 awarding of grants under this section with the
3 awarding of grants and contracts under section 765
4 to connect and integrate diversity health training
5 programs.”; and

6 (2) in subsection (j), by striking “and such
7 sums as may be necessary for each of fiscal years
8 2003 through 2006” and inserting “, such sums as
9 may be necessary for each of fiscal years 2008
10 through 2010, and \$60,000,000 for each of fiscal
11 years 2011 through 2015”.

12 **SEC. 209. MCNAIR POSTBACCALAUREATE ACHIEVEMENT**
13 **PROGRAM.**

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

17 “(f) COLLABORATION IN HEALTH PROFESSION DI-
18 VERSITY TRAINING PROGRAMS.—The Secretary of Edu-
19 cation shall coordinate with the Secretary of Health and
20 Human Services to ensure that there is collaboration be-
21 tween the goals of the program under this section and pro-
22 grams of the Health Resources and Services Administra-
23 tion that promote health workforce diversity. The Sec-
24 retary of Education shall take such measures as may be

1 necessary to encourage participants in programs under
2 this section to consider health profession careers.

3 “(g) FUNDING.—From amounts appropriated pursu-
4 ant to the authority of section 402A(f), the Secretary
5 shall, to the extent practicable, allocate funds for projects
6 authorized by this section in an amount which is not less
7 than \$31,000,000 for each of the fiscal years 2008
8 through 2014.”.

9 **SEC. 210. ENSURING PROPORTIONAL REPRESENTATION OF**
10 **INTERESTS OF RURAL AREAS ON MEDPAC.**

11 (a) IN GENERAL.—Section 1805(c)(2) of the Social
12 Security Act (42 U.S.C. 1395b–6(c)(2)) is amended—

13 (1) in subparagraph (A), by inserting “con-
14 sistent with subparagraph (E)” after “rural rep-
15 resentatives”; and

16 (2) by adding at the end the following new sub-
17 paragraph:

18 “(E) PROPORTIONAL REPRESENTATION OF
19 INTERESTS OF RURAL AREAS.—In order to pro-
20 vide a balance between urban and rural rep-
21 resentatives under subparagraph (A), the pro-
22 portion of members who represent the interests
23 of health care providers and Medicare bene-
24 ficiaries located in rural areas shall be no less
25 than the proportion, of the total number of

1 Medicare beneficiaries, who reside in rural
2 areas.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply with respect to appointments
5 made to the Medicare Payment Advisory Commission after
6 the date of the enactment of this Act.

7 **TITLE III—DATA COLLECTION**
8 **AND REPORTING**

9 **SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
10 **ACT.**

11 (a) PURPOSE.—It is the purpose of this section to
12 promote data collection, analysis, and reporting by race,
13 ethnicity, and primary language among federally sup-
14 ported health programs.

15 (b) AMENDMENT.—Title XXX of the Public Health
16 Service Act, as amended by title II of this Act, is further
17 amended by adding at the end the following:

18 **“Subtitle B—Strengthening Data**
19 **Collection, Improving Data**
20 **Analysis, and Expanding Data**
21 **Reporting**

22 **“SEC. 3031. DATA ON RACE, ETHNICITY, AND PRIMARY LAN-**
23 **GUAGE.**

24 **“(a) REQUIREMENTS.—**

1 “(1) IN GENERAL.—Each health-related pro-
2 gram operated by or that receives funding or reim-
3 bursement, in whole or in part, either directly or in-
4 directly from the Department of Health and Human
5 Services shall—

6 “(A) require the collection, by the agency
7 or program involved, of data on the race, eth-
8 nicity, and primary language of each applicant
9 for and recipient of health-related assistance
10 under such program—

11 “(i) using, at a minimum, the cat-
12 egories for race and ethnicity described in
13 the 1997 Office of Management and Budget
14 Standards for Maintaining, Collecting,
15 and Presenting Federal Data on Race and
16 Ethnicity;

17 “(ii) using the standards developed
18 under subsection (e) for the collection of
19 language data;

20 “(iii) collecting data for additional
21 population groups if such groups can be
22 aggregated into the minimum race and
23 ethnicity categories; and

24 “(iv) where practicable, through self-
25 report;

1 “(B) with respect to the collection of the
2 data described in subparagraph (A) for appli-
3 cants and recipients who are minors or other-
4 wise legally incapacitated, require that—

5 “(i) such data be collected from the
6 parent or legal guardian of such an appli-
7 cant or recipient; and

8 “(ii) the preferred language of the
9 parent or legal guardian of such an appli-
10 cant or recipient be collected;

11 “(C) systematically analyze such data
12 using the smallest appropriate units of analysis
13 feasible to detect racial and ethnic disparities in
14 health and health care and when appropriate,
15 for men and women separately, and report the
16 results of such analysis to the Secretary, the
17 Director of the Office for Civil Rights, the Com-
18 mittee on Health, Education, Labor, and Pen-
19 sions and the Committee on Finance of the
20 Senate, and the Committee on Energy and
21 Commerce and the Committee on Ways and
22 Means of the House of Representatives;

23 “(D) provide such data to the Secretary on
24 at least an annual basis; and

1 “(E) ensure that the provision of assist-
2 ance to an applicant or recipient of assistance
3 is not denied or otherwise adversely affected be-
4 cause of the failure of the applicant or recipient
5 to provide race, ethnicity, and primary language
6 data.

7 “(2) RULES OF CONSTRUCTION.—Nothing in
8 this subsection shall be construed to—

9 “(A) permit the use of information col-
10 lected under this subsection in a manner that
11 would adversely affect any individual providing
12 any such information; and

13 “(B) require health care providers to col-
14 lect data.

15 “(b) PROTECTION OF DATA.—The Secretary shall
16 ensure (through the promulgation of regulations or other-
17 wise) that all data collected pursuant to subsection (a) is
18 protected—

19 “(1) under the same privacy protections as the
20 Secretary applies to other health data under the reg-
21 ulations promulgated under section 264(c) of the
22 Health Insurance Portability and Accountability Act
23 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
24 lating to the privacy of individually identifiable
25 health information and other protections; and

1 “(2) from all inappropriate internal use by any
2 entity that collects, stores, or receives the data, in-
3 cluding use of such data in determinations of eligi-
4 bility (or continued eligibility) in health plans, and
5 from other inappropriate uses, as defined by the
6 Secretary.

7 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
8 Secretary shall develop and implement a national plan to
9 ensure the collection of data in a culturally appropriate
10 and competent manner, and to improve the collection,
11 analysis, and reporting of racial, ethnic, and primary lan-
12 guage data at the Federal, State, territorial, Tribal, and
13 local levels, including data to be collected under subsection
14 (a). The Data Council of the Department of Health and
15 Human Services, in consultation with the National Com-
16 mittee on Vital Health Statistics, the Office of Minority
17 Health, and other appropriate public and private entities,
18 shall make recommendations to the Secretary concerning
19 the development, implementation, and revision of the na-
20 tional plan. Such plan shall include recommendations on
21 how to—

22 “(1) implement subsection (a) while minimizing
23 the cost and administrative burdens of data collec-
24 tion and reporting;

1 “(2) expand awareness among Federal agencies,
2 States, territories, Indian tribes, health providers,
3 health plans, health insurance issuers, and the gen-
4 eral public that data collection, analysis, and report-
5 ing by race, ethnicity, and primary language is legal
6 and necessary to assure equity and non-discrimina-
7 tion in the quality of health care services;

8 “(3) ensure that future patient record systems
9 have data code sets for racial, ethnic, and primary
10 language identifiers and that such identifiers can be
11 retrieved from clinical records, including records
12 transmitted electronically;

13 “(4) improve health and health care data collec-
14 tion and analysis for more population groups if such
15 groups can be aggregated into the minimum race
16 and ethnicity categories, including exploring the fea-
17 sibility of enhancing collection efforts in States for
18 racial and ethnic groups that comprise a significant
19 proportion of the population of the State;

20 “(5) provide researchers with greater access to
21 racial, ethnic, and primary language data, subject to
22 privacy and confidentiality regulations; and

23 “(6) safeguard and prevent the misuse of data
24 collected under subsection (a).

1 “(d) COMPLIANCE WITH STANDARDS.—Data col-
2 lected under subsection (a) shall be obtained, maintained,
3 and presented (including for reporting purposes) in ac-
4 cordance with the 1997 Office of Management and Budget
5 Standards for Maintaining, Collecting, and Presenting
6 Federal Data on Race and Ethnicity (at a minimum).

7 “(e) LANGUAGE COLLECTION STANDARDS.—Not
8 later than 1 year after the date of enactment of this title,
9 the Deputy Assistant Secretary for Minority Health, in
10 consultation with the Office for Civil Rights of the Depart-
11 ment of Health and Human Services, shall develop and
12 disseminate Standards for the Classification of Federal
13 Data on Preferred Written and Spoken Language.

14 “(f) TECHNICAL ASSISTANCE FOR THE COLLECTION
15 AND REPORTING OF DATA.—

16 “(1) IN GENERAL.—The Secretary may, either
17 directly or through grant or contract, provide tech-
18 nical assistance to enable a health care program or
19 an entity operating under such program to comply
20 with the requirements of this section.

21 “(2) TYPES OF ASSISTANCE.—Assistance pro-
22 vided under this subsection may include assistance
23 to—

1 “(A) enhance or upgrade computer tech-
2 nology that will facilitate racial, ethnic, and pri-
3 mary language data collection and analysis;

4 “(B) improve methods for health data col-
5 lection and analysis including additional popu-
6 lation groups beyond the Office of Management
7 and Budget categories if such groups can be
8 aggregated into the minimum race and ethnicity
9 categories;

10 “(C) develop mechanisms for submitting
11 collected data subject to existing privacy and
12 confidentiality regulations; and

13 “(D) develop educational programs to in-
14 form health insurance issuers, health plans,
15 health providers, health-related agencies, and
16 the general public that data collection and re-
17 porting by race, ethnicity, and preferred lan-
18 guage are legal and essential for eliminating
19 health and health care disparities.

20 “(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The
21 Secretary, acting through the Director of the Agency for
22 Healthcare Research and Quality and in coordination with
23 the Administrator of the Centers for Medicare & Medicaid
24 Services, shall provide technical assistance to agencies of
25 the Department of Health and Human Services in meeting

1 Federal standards for race, ethnicity, and primary lan-
2 guage data collection and analysis of racial and ethnic dis-
3 parities in health and health care in public programs by—

4 “(1) identifying appropriate quality assurance
5 mechanisms to monitor for health disparities;

6 “(2) specifying the clinical, diagnostic, or thera-
7 peutic measures which should be monitored;

8 “(3) developing new quality measures relating
9 to racial and ethnic disparities in health and health
10 care;

11 “(4) identifying the level at which data analysis
12 should be conducted; and

13 “(5) sharing data with external organizations
14 for research and quality improvement purposes.

15 “(h) REPORT.—Not later than 2 years after the date
16 of enactment of this title, and biennially thereafter, the
17 Secretary shall submit to the appropriate committees of
18 Congress a report on the effectiveness of data collection,
19 analysis, and reporting on race, ethnicity, and primary
20 language under the programs and activities of the Depart-
21 ment of Health and Human Services and under other Fed-
22 eral data collection systems with which the Department
23 interacts to collect relevant data on race and ethnicity.
24 The report shall evaluate the progress made in the De-

1 partment with respect to the national plan under sub-
2 section (c) or subsequent revisions thereto.

3 “(i) DEFINITION.—In this section, the term ‘health-
4 related program’ mean a program—

5 “(1) under the Social Security Act (42 U.S.C.
6 301 et seq.) that pay for health care and services;
7 and

8 “(2) under this Act that provide Federal finan-
9 cial assistance for health care, biomedical research,
10 health services research, and programs designed to
11 improve the public’s health.

12 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
13 is authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2008 through 2013.

16 **“SEC. 3032. PROVISIONS RELATING TO NATIVE AMERICANS.**

17 “(a) ESTABLISHMENT OF EPIDEMIOLOGY CEN-
18 TERS.—The Secretary shall establish an epidemiology cen-
19 ter in each service area to carry out the functions de-
20 scribed in subsection (b). Any new center established after
21 the date of the enactment of the Health Equity and Ac-
22 countability Act of 2007 may be operated under a grant
23 authorized by subsection (d), but funding under such a
24 grant shall not be divisible.

1 “(b) FUNCTIONS OF CENTERS.—In consultation with
2 and upon the request of Indian Tribes, Tribal Organiza-
3 tions, and Urban Indian Organizations, each service area
4 epidemiology center established under this subsection
5 shall, with respect to such service area—

6 “(1) collect data relating to, and monitor
7 progress made toward meeting, each of the health
8 status objectives of the Service, the Indian Tribes,
9 Tribal Organizations, and Urban Indian Organiza-
10 tions in the service area;

11 “(2) evaluate existing delivery systems, data
12 systems, and other systems that impact the improve-
13 ment of Indian health;

14 “(3) assist Indian Tribes, Tribal Organizations,
15 and Urban Indian Organizations in identifying their
16 highest priority health status objectives and the
17 services needed to achieve such objectives, based on
18 epidemiological data;

19 “(4) make recommendations for the targeting
20 of services needed by the populations served;

21 “(5) make recommendations to improve health
22 care delivery systems for Indians and Urban Indi-
23 ans;

24 “(6) provide requested technical assistance to
25 Indian Tribes, Tribal Organizations, and Urban In-

1 dian Organizations in the development of local
2 health service priorities and incidence and prevalence
3 rates of disease and other illness in the community;
4 and

5 “(7) provide disease surveillance and assist In-
6 dian Tribes, Tribal Organizations, and Urban Indian
7 Organizations to promote public health.

8 “(c) TECHNICAL ASSISTANCE.—The Director of the
9 Centers for Disease Control and Prevention shall provide
10 technical assistance to the centers in carrying out the re-
11 quirements of this subsection.

12 “(d) GRANTS FOR STUDIES.—

13 “(1) IN GENERAL.—The Secretary may make
14 grants to Indian Tribes, Tribal Organizations,
15 Urban Indian Organizations, and eligible intertribal
16 consortia to conduct epidemiological studies of In-
17 dian communities.

18 “(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An
19 intertribal consortium is eligible to receive a grant
20 under this subsection if—

21 “(A) the intertribal consortium is incor-
22 porated for the primary purpose of improving
23 Indian health; and

24 “(B) the intertribal consortium is rep-
25 resentative of the Indian Tribes or urban In-

1 dian communities in which the intertribal con-
2 sortium is located.

3 “(3) APPLICATIONS.—An application for a
4 grant under this subsection shall be submitted in
5 such manner and at such time as the Secretary shall
6 prescribe.

7 “(4) REQUIREMENTS.—An applicant for a
8 grant under this subsection shall—

9 “(A) demonstrate the technical, adminis-
10 trative, and financial expertise necessary to
11 carry out the functions described in paragraph
12 (5);

13 “(B) consult and cooperate with providers
14 of related health and social services in order to
15 avoid duplication of existing services; and

16 “(C) demonstrate cooperation from Indian
17 tribes or Urban Indian Organizations in the
18 area to be served.

19 “(5) USE OF FUNDS.—A grant awarded under
20 paragraph (1) may be used—

21 “(A) to carry out the functions described
22 in subsection (b);

23 “(B) to provide information to and consult
24 with tribal leaders, urban Indian community

1 leaders, and related health staff on health care
2 and health service management issues; and

3 “(C) in collaboration with Indian Tribes,
4 Tribal Organizations, and urban Indian com-
5 munities, to provide the Service with informa-
6 tion regarding ways to improve the health sta-
7 tus of Indians.

8 “(e) ACCESS TO INFORMATION.—An epidemiology
9 center operated by a grantee pursuant to a grant awarded
10 under subsection (d) shall be treated as a public health
11 authority for purposes of the Health Insurance Portability
12 and Accountability Act of 1996 (Public Law 104–191; 110
13 Stat. 2033), as such entities are defined in part 164.501
14 of title 45, Code of Federal Regulations (or a successor
15 regulation). The Secretary shall grant such grantees ac-
16 cess to and use of data, data sets, monitoring systems,
17 delivery systems, and other protected health information
18 in the possession of the Secretary.”.

19 **SEC. 302. COLLECTION OF RACE AND ETHNICITY DATA BY**
20 **THE SOCIAL SECURITY ADMINISTRATION.**

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

1 **“SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA**
2 **BY THE SOCIAL SECURITY ADMINISTRATION.**

3 “(a) REQUIREMENT.—The Commissioner of Social
4 Security, in consultation with the Administrator of the
5 Centers for Medicare & Medicaid Services, shall—

6 “(1) require the collection of data on the race,
7 ethnicity, and primary language of all applicants for
8 social security account numbers or benefits under
9 title II or part A of title XVIII and all individuals
10 with respect to whom the Commissioner maintains
11 records of wages and self-employment income in ac-
12 cordance with reports received by the Commissioner
13 or the Secretary of the Treasury—

14 “(A) using, at a minimum, the categories
15 for race and ethnicity described in the 1997 Of-
16 fice of Management and Budget Standards for
17 Maintaining, Collecting, and Presenting Federal
18 Data on Race and Ethnicity and available lan-
19 guage standards; and

20 “(B) where practicable, collecting data for
21 additional population groups if such groups can
22 be aggregated into the minimum race and eth-
23 nicity categories;

24 “(2) with respect to the collection of the data
25 described in paragraph (1) for applicants who are

1 under 18 years of age or otherwise legally incapacitated, require that—

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

3 “(B) the primary language of the parent or legal guardian of such an applicant or recipient be used;

4 “(3) require that such data be uniformly analyzed and reported at least annually to the Commissioner of Social Security;

5 “(4) be responsible for storing the data reported under paragraph (3);

6 “(5) ensure transmission to the Centers for Medicare & Medicaid Services and other Federal health agencies;

7 “(6) provide such data to the Secretary on at least an annual basis; and

8 “(7) ensure that the provision of assistance to an applicant is not denied or otherwise adversely affected because of the failure of the applicant to provide race, ethnicity, and primary language data.

9 “(b) PROTECTION OF DATA.—The Commissioner of Social Security shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant subsection (a) is protected—

1 “(1) under the same privacy protections as the
2 Secretary applies to health data under the regula-
3 tions promulgated under section 264(c) of the
4 Health Insurance Portability and Accountability Act
5 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
6 lating to the privacy of individually identifiable
7 health information and other protections; and

8 “(2) from all inappropriate internal use by any
9 entity that collects, stores, or receives the data, in-
10 cluding use of such data in determinations of eligi-
11 bility (or continued eligibility) in health plans, and
12 from other inappropriate uses, as defined by the
13 Secretary.

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

19 “(d) TECHNICAL ASSISTANCE.—The Secretary may,
20 either directly or by grant or contract, provide technical
21 assistance to enable any health entity to comply with the
22 requirements of this section.

23 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated to carry out this section,

1 such sums as may be necessary for each of fiscal years
2 2008 through 2013.”.

3 **SEC. 303. REVISION OF HIPAA CLAIMS STANDARDS.**

4 (a) IN GENERAL.—Not later than 1 year after the
5 date of enactment of this Act, the Secretary of Health and
6 Human Services shall revise the regulations promulgated
7 under part C of title XI of the Social Security Act (42
8 U.S.C. 1320d et seq.), as added by the Health Insurance
9 Portability and Accountability Act of 1996 (Public Law
10 104–191), relating to the collection of data on race, eth-
11 nicity, and primary language in a health-related trans-
12 action to require—

13 (1) the use, at a minimum, of the categories for
14 race and ethnicity described in the 1997 Office of
15 Management and Budget Standards for Maintain-
16 ing, Collecting, and Presenting Federal Data on
17 Race and Ethnicity;

18 (2) the establishment of a new data code set for
19 primary language; and

20 (3) the designation of the racial, ethnic, and
21 primary language code sets as “required” for claims
22 and enrollment data.

23 (b) DISSEMINATION.—The Secretary of Health and
24 Human Services shall disseminate the new standards de-
25 veloped under subsection (a) to all health entities that are

1 subject to the regulations described in such subsection and
2 provide technical assistance with respect to the collection
3 of the data involved.

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

9 **SEC. 304. NATIONAL CENTER FOR HEALTH STATISTICS.**

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

12 (1) in paragraph (1), by striking “2003” and
13 inserting “2012”;

14 (2) in paragraph (2), in the first sentence, by
15 striking “2003” and inserting “2012”; and

16 (3) in paragraph (3), by striking “2002” and
17 inserting “2012”.

18 **SEC. 305. GEO-ACCESS STUDY.**

19 The Administrator of the Substance Abuse and Men-
20 tal Health Services Administration shall—

21 (1) conduct a study to—

22 (A) determine which geographic areas of
23 the United States have shortages of specialty
24 mental health providers; and

1 (B) assess the preparedness of speciality
2 mental health providers to deliver culturally and
3 linguistically appropriate services; and

4 (2) submit a report to the Congress on the re-
5 sults of such study.

6 **SEC. 306. RACIAL, ETHNIC, AND LINGUISTIC DATA COL-**
7 **LECTED BY THE FEDERAL GOVERNMENT.**

8 (a) COLLECTION; SUBMISSION.—Not later than 90
9 days after the date of the enactment of this Act, and Jan-
10 uary 31st of each year thereafter, each department, agen-
11 cy, and office of the Federal Government that has col-
12 lected racial, ethnic, or linguistic data during the pre-
13 ceding calendar year shall submit such data to the Sec-
14 retary of Health and Human Services.

15 (b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
16 Not later than April 30, 2008, and each April 30th there-
17 after, the Secretary of Health and Human Services, acting
18 through the Director of the National Center on Minority
19 Health and Health Disparities and the Deputy Assistant
20 Secretary for Minority Health, shall—

21 (1) collect and analyze the racial, ethnic, and
22 linguistic data submitted under subsection (a) for
23 the preceding calendar year;

24 (2) make publicly available such data and the
25 results of such analysis; and

1 (3) submit a report to the Congress on such
2 data and analysis.

3 **SEC. 307. HEALTH INFORMATION TECHNOLOGY GRANTS.**

4 (a) **AUTHORITY.**—The Deputy Assistant Secretary
5 for Minority Health, in coordination with the Office of the
6 National Coordinator for Health Information Technology,
7 the Health Resources and Services Administration, the
8 Substance Abuse and Mental Health Services Administra-
9 tion, and the National Center on Minority Health and
10 Health Disparities, may award grants to appropriate enti-
11 ties for the purpose of ensuring appropriate and best prac-
12 tices to collect appropriate data and documents on the re-
13 duction of health disparities.

14 (b) **USE OF FUNDS.**—A grant received under sub-
15 section (a) shall be used to achieve the purpose described
16 in such subsection through one or more of the following:

17 (1) Purchasing new, or enhancing existing,
18 health information technology.

19 (2) Providing support and training to providers
20 concerning such technology.

21 (3) Conducting outreach and education on
22 health information technology and its benefits to pa-
23 tients, physicians, allied health professionals, and
24 advocacy groups in medically underserved commu-

1 nities (as defined in section 799B of the Public
2 Health Service Act (42 U.S.C. 295p)).

3 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
4 out this section, there are authorized to be appropriated
5 \$20,000,000 for each of fiscal years 2008 through 2013.

6 **SEC. 308. STUDY OF HEALTH INFORMATION TECHNOLOGY**
7 **IN MEDICALLY UNDERSERVED COMMU-**
8 **NITIES.**

9 (a) STUDY.—The National Coordinator for Health
10 Information Technology shall conduct a study on the de-
11 velopment and implementation of health information tech-
12 nology in medically underserved communities. The study
13 shall—

14 (1) identify barriers to successful implementa-
15 tion of health information technology in these com-
16 munities;

17 (2) examine the impact of health information
18 technology on providing quality care and reducing
19 the cost of care to these communities;

20 (3) examine urban and rural community health
21 systems and determine the impact that health infor-
22 mation technology may have on the capacity of pri-
23 mary health providers; and

1 (4) assess the feasibility and the costs of associ-
2 ated with the use of health information technology
3 in these communities.

4 (b) REPORT.—Not later than 18 months after the
5 date of the enactment of this Act, the National Coordi-
6 nator for Health Information Technology shall submit to
7 the Congress a report on the study conducted under sub-
8 section (a) and shall include in such report such rec-
9 ommendations for legislation or administrative action as
10 the Coordinator determines appropriate.

11 **SEC. 309. HEALTH INFORMATION TECHNOLOGY IN MEDI-**
12 **CALLY UNDERSERVED COMMUNITIES.**

13 The National Coordinator for Health Information
14 Technology shall—

15 (1) identify sources of funds that will be made
16 available to promote and support the planning and
17 adoption of health information technology in medi-
18 cally underserved communities (as defined in section
19 799B of the Public Health Service Act (42 U.S.C.
20 295p)), including in urban and rural areas, either
21 through grants or technical assistance;

22 (2) coordinate with the funding sources to help
23 such communities connect to identified funding; and

24 (3) collaborate with the Agency for Healthcare
25 Research and Quality, the Health Resources and

1 Services Administration, and other Federal agencies
2 to support technical assistance, knowledge dissemi-
3 nation, and resource development, to such commu-
4 nities seeking to plan for and adopt technology and
5 establish electronic health information networks
6 across providers.

7 **SEC. 310. DATA COLLECTION AND ANALYSIS GRANTS TO MI-**
8 **NORITY-SERVING INSTITUTIONS.**

9 (a) **AUTHORITY.**—The Secretary of Health and
10 Human Services, acting through the Center on Minority
11 Health and Health Disparities and the Office of Minority
12 Health, may award grants to access and analyze racial and
13 ethnic, and where possible, primary language data to mon-
14 itor and report on progress to reduce and eliminate racial
15 and ethnic disparities in health and health care.

16 (b) **ELIGIBLE ENTITY.**—In this section, the term “el-
17 igible entity” means a historically Black college or univer-
18 sity, an Hispanic-serving institution, a tribal college or
19 university, or an Asian American and Pacific Islander-
20 serving institution with an accredited public health, health
21 policy, or health services research program.

22 **SEC. 311. HEALTH INFORMATION TECHNOLOGY GRANTS**
23 **FOR RURAL HEALTH CARE PROVIDERS.**

24 Title II of the Public Health Service Act is amended
25 by adding at the end the following new part:

1 **“PART D—HEALTH INFORMATION TECHNOLOGY**
2 **GRANTS**

3 **“SEC. 271. GRANTS TO FACILITATE THE WIDESPREAD**
4 **ADOPTION OF INTEROPERABLE HEALTH IN-**
5 **FORMATION TECHNOLOGY IN RURAL AREAS.**

6 “(a) **COMPETITIVE GRANTS TO ELIGIBLE ENTITIES**
7 **IN RURAL AREAS.—**

8 “(1) **IN GENERAL.—**The Secretary may award
9 competitive grants to eligible entities in rural areas
10 to facilitate the purchase and enhance the utilization
11 of qualified health information technology systems to
12 improve the quality and efficiency of health care.

13 “(2) **ELIGIBILITY.—**To be eligible to receive a
14 grant under paragraph (1) an entity shall—

15 “(A) submit to the Secretary an applica-
16 tion at such time, in such manner, and con-
17 taining such information as the Secretary may
18 require;

19 “(B) submit to the Secretary a strategic
20 plan for the implementation of data sharing
21 and interoperability measures;

22 “(C) be a rural health care provider;

23 “(D) adopt any applicable core interoper-
24 ability guidelines (endorsed under other provi-
25 sions of law);

1 “(E) agree to notify patients if their indi-
2 vidually identifiable health information is
3 wrongfully disclosed;

4 “(F) demonstrate significant financial
5 need; and

6 “(G) provide matching funds in accordance
7 with paragraph (4).

8 “(3) USE OF FUNDS.—Amounts received under
9 a grant under this subsection shall be used to facili-
10 tate the purchase and enhance the utilization of
11 qualified health information technology systems and
12 training personnel in the use of such technology.

13 “(4) MATCHING REQUIREMENT.—To be eligible
14 for a grant under this subsection an entity shall con-
15 tribute non-Federal contributions to the costs of car-
16 rying out the activities for which the grant is award-
17 ed in an amount equal to \$1 for each \$3 of Federal
18 funds provided under the grant.

19 “(5) LIMIT ON GRANT AMOUNT.—In no case
20 shall the payment amount under this subsection with
21 respect to the purchase or enhanced utilization of
22 qualified health information technology for a rural
23 health care provider, in addition to the amount of
24 any loan made to the provider from a grant to a
25 State under subsection (b) for such purpose, exceed

1 100 percent of the provider’s costs for such purchase
2 or enhanced utilization (taking into account costs for
3 training, implementation, and maintenance).

4 “(6) PREFERENCE IN AWARDING GRANTS.—In
5 awarding grants to eligible entities under this sub-
6 section, the Secretary shall give preference to each
7 of the following types of applicants:

8 “(A) An entity that is located in a frontier
9 or other rural underserved area as determined
10 by the Secretary.

11 “(B) An entity that will link, to the extent
12 practicable, the qualified health information
13 system to a local or regional health information
14 plan or plans.

15 “(C) A rural health care provider that is a
16 nonprofit hospital or a Federally qualified
17 health center.

18 “(D) A rural health care provider that is
19 an individual practice or group practice.

20 “(b) AUTHORIZATION OF APPROPRIATIONS.—

21 “(1) IN GENERAL.—For the purpose of car-
22 rying out this section, there is authorized to be ap-
23 propriated \$20,000,000 for fiscal year 2008,
24 \$30,000,000 for fiscal year 2009, and such sums as

1 may be necessary, but not to exceed \$30,000,000 for
2 each of fiscal years 2010 through 2012.

3 “(2) AVAILABILITY.—Amounts appropriated
4 under paragraph (1) shall remain available through
5 fiscal year 2011.

6 “(c) DEFINITIONS.—In this section:

7 “(1) FEDERALLY QUALIFIED HEALTH CEN-
8 TER.—The term ‘Federally qualified health center’
9 has the meaning given that term in section
10 1861(aa)(4) of the Social Security Act (42 U.S.C.
11 1395x(aa)(4)).

12 “(2) GROUP PRACTICE.—The term ‘group prac-
13 tice’ has the meaning given that term in section
14 1877(h)(4) of the Social Security Act (42 U.S.C.
15 1395nn(h)(4)).

16 “(3) HEALTH CARE PROVIDER.—The term
17 ‘health care provider’ means a hospital, skilled nurs-
18 ing facility, home health agency (as defined in sub-
19 section (o) of section 1861 of the Social Security
20 Act, 42 U.S.C. 1395x), health care clinic, rural
21 health clinic, Federally qualified health center, group
22 practice, a pharmacist, a pharmacy, a laboratory, a
23 physician (as defined in subsection (r) of such sec-
24 tion), a practitioner (as defined in section
25 1842(b)(18)(CC) of such Act, 42 U.S.C.

1 1395u(b)(18)(CC)), a health facility operated by or
2 pursuant to a contract with the Indian Health Serv-
3 ice, and any other category of facility or clinician de-
4 termined appropriate by the Secretary.

5 “(4) HEALTH INFORMATION; INDIVIDUALLY
6 IDENTIFIABLE HEALTH INFORMATION.—The terms
7 ‘health information’ and ‘individually identifiable
8 health information’ have the meanings given those
9 terms in paragraphs (4) and (6), respectively, of sec-
10 tion 1171 of the Social Security Act (42 U.S.C.
11 1320d).

12 “(5) LABORATORY.—The term ‘laboratory’ has
13 the meaning given that term in section 353.

14 “(6) PHARMACIST.—The term ‘pharmacist’ has
15 the meaning given that term in section 804(a)(2) of
16 the Federal Food, Drug, and Cosmetic Act (21
17 U.S.C. 384(a)(2)).

18 “(7) QUALIFIED HEALTH INFORMATION TECH-
19 NOLOGY.—The term ‘qualified health information
20 technology’ means a system or components of health
21 information technology that meet any applicable core
22 interoperability guidelines (endorsed under applica-
23 ble provisions of law) when in use or that use inter-
24 face software that allows for interoperability in ac-
25 cordance with such guidelines.

1 “(8) RURAL AREA.—The term ‘rural area’ has
2 the meaning given such term for purposes of section
3 1886(d)(2)(D) of the Social Security Act (42 U.S.C.
4 1395ww(d)(2)(D)).

5 “(9) RURAL HEALTH CARE PROVIDER.—The
6 term ‘rural health care provider’ means a health
7 care provider that is located in a rural area.”.

8 **TITLE IV—ACCOUNTABILITY**
9 **AND EVALUATION**

10 **Subtitle A—General Provisions**

11 **SEC. 401. FEDERAL AGENCY PLAN TO ELIMINATE DISPARI-**
12 **TIES AND IMPROVE THE HEALTH OF MINOR-**
13 **ITY POPULATIONS.**

14 (a) IN GENERAL.—Not later than September 1,
15 2008, each Federal health agency shall develop and imple-
16 ment a national strategic action plan to eliminate dispari-
17 ties on the basis of race, ethnicity, and primary language
18 and improve the health and health care of minority popu-
19 lations, through programs relevant to the mission of the
20 agency.

21 (b) PUBLICATION.—Each action plan described in
22 paragraph (1) shall—

23 (1) be publicly reported in draft form for public
24 review and comment;

1 (2) include a response to the review and com-
2 ment described in paragraph (1) in the final plan;

3 (3) include the agency response to the 2002 In-
4 stitute of Medicine report, Unequal Treatment—
5 Confronting Racial and Ethnic Disparities in
6 Healthcare;

7 (4) respond to data and analyses presented in
8 the National Healthcare Disparities Report and the
9 National Healthcare Quality Report published annu-
10 ally by the Agency for Healthcare Research and
11 Quality;

12 (5) demonstrate progress in meeting the
13 Healthy People 2010 objectives; and

14 (6) be updated, including progress reports, for
15 inclusion in an annual report to Congress.

16 **SEC. 402. ACCOUNTABILITY WITHIN THE DEPARTMENT OF**
17 **HEALTH AND HUMAN SERVICES.**

18 Title XXX of the Public Health Service Act, as
19 amended by titles II and III of this Act, is further amend-
20 ed by adding at the end the following:

21 **“Subtitle C—Strengthening**
22 **Accountability**

23 **“SEC. 3041. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

24 “(a) IN GENERAL.—The Secretary shall establish
25 within the Office for Civil Rights an Office of Health Dis-

1 parities, which shall be headed by a director to be ap-
2 pointed by the Secretary.

3 “(b) PURPOSE.—The Office of Health Disparities
4 shall ensure that the health programs, activities, and oper-
5 ations of health entities which receive Federal financial as-
6 sistance are in compliance with title VI of the Civil Rights
7 Act, which prohibits discrimination on the basis of race,
8 color, or national origin. The activities of the Office shall
9 include the following:

10 “(1) The development and implementation of
11 an action plan to address racial and ethnic health
12 care disparities, which shall address concerns relat-
13 ing to the Office for Civil Rights as released by the
14 United States Commission on Civil Rights in the re-
15 port entitled ‘Health Care Challenge: Acknowledging
16 Disparity, Confronting Discrimination, and Ensuring
17 Equity’ (September, 1999) in conjunction with
18 the reports by the Institute of Medicine entitled ‘Un-
19 equal Treatment: Confronting Racial and Ethnic
20 Disparities in Health Care’, ‘Crossing the Quality
21 Chasm: A New Health System for the 21st Cen-
22 tury’, and ‘In the Nation’s Compelling Interest: En-
23 suring Diversity in the Health Care Workforce’ and
24 other related reports by the Institute of Medicine.
25 This plan shall be publicly disclosed for review and

1 comment and the final plan shall address any com-
2 ments or concerns that are received by the Office.

3 “(2) Investigative and enforcement actions
4 against intentional discrimination and policies and
5 practices that have a disparate impact on minorities.

6 “(3) The review of racial, ethnic, and primary
7 language health data collected by Federal health
8 agencies to assess health care disparities related to
9 intentional discrimination and policies and practices
10 that have a disparate impact on minorities.

11 “(4) Outreach and education activities relating
12 to compliance with title VI of the Civil Rights Act.

13 “(5) The provision of technical assistance for
14 health entities to facilitate compliance with title VI
15 of the Civil Rights Act.

16 “(6) Coordination and oversight of activities of
17 the civil rights compliance offices established under
18 section 3042.

19 “(7) Ensuring compliance with the 1997 Office
20 of Management and Budget Standards for Maintain-
21 ing, Collecting, and Presenting Federal Data on
22 Race, Ethnicity and the available language stand-
23 ards.

1 “(c) FUNDING AND STAFF.—The Secretary shall en-
2 sure the effectiveness of the Office of Health Disparities
3 by ensuring that the Office is provided with—

4 “(1) adequate funding to enable the Office to
5 carry out its duties under this section; and

6 “(2) staff with expertise in—

7 “(A) epidemiology;

8 “(B) statistics;

9 “(C) health quality assurance;

10 “(D) minority health and health dispari-
11 ties;

12 “(E) cultural and linguistic competency;

13 and

14 “(F) civil rights.

15 “(d) REPORT.—Not later than December 31, 2008,
16 and annually thereafter, the Secretary, in collaboration
17 with the Director of the Office for Civil Rights and the
18 Director of the Office of Minority Health, shall submit a
19 report to the Committee on Health, Education, Labor, and
20 Pensions of the Senate and the Committee on Energy and
21 Commerce of the House of Representatives that in-
22 cludes—

23 “(1) the number of cases filed, broken down by
24 category;

1 administer their programs, services, and activities in a
2 manner that—

3 “(1) does not discriminate, either intentionally
4 or in effect, on the basis of race, national origin, lan-
5 guage, ethnicity, sex, age, or disability; and

6 “(2) promotes the reduction and elimination of
7 disparities in health and health care based on race,
8 national origin, language, ethnicity, sex, age, and
9 disability.

10 “(c) POWERS AND DUTIES.—The offices established
11 in subsection (a) shall have the following powers and du-
12 ties:

13 “(1) The establishment of compliance and pro-
14 gram participation standards for recipients of Fed-
15 eral financial assistance under each program admin-
16 istered by an agency within the Department of
17 Health and Human Services including the establish-
18 ment of disparity reduction standards to encompass
19 disparities in health and health care related to race,
20 national origin, language, ethnicity, sex, age, and
21 disability.

22 “(2) The development and implementation of
23 program-specific guidelines that interpret and apply
24 Department of Health and Human Services guid-
25 ance under title VI of the Civil Rights Act of 1964

1 to each Federal health program administered by the
2 agency.

3 “(3) The development of a disparity-reduction
4 impact analysis methodology that shall be applied to
5 every rule issued by the agency and published as
6 part of the formal rulemaking process under sections
7 555, 556, and 557 of title 5, United States Code.

8 “(4) Oversight of data collection, analysis, and
9 publication requirements for all recipients of Federal
10 financial assistance under each Federal health pro-
11 gram administered by the agency, and compliance
12 with the 1997 Office of Management and Budget
13 Standards for Maintaining, Collecting, and Pre-
14 senting Federal Data on Race and Ethnicity and the
15 available language standards.

16 “(5) The conduct of publicly available studies
17 regarding discrimination within Federal health pro-
18 grams administered by the agency as well as dis-
19 parity reduction initiatives by recipients of Federal
20 financial assistance under Federal health programs.

21 “(6) Annual reports to the Committee on
22 Health, Education, Labor, and Pensions and the
23 Committee on Finance of the Senate and the Com-
24 mittee on Energy and Commerce and the Committee
25 on Ways and Means of the House of Representatives

1 on the progress in reducing disparities in health and
2 health care through the Federal programs adminis-
3 tered by the agency.

4 “(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS
5 IN THE DEPARTMENT OF JUSTICE.—

6 “(1) DEPARTMENT OF HEALTH AND HUMAN
7 SERVICES.—The Office for Civil Rights in the De-
8 partment of Health and Human Services shall pro-
9 vide standard-setting and compliance review inves-
10 tigation support services to the Civil Rights Compli-
11 ance Office for each agency.

12 “(2) DEPARTMENT OF JUSTICE.—The Office
13 for Civil Rights in the Department of Justice shall
14 continue to maintain the power to institute formal
15 proceedings when an agency Office for Civil Rights
16 determines that a recipient of Federal financial as-
17 sistance is not in compliance with the disparity re-
18 duction standards of the agency.

19 “(e) DEFINITION.—In this section, the term ‘Federal
20 health programs’ mean programs—

21 “(1) under the Social Security Act (42 U.S.C.
22 301 et seq.) that pay for health care and services;
23 and

24 “(2) under this Act that provide Federal finan-
25 cial assistance for health care, biomedical research,

1 health services research, and programs designed to
2 improve the public’s health.”.

3 **SEC. 403. OFFICE OF MINORITY HEALTH.**

4 Section 1707 of the Public Health Service Act (42
5 U.S.C. 300u–6) is amended—

6 (1) by striking subsection (b) and inserting the
7 following:

8 “(b) DUTIES.—With respect to improving the health
9 of racial and ethnic minority groups, the Secretary, acting
10 through the Deputy Assistant Secretary for Minority
11 Health (in this section referred to as the ‘Deputy Assist-
12 ant Secretary’), shall carry out the following:

13 “(1) Establish, implement, monitor, and evalu-
14 ate short-range and long-range goals and objectives
15 and oversee all other activities within the Public
16 Health Service that relate to disease prevention,
17 health promotion, service delivery, and research con-
18 cerning minority groups. The heads of each of the
19 agencies of the Service shall consult with the Deputy
20 Assistant Secretary to ensure the coordination of
21 such activities.

22 “(2) Oversee all activities within the Depart-
23 ment of Health and Human Services that relate to
24 reducing or eliminating disparities in health and
25 health care in racial and ethnic minority populations

1 and in rural and underserved communities, including
2 coordinating—

3 “(A) the design of programs, support for
4 programs, and the evaluation of programs;

5 “(B) the monitoring of trends in health
6 and health care;

7 “(C) research efforts;

8 “(D) the training of health providers; and

9 “(E) information and education programs
10 and campaigns.

11 “(3) Enter into interagency and intra-agency
12 agreements with other agencies of the Public Health
13 Service.

14 “(4) Ensure that the Federal health agencies
15 and the National Center for Health Statistics collect
16 data on the health status and health care of each
17 minority group, using at a minimum the categories
18 specified in the 1997 OMB Standards for Maintain-
19 ing, Collecting, and Presenting Federal Data on
20 Race and Ethnicity as required under subtitle B and
21 available language standards.

22 “(5) Provide technical assistance to States,
23 local agencies, territories, Indian tribes, and entities
24 for activities relating to the elimination of racial and
25 ethnic disparities in health and health care.

1 “(6) Support a national minority health re-
2 source center to carry out the following:

3 “(A) Facilitate the exchange of informa-
4 tion regarding matters relating to health infor-
5 mation, health promotion and wellness, preven-
6 tive health services, clinical trials, health infor-
7 mation technology, and education in the appro-
8 priate use of health services.

9 “(B) Facilitate timely access to culturally
10 and linguistically appropriate information.

11 “(C) Assist in the analysis of such infor-
12 mation.

13 “(D) Provide technical assistance with re-
14 spect to the exchange of such information (in-
15 cluding facilitating the development of materials
16 for such technical assistance).

17 “(7) Carry out programs to improve access to
18 health care services for individuals with limited
19 English proficiency, including developing and car-
20 rying out programs to provide bilingual or interpre-
21 tive services through the development and support of
22 the Robert T. Matsui Center for Cultural and Lin-
23 guistic Competence in Health Care as provided for
24 in section 3003.

1 “(8) Carry out programs to improve access to
2 health care services and to improve the quality of
3 health care services for individuals with low func-
4 tional health literacy. As used in the preceding sen-
5 tence, the term ‘functional health literacy’ means the
6 ability to obtain, process, and understand basic
7 health information and services needed to make ap-
8 propriate health decisions.

9 “(9) Advise in matters related to the develop-
10 ment, implementation, and evaluation of health pro-
11 fessions education on decreasing disparities in health
12 care outcomes, with focus on cultural competency as
13 a method of eliminating disparities in health and
14 health care in racial and ethnic minority popu-
15 lations.

16 “(10) Assist health care professionals, commu-
17 nity and advocacy organizations, academic centers
18 and public health departments in the design and im-
19 plementation of programs that will improve the qual-
20 ity of health outcomes by strengthening the pro-
21 vider-patient relationship.”;

22 (2) by redesignating subsections (f) through (h)
23 as subsections (g) through (i) , respectively;

24 (3) by inserting after subsection (d) the fol-
25 lowing:

1 “(f) PREPARATION OF HEALTH PROFESSIONALS TO
2 PROVIDE HEALTH CARE TO MINORITY POPULATIONS.—
3 The Secretary, in collaboration with the Director of the
4 Bureau of Health Professions and the Deputy Assistant
5 Secretary for Minority Health, shall require that health
6 professional schools that receive Federal funds train fu-
7 ture health professionals to provide culturally and linguis-
8 tically appropriate health care to diverse populations.”;
9 and

10 (4) by striking subsection (i) (as so redesign-
11 nated) and inserting the following:

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—For the
13 purpose of carrying out this section, there are authorized
14 to be appropriated \$100,000,000 for fiscal year 2008, and
15 such sums as may be necessary for each of fiscal years
16 2009 through 2013.”.

17 **SEC. 404. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
18 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
19 **SERVICE.**

20 (a) ESTABLISHMENT.—

21 (1) IN GENERAL.—In order to more effectively
22 and efficiently carry out the responsibilities, authori-
23 ties, and functions of the United States to provide
24 health care services to Indians and Indian tribes, as
25 are or may be hereafter provided by Federal statute

1 or treaties, there is established within the Public
2 Health Service of the Department of Health and
3 Human Services the Indian Health Service.

4 (2) ASSISTANT SECRETARY OF INDIAN
5 HEALTH.—The Service shall be administered by an
6 Assistant Secretary of Indian Health, who shall be
7 appointed by the President, by and with the advice
8 and consent of the Senate. The Assistant Secretary
9 shall report to the Secretary. Effective with respect
10 to an individual appointed by the President, by and
11 with the advice and consent of the Senate the term
12 of service of the Assistant Secretary shall be 4 years.
13 An Assistant Secretary may serve more than 1 term.

14 (b) AGENCY.—The Service shall be an agency within
15 the Public Health Service of the Department, and shall
16 not be an office, component, or unit of any other agency
17 of the Department.

18 (c) FUNCTIONS AND DUTIES.—The Secretary shall
19 carry out through the Assistant Secretary of the Service—

20 (1) all functions which were, on the day before
21 the date of enactment of the Indian Health Care
22 Amendments of 1988, carried out by or under the
23 direction of the individual serving as Director of the
24 Service on such day;

1 (2) all functions of the Secretary relating to the
2 maintenance and operation of hospital and health fa-
3 cilities for Indians and the planning for, and provi-
4 sion and utilization of, health services for Indians;

5 (3) all health programs under which health care
6 is provided to Indians based upon their status as In-
7 dians which are administered by the Secretary, in-
8 cluding programs under—

9 (A) the Indian Health Care Improvement
10 Act;

11 (B) the Act of November 2, 1921 (25
12 U.S.C. 13);

13 (C) the Act of August 5, 1954 (42 U.S.C.
14 2001, et seq.);

15 (D) the Act of August 16, 1957 (42
16 U.S.C. 2005 et seq.);

17 (E) the Indian Self-Determination Act (25
18 U.S.C. 450f, et seq.); and

19 (F) title XXX of the Public Health Service
20 Act, as added by this Act; and

21 (4) all scholarship and loan functions carried
22 out under title I of the Indian Health Care Improve-
23 ment Act.

24 (d) AUTHORITY.—

1 (1) IN GENERAL.—The Secretary, acting
2 through the Assistant Secretary, shall have the au-
3 thority—

4 (A) except to the extent provided for in
5 paragraph (2), to appoint and compensate em-
6 ployees for the Service in accordance with title
7 5, United States Code;

8 (B) to enter into contracts for the procure-
9 ment of goods and services to carry out the
10 functions of the Service; and

11 (C) to manage, expend, and obligate all
12 funds appropriated for the Service.

13 (2) PERSONNEL ACTIONS.—Notwithstanding
14 any other provision of law, the provisions of section
15 12 of the Act of June 18, 1934 (48 Stat. 986; 25
16 U.S.C. 472), shall apply to all personnel actions
17 taken with respect to new positions created within
18 the Service as a result of its establishment under
19 subsection (a).

20 (e) RATE OF PAY.—

21 (1) POSITIONS AT LEVEL IV.—Section 5315 of
22 title 5, United States Code, is amended by striking
23 the following: “Assistant Secretaries of Health and
24 Human Services (6).” and inserting “Assistant Sec-
25 retaries of Health and Human Services (7).”.

1 (2) POSITIONS AT LEVEL V.—Section 5316 of
2 such title is amended by striking the following: “Di-
3 rector, Indian Health Service, Department of Health
4 and Human Services.”.

5 (f) DUTIES OF ASSISTANT SECRETARY FOR INDIAN
6 HEALTH.—Section 601 of the Indian Health Care Im-
7 provement Act (25 U.S.C. 1661) is amended in subsection
8 (a)—

9 (1) by inserting “(1)” after “(a)”;

10 (2) in the second sentence of paragraph (1), as
11 so designated, by striking “a Director,” and insert-
12 ing “the Assistant Secretary for Indian Health,”;

13 (3) by striking the third sentence of paragraph
14 (1), as so designated, and all that follows through
15 the end of the subsection (a) of such section and in-
16 serting the following: “The Assistant Secretary for
17 Indian Health shall carry out the duties specified in
18 paragraph (2).”; and

19 (4) by adding after paragraph (1) the following:

20 “(2) The Assistant Secretary for Indian Health
21 shall—

22 “(A) report directly to the secretary con-
23 cerning all policy and budget-related matters
24 affecting Indian health;

1 “(B) collaborate with the Assistant Sec-
2 retary for Health concerning appropriate mat-
3 ters of Indian health that affect the agencies of
4 the Public Health Service;

5 “(C) advise each Assistant Secretary of the
6 Department of Health and Human Services
7 concerning matters of Indian health with re-
8 spect to which that Assistant Secretary has au-
9 thority and responsibility;

10 “(D) advise the heads of other agencies
11 and programs of the Department of Health and
12 Human Services concerning matters of Indian
13 health with respect to which those heads have
14 authority and responsibility; and

15 “(E) coordinate the activities of the De-
16 partment of Health and Human Services con-
17 cerning matters of Indian health.”.

18 (g) CONTINUED SERVICE BY INCUMBENT.—The indi-
19 vidual serving in the position of Director of the Indian
20 Health Service on the date preceding the date of enact-
21 ment of this Act may serve as Assistant Secretary for In-
22 dian Health, at the pleasure of the President after the
23 date of enactment of this Act.

24 (h) CONFORMING AMENDMENTS.—

1 (1) AMENDMENTS TO INDIAN HEALTH CARE IM-
2 PROVEMENT ACT.—The Indian Health Care Im-
3 provement Act (25 U.S.C. 1601 et seq.) is amend-
4 ed—

5 (A) in section 601—

6 (i) in subsection (c), by striking “Di-
7 rector of the Indian Health Service” both
8 places it appears and inserting “Assistant
9 Secretary for Indian Health”; and

10 (ii) in subsection (d), by striking “Di-
11 rector of the Indian Health Service” and
12 inserting “Assistant Secretary for Indian
13 Health”; and

14 (B) in section 816(c)(1), by striking “Di-
15 rector of the Indian Health Service” and insert-
16 ing “Assistant Secretary for Indian Health”.

17 (2) AMENDMENTS TO OTHER PROVISIONS OF
18 LAW.—The following provisions are each amended
19 by striking “Director of the Indian Health Service”
20 each place it appears and inserting “Assistant Sec-
21 retary for Indian Health”:

22 (A) Section 203(a)(1) of the Rehabilitation
23 Act of 1973 (29 U.S.C. 763(a)(1)).

1 (B) Subsections (b) and (e) of section 518
2 of the Federal Water Pollution Control Act (33
3 U.S.C. 1377 (b) and (e)).

4 (C) Section 803B(d)(1) of the Native
5 American Programs Act of 1974 (42 U.S.C.
6 2991b-2(d)(1)).

7 (i) REFERENCES.—Reference in any other Federal
8 law, Executive order, rule, regulation, or delegation of au-
9 thority, or any document of or relating to the Director
10 of the Indian Health Service shall be deemed to refer to
11 the Assistant Secretary for Indian Health.

12 (j) DEFINITIONS.—For purposes of this section, the
13 definitions contained in section 4 of the Indian Health
14 Care Improvement Act shall apply.

15 **SEC. 405. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MI-**
16 **NORITY HEALTH WITHIN AGENCIES OF THE**
17 **PUBLIC HEALTH SERVICE.**

18 Title XVII of the Public Health Service Act (42
19 U.S.C. 300u et seq.) is amended by inserting after section
20 1707 the following section:

21 “INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN
22 PUBLIC HEALTH SERVICE

23 “SEC. 1707A.

24 “(a) IN GENERAL.—The head of each agency speci-
25 fied in subsection (b)(1) shall establish within the agency
26 an office to be known as the Office of Minority Health.

1 Each such Office shall be headed by a director, who shall
2 be appointed by the head of the agency within which the
3 Office is established, and who shall report directly to the
4 head of the agency. The head of such agency shall carry
5 out this section (as this section relates to the agency) act-
6 ing through such Director.

7 “(b) SPECIFIED AGENCIES.—

8 “(1) IN GENERAL.—The agencies referred to in
9 subsection (a) are the following:

10 “(A) The Centers for Disease Control and
11 Prevention.

12 “(B) The Health Resources and Services
13 Administration.

14 “(C) The Substance Abuse and Mental
15 Health Services Administration; and

16 “(D) The Administration on Aging.

17 “(c) COMPOSITION.—The head of each specified
18 agency shall ensure that the officers and employees of the
19 minority health office of the agency are, collectively, expe-
20 rienced in carrying out community-based health programs
21 for each of the various racial and ethnic minority groups
22 that are present in significant numbers in the United
23 States.

24 “(d) DUTIES.—Each Director of a minority health of-
25 fice shall establish and monitor the programs of the speci-

1 fied agency of such office in order to carry out the fol-
2 lowing:

3 “(1) Determine the extent to which the pur-
4 poses of the programs are being carried out with re-
5 spect to racial and ethnic minority groups;

6 “(2) Determine the extent to which members of
7 such groups are represented among the Federal offi-
8 cers and employees who administer the programs;
9 and

10 “(3) Make recommendations to the head of
11 such agency on carrying out the programs with re-
12 spect to such groups. In the case of programs that
13 provide services, such recommendations shall include
14 recommendations toward ensuring that—

15 “(A) the services are equitably delivered
16 with respect to racial and ethnic minority
17 groups;

18 “(B) the programs provide the services in
19 the language and cultural context that is most
20 appropriate for the individuals for whom the
21 services are intended; and

22 “(C) the programs utilize racial and ethnic
23 minority community-based organizations to de-
24 liver services.

1 “(e) BIENNIAL REPORTS TO SECRETARY.—The head
2 of each specified agency shall submit to the Secretary for
3 inclusion in each biennial report describing—

4 “(1) the extent to which the minority health of-
5 fice of the agency employs individuals who are mem-
6 bers of racial and ethnic minority groups, including
7 a specification by minority group of the number of
8 such individuals employed by such office.

9 “(f) FUNDING.—

10 “(1) ALLOCATIONS.—Of the amounts appro-
11 priated for a specified agency for a fiscal year, the
12 Secretary must designate an appropriate amount of
13 funds for the purpose of carrying out activities
14 under this section through the minority health office
15 of the agency. In reserving an amount under the
16 preceding sentence for a minority health office for a
17 fiscal year, the Secretary shall reduce, by substan-
18 tially the same percentage, the amount that other-
19 wise would be available for each of the programs of
20 the designated agency involved.

21 “(2) AVAILABILITY OF FUNDS FOR STAFF-
22 ING.—The purposes for which amounts made avail-
23 able under paragraph may be expended by a minor-
24 ity health office include the costs of employing staff
25 for such office.”.

1 **SEC. 406. OFFICE OF MINORITY HEALTH AT THE CENTERS**
2 **FOR MEDICARE & MEDICAID SERVICES.**

3 (a) IN GENERAL.—Not later than 60 days after the
4 date of enactment of this Act, the Secretary of Health and
5 Human Services shall establish within the Centers for
6 Medicare & Medicaid Services an Office of Minority
7 Health (referred to in this section as the “Office”).

8 (b) DUTIES.—The Office shall be responsible for the
9 coordination and facilitation of activities of the Centers
10 for Medicare & Medicaid Services to improve minority
11 health and health care and to reduce racial and ethnic dis-
12 parities in health and health care, which shall include—

13 (1) creating a strategic plan, which shall be
14 made available for public review, to improve the
15 health and health care of Medicare, Medicaid, and
16 SCHIP beneficiaries;

17 (2) promoting agency-wide policies relating to
18 health care delivery and financing that could have a
19 beneficial impact on the health and health care of
20 minority populations;

21 (3) assisting health plans, hospitals, and other
22 health entities in providing culturally and linguis-
23 tically appropriate health care services;

24 (4) increasing awareness and outreach activities
25 for minority health care consumers and providers

1 about the causes and remedies for health and health
2 care disparities;

3 (5) developing grant programs and demonstra-
4 tion projects to identify, implement and evaluate in-
5 novative approaches to improving the health and
6 health care of minority beneficiaries in the Medicare,
7 Medicaid, and SCHIP programs;

8 (6) considering incentive programs relating to
9 reimbursement that would reward health entities for
10 providing quality health care for minority popu-
11 lations using established benchmarks for quality of
12 care;

13 (7) collaborating with the compliance office to
14 ensure compliance with the anti-discrimination provi-
15 sions under title VI of the Civil Rights Act of 1964;

16 (8) identifying barriers to enrollment in public
17 programs under the jurisdiction of the Centers for
18 Medicare & Medicaid Services;

19 (9) monitoring and evaluating on a regular
20 basis the success of minority health programs and
21 initiatives;

22 (10) publishing an annual report about the ac-
23 tivities of the Centers for Medicare & Medicaid Serv-
24 ices relating to minority health improvement; and

1 (11) other activities determined appropriate by
2 the Secretary of Health and Human Services.

3 (c) STAFF.—The staff at the Office shall include—

4 (1) one or more individuals with expertise in
5 minority health and racial and ethnic health dispari-
6 ties; and

7 (2) one or more individuals with expertise in
8 health care financing and delivery in underserved
9 communities.

10 (d) COORDINATION.—In carrying out its duties under
11 this section, the Office shall coordinate with—

12 (1) the Office of Minority Health in the Office
13 of the Secretary of Health and Human Services;

14 (2) the National Centers for Minority Health
15 and Health Disparities in the National Institutes of
16 Health; and

17 (3) the Office of Minority Health in the Centers
18 for Disease Control and Prevention.

19 (e) AUTHORIZATION OF APPROPRIATIONS.—For the
20 purpose of carrying out this section, there are authorized
21 to be appropriated \$10,000,000 for fiscal year 2008, and
22 such sums may be necessary for each of fiscal years 2009
23 through 2014.

1 **SEC. 407. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND**
2 **DRUG ADMINISTRATION.**

3 Chapter IX of the Federal Food, Drug, and Cosmetic
4 Act (21 U.S.C. 391 et seq.) is amended by adding at the
5 end the following:

6 **“SEC. 910. OFFICE OF MINORITY AFFAIRS.**

7 “(a) IN GENERAL.—Not later than 60 days after the
8 date of enactment of this section, the Secretary shall es-
9 tablish within the Office of the Commissioner of Food and
10 Drugs an Office of Minority Affairs (referred to in this
11 section as the ‘Office’).

12 “(b) DUTIES.—The Office shall be responsible for the
13 coordination and facilitation of activities of the Food and
14 Drug Administration to improve minority health and
15 health care and to reduce racial and ethnic disparities in
16 health and health care, which shall include—

17 “(1) promoting policies in the development and
18 review of medical products that reduce racial and
19 ethnic disparities in health and health care;

20 “(2) encouraging appropriate data collection,
21 analysis, and dissemination of racial and ethnic dif-
22 ferences using, at a minimum, the categories de-
23 scribed in the 1997 Office of Management and
24 Budget standards, in response to different therapies
25 in both adult and pediatric populations;

1 “(3) providing, in coordination with other ap-
2 propriate government agencies, education, training,
3 and support to increase participation of minority pa-
4 tients and physicians in clinical trials;

5 “(4) collecting and analyzing data using, at a
6 minimum, the categories described in the 1997 Of-
7 fice of Management and Budget standards, on the
8 number of participants from minority racial and eth-
9 nic backgrounds in clinical trials used to support
10 medical product approvals;

11 “(5) the identification of methods to reduce lan-
12 guage and literacy barriers; and

13 “(6) publishing an annual report about the ac-
14 tivities of the Food and Drug Administration per-
15 taining to minority health.

16 “(c) STAFF.—The staff of the Office shall include—

17 “(1) one or more individuals with expertise in
18 the design and conduct of clinical trials of drugs, bi-
19 ological products, and medical devices; and

20 “(2) one or more individuals with expertise in
21 therapeutic classes or disease states for which med-
22 ical evidence suggests a difference based on race or
23 ethnicity.

24 “(d) COORDINATION.—In carrying out its duties
25 under this section, the Office shall coordinate with—

1 “(1) the Office of Minority Health in the Office
2 of the Secretary of Health and Human Services;

3 “(2) the National Center for Minority Health
4 and Health Disparities in the National Institutes of
5 Health; and

6 “(3) the Office of Minority Health in the Cen-
7 ters for Disease Control and Prevention.

8 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
9 purpose of carrying out this section, there are authorized
10 to be appropriated such sums as may be necessary for
11 each of the fiscal years 2008 through 2013.”.

12 **SEC. 408. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
13 **RESPECT TO RACIAL AND ETHNIC BACK-**
14 **GROUND.**

15 (a) IN GENERAL.—Chapter V of the Federal Food,
16 Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amend-
17 ed by adding after section 505B the following:

18 **“SEC. 505C. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
19 **RESPECT TO RACIAL AND ETHNIC BACK-**
20 **GROUND.**

21 “(a) PRE-APPROVAL STUDIES.—If there is evidence
22 that there may be a disparity on the basis of racial or
23 ethnic background as to the safety or effectiveness of a
24 drug, then—

1 “(1)(A) the investigations required under sec-
2 tion 505(b)(1)(A) shall include adequate and well-
3 controlled investigations of the disparity; or

4 “(B) the evidence required under section 351(a)
5 of the Public Health Service Act for approval of a
6 biologics license application for the drug shall in-
7 clude adequate and well-controlled investigations of
8 the disparity; and

9 “(2) if the investigations confirm that there is
10 a disparity, the labeling of the drug shall include ap-
11 propriate information about the disparity.

12 “(b) POST-MARKET STUDIES.—

13 “(1) IN GENERAL.—If there is evidence that
14 there may be a disparity on the basis of racial or
15 ethnic background as to the safety or effectiveness
16 of a drug for which there is an approved application
17 under section 505 or a license under section 351 of
18 the Public Health Service Act, the Secretary may by
19 order require the holder of the approved application
20 or license to conduct, by a date specified by the Sec-
21 retary, post-marketing studies to investigate the dis-
22 parity.

23 “(2) LABELING.—If the Secretary determines
24 that the post-market studies confirm that there is a
25 disparity described in paragraph (1), the labeling of

1 the drug shall include appropriate information about
2 the disparity.

3 “(3) STUDY DESIGN.—The Secretary may
4 specify all aspects of study design, including the
5 number of studies and study participants, in the
6 order requiring post-market studies of the drug.

7 “(4) MODIFICATIONS OF STUDY DESIGN.—The
8 Secretary may by order modify any aspect of the
9 study design as necessary after issuing an order
10 under paragraph (1).

11 “(5) STUDY RESULTS.—The results from stud-
12 ies required under paragraph (1) shall be submitted
13 to the Secretary as supplements to the drug applica-
14 tion or biological license application.

15 “(c) DISPARITY.—The term ‘evidence that there may
16 be a disparity on the basis of racial or ethnic background
17 for adult and pediatric populations as to the safety or ef-
18 fectiveness of a drug’ includes—

19 “(1) evidence that there is a disparity on the
20 basis of racial or ethnic background as to safety or
21 effectiveness of a drug in the same chemical class as
22 the drug;

23 “(2) evidence that there is a disparity on the
24 basis of racial or ethnic background in the way the
25 drug is metabolized; and

1 “(3) other evidence as the Secretary may deter-
2 mine.

3 “(d) APPLICATIONS UNDER SECTION 505(b)(2) AND
4 505(j).—

5 “(1) IN GENERAL.—A drug for which an appli-
6 cation has been submitted or approved under section
7 505(j) shall not be considered ineligible for approval
8 under that section or misbranded under section 502
9 on the basis that the labeling of the drug omits in-
10 formation relating to a disparity on the basis of ra-
11 cial or ethnic background as to the safety or effec-
12 tiveness of the drug, whether derived from investiga-
13 tions or studies required under this section or de-
14 rived from other sources, when the omitted informa-
15 tion is protected by patent or by exclusivity under
16 clause (iii) or (iv) of section 505(j)(5)(B).

17 “(2) LABELING.—Notwithstanding clauses (iii)
18 and (iv) of section 505(j)(5)(B), the Secretary may
19 require that the labeling of a drug approved under
20 section 505(j) that omits information relating to a
21 disparity on the basis of racial or ethnic background
22 as to the safety or effectiveness of the drug include
23 a statement of any appropriate contraindications,
24 warnings, or precautions related to the disparity
25 that the Secretary considers necessary.”.

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

4 “(y) If it is a drug and the holder of the approved
5 application under section 505 or license under section 351
6 of the Public Health Service Act for the drug has failed
7 to complete the investigations or studies, or comply with
8 any other requirement, of section 505C.”.

9 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
10 Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h)
11 is amended by adding after “are required” the following:
12 “, including supplements required under section 505C”.

13 **SEC. 409. UNITED STATES COMMISSION ON CIVIL RIGHTS.**

14 (a) COORDINATION WITHIN DEPARTMENT OF JUS-
15 TICE OF ACTIVITIES REGARDING HEALTH DISPARI-
16 TIES.—Section 3 of the Civil Rights Commission Act of
17 1983 (42 U.S.C. 1975a) is amended—

18 (1) in paragraph (1)(B), by striking “and” at
19 the end;

20 (2) in paragraph (2), in the matter after and
21 below subparagraph (D), by striking the period and
22 inserting “; and”; and

23 (3) by adding at the end the following:

24 “(3) shall, with respect to activities carried out
25 in health care and correctional facilities toward the

1 goal of eliminating health disparities between the
2 general population and members of racial or ethnic
3 minority groups, coordinate such activities of—

4 “(A) the Office for Civil Rights within the
5 Department of Justice;

6 “(B) the Office of Justice Programs within
7 the Department of Justice;

8 “(C) the Office for Civil Rights within the
9 Department of Health and Human Services;
10 and

11 “(D) the Office of Minority Health within
12 the Department of Health and Human Services
13 (headed by the Deputy Assistant Secretary for
14 Minority Health).”.

15 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
16 5 of the Civil Rights Commission Act of 1983 (42 U.S.C.
17 1975c) is amended by striking the first sentence and in-
18 serting the following: “For the purpose of carrying out
19 this Act, there are authorized to be appropriated
20 \$30,000,000 for fiscal year 2008, and such sums as may
21 be necessary for each of the fiscal years 2009 through
22 2013.”.

1 **SEC. 410. SENSE OF CONGRESS CONCERNING FULL FUND-**
2 **ING OF ACTIVITIES TO ELIMINATE RACIAL**
3 **AND ETHNIC HEALTH DISPARITIES.**

4 (a) FINDINGS.—Congress makes the following find-
5 ings:

6 (1) The health status of the American populace
7 is declining and the United States currently ranks
8 below most industrialized nations in health status
9 measured by longevity, sickness, and mortality.

10 (2) Racial and ethnic minority populations tend
11 have the poorest health status and face substantial
12 cultural, social, and economic barriers to obtaining
13 quality health care.

14 (3) Efforts to improve minority health have
15 been limited by inadequate resources (funding, staff-
16 ing, and stewardship) and accountability.

17 (b) SENSE OF CONGRESS.—It is the sense of Con-
18 gress that—

19 (1) funding should be doubled by fiscal year
20 2008 for the National Center for Minority Health
21 Disparities, the Office of Civil Rights in the Depart-
22 ment of Health and Human Services, the National
23 Institute of Nursing Research, and the Office of Mi-
24 nority Health;

25 (2) adequate funding by fiscal year 2008, and
26 subsequent funding increases, should be provided for

1 health professions training programs, the Racial and
2 Ethnic Approaches to Community Health (REACH)
3 at the Center for Disease Control and Prevention,
4 the Minority HIV/AIDS Initiative, and the Excel-
5 lence Centers to Eliminate Ethnic/Racial Disparities
6 (EXCEED) Program at the Agency for Healthcare
7 Research and Quality;

8 (3) current and newly-created health disparity
9 elimination incentives, programs, agencies, and de-
10 partments under this Act (and the amendments
11 made by this Act) should receive adequate staffing
12 and funding by fiscal year 2008; and

13 (4) stewardship and accountability should be
14 provided to Congress and the President for measur-
15 able and sustainable progress toward health dis-
16 parity elimination.

17 **SEC. 411. GUIDELINES FOR DISEASE SCREENING FOR MI-**
18 **NORITY PATIENTS.**

19 (a) IN GENERAL.—The Secretary, acting through the
20 Director of the Agency for Healthcare Research and Qual-
21 ity, shall convene a series of meetings to develop guidelines
22 for disease screening for minority patient populations
23 which have a higher than average risk for many chronic
24 diseases and cancers.

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

4 (1) professional societies and associations;

5 (2) minority health organizations;

6 (3) health care researchers and providers, in-
7 cluding those with expertise in minority health;

8 (4) Federal health agencies, including the Of-
9 fice of Minority Health and the National Institutes
10 of Health; and

11 (5) other experts determined appropriate by the
12 Secretary.

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

15 (1) hypertension;

16 (2) hypercholesterolemia;

17 (3) diabetes;

18 (4) cardiovascular disease;

19 (5) cancers, including breast, prostate, colon,
20 cervical, and lung cancer;

21 (6) asthma;

22 (7) diabetes;

23 (8) kidney diseases;

24 (9) eye diseases and disorders, including glau-
25 coma;

1 (10) HIV/AIDS and sexually transmitted dis-
2 eases;

3 (11) uterine fibroids;

4 (12) autoimmune disease;

5 (13) mental health conditions;

6 (14) dental health conditions and oral diseases;

7 (15) environmental and related health illnesses
8 and conditions;

9 (16) Sickle cell disease;

10 (17) violence and injury prevention and control;

11 (18) genetic and related conditions;

12 (19) heart disease and stroke;

13 (20) tuberculosis;

14 (21) chronic obstructive pulmonary disease; and

15 (22) other diseases determined appropriate by
16 the Secretary.

17 (d) DISSEMINATION.—Not later than 24 months
18 after the date of enactment of this title, the Secretary
19 shall publish and disseminate to health care provider orga-
20 nizations the guidelines developed under subsection (a).

21 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
22 authorized to be appropriated to carry out this section,
23 sums as may be necessary for each of fiscal years 2008
24 through 2013.

1 **SEC. 412. NATIONAL CENTER FOR MINORITY HEALTH AND**
2 **HEALTH DISPARITIES REAUTHORIZATION.**

3 (a) IN GENERAL.—Section 485E of the Public
4 Health Service Act (42 U.S.C. 287e-31) is amended—

5 (1) by striking subsection (e) and inserting the
6 following:

7 “(e) DUTIES OF THE DIRECTOR.—

8 “(1) INTERAGENCY COORDINATION OF MINOR-
9 ITY HEALTH AND HEALTH DISPARITIES ACTIVI-
10 TIES.—With respect to minority health and health
11 disparities, the Director of the Center shall plan, co-
12 ordinate, and evaluate research and other activities
13 conducted or supported by the agencies of the Na-
14 tional Institutes of Health. In carrying out the pre-
15 ceding sentence, the Director of the Center shall
16 evaluate the minority health and health disparity ac-
17 tivities of each of such agencies and shall provide for
18 the timely periodic re-evaluation of such activities.

19 “(2) CONSULTATIONS.—The Director of the
20 Center shall carry out this subpart (including devel-
21 oping and revising the plan and budget required in
22 subsection (f)) in consultation with the Directors of
23 the agencies (or a designee of the Directors) of the
24 National Institutes of Health, with the advisory
25 councils of the agencies, and with the advisory coun-
26 cil established under section (j).

1 “(3) COORDINATION OF ACTIVITIES.—The Di-
2 rector of the Center shall act as the primary Federal
3 official with responsibility for coordinating all minor-
4 ity health disparities research and other health dis-
5 parities research conducted or supported by the Na-
6 tional Institutes of Health and shall—

7 “(A) represent the health disparities re-
8 search program of the National Institutes of
9 Health including the minority health disparities
10 research program at all relevant executive
11 branch task forces, committees, and planning
12 activities;

13 “(B) maintain communications with all rel-
14 evant Public Health Service agencies, including
15 the Indian Health Service and various other de-
16 partments of the Federal Government, to en-
17 sure the timely transmission of information con-
18 cerning advances in minority health disparities
19 research and other health disparities research
20 between these various agencies for dissemina-
21 tion to affected communities and health care
22 providers;

23 “(C) undertake research to further refine
24 and develop the conceptual, definitional, and
25 methodological issues involved in health dispari-

1 ties research and to further the understanding
2 of the cause of disparities; and

3 “(D) engage with national and community-
4 based organizations and health provider groups,
5 led by and serving racial and ethnic minorities,
6 to—

7 “(i) increase education, awareness,
8 and participation with respect to the Cen-
9 ter’s activities and areas of research focus;
10 and

11 “(ii) accelerate the translation of re-
12 search findings into programs including
13 those carried out by community-based or-
14 ganizations.”;

15 (2) in subsection (f)—

16 (A) by striking the subsection heading and
17 inserting the following: “COMPREHENSIVE
18 PLAN FOR RESEARCH; BUDGET ESTIMATE; AL-
19 LOCATION OF APPROPRIATIONS.—”;

20 (B) in paragraph (1)—

21 (i) by striking the paragraph designa-
22 tion, the paragraph heading, the matter
23 preceding subparagraph (A), and subpara-
24 graph (A) and inserting the following:

1 “(1) IN GENERAL.—Subject to the provisions of
2 this section and other applicable law, the Director of
3 the Center, in consultation with the Director of
4 NIH, the Directors of the other agencies of the Na-
5 tional Institutes of Health, and the advisory council
6 established under subsection (j) shall—

7 “(A) annually review and revise a com-
8 prehensive plan (referred to in this section as
9 ‘the plan’) and budget for the conduct and sup-
10 port of all minority health and health dispari-
11 ties research and other health disparities re-
12 search activities of the agencies of the National
13 Institutes of Health that includes time-based
14 targeted objectives with measurable outcomes
15 and assure that the annual review and revision
16 of the plan uses an established trans-NIH proc-
17 ess subject to timely review, approval, and dis-
18 semination;”;

19 (ii) in subparagraph (D), by striking
20 “, with respect to amounts appropriated
21 for activities of the Center;”;

22 (iii) by striking subparagraph (F) and
23 inserting the following:

24 “(F) ensure that the plan and budget are
25 presented to and considered by the Director in

1 a clear and timely process during the formula-
2 tion of the overall annual budget for the Na-
3 tional Institutes of Health;”;

4 (iv) by redesignating subparagraphs
5 (G) and (H) as subparagraphs (I) and (J),
6 respectively; and

7 (v) by inserting after subparagraph
8 (F), the following:

9 “(G) annually submit to the Congress a re-
10 port on the progress made with respect to the
11 plan;

12 “(H) create and implement a plan for the
13 systematic review of research activities sup-
14 ported by the National Institutes of Health that
15 are within the mission of both the Center and
16 other agencies of the National Institutes of
17 Health, by establishing mechanisms for—

18 “(i) tracking minority health and
19 health disparity research conducted within
20 the agencies and assessing the appropriate-
21 ness of this research with regard to the
22 overall goals and objectives of the plan;

23 “(ii) the early identification of appli-
24 cations and proposals for grants, contracts,
25 and cooperative agreements supporting ex-

1 tramural training, research, and develop-
2 ment, that are submitted to the agencies
3 and that are within the mission of the Cen-
4 ter;

5 “(iii) providing the Center with the
6 written descriptions and scientific peer re-
7 view results of such applications and pro-
8 posals;

9 “(iv) enabling the agencies to consult
10 with the Director of the Center prior to
11 final approval of such applications and
12 proposals; and

13 “(v) reporting to the Director of the
14 Center all such applications and proposals
15 that are approved for funding by the agen-
16 cies;”; and

17 (C) in paragraph (2)—

18 (i) in subparagraph (D), by striking
19 “and” at the end;

20 (ii) in subparagraph (E), by striking
21 the period and inserting “; and”; and

22 (iii) by adding at the end the fol-
23 lowing:

24 “(F) the number and type of personnel
25 needs of the Center.”;

1 (3) in subsection (h)—

2 (A) in paragraph (1), by striking “endow-
3 ments at centers of excellence under section
4 736.” and inserting the following: “endowments
5 at—

6 “(A) centers of excellence under section
7 736; and

8 “(B) centers of excellence under section
9 485F.”; and

10 (B) in paragraph (2)(A), by striking “aver-
11 age” and inserting “median”; and

12 (4) by inserting after subsection (j), the fol-
13 lowing:

14 “(k) REPRESENTATION OF MINORITIES AMONG RE-
15 SEARCHERS.—The Secretary, in collaboration with the Di-
16 rector of the Center, shall determine, by means of the col-
17 lection and reporting of aggregated and disaggregated
18 data, the extent to which racial and ethnic minority groups
19 are represented among senior physicians and scientists of
20 the national research institutes and among physicians and
21 scientists conducting research with funds provided by such
22 institutes, and as appropriate, carry out activities to in-
23 crease the extent of such representation, including devel-
24 oping a pipeline of minority researchers interested in the
25 study of health and health disparities, as well as attracting

1 minority scientists in social and behavioral science fields
2 who can bring their expertise to the study of health dis-
3 parities.

4 “(1) CANCER RESEARCH.—The Secretary, in collabo-
5 ration with the Director of the Center, shall designate and
6 support a cancer prevention, control, and population
7 science center to address the significantly elevated rate of
8 morbidity and mortality from cancer in racial and ethnic
9 minority populations. Such designated center shall be
10 housed within an existing, stand-alone cancer center at a
11 minority-serving institution that has a demonstrable com-
12 mitment to and expertise in cancer research in the basic,
13 clinical, and population sciences.”.

14 (b) AUTHORIZATION OF APPROPRIATIONS.—

15 (1) IN GENERAL.—To carry out section 485E
16 of the Public Health Service Act (42 U.S.C.287c-
17 31), as amended by subsection (a), there are author-
18 ized to be appropriated \$240,000,000 for fiscal year
19 2008 and such sums as may be necessary for each
20 of fiscal years 2009 through 2012.

21 (2) EXPENDITURE.—The Director of the Na-
22 tional Center on Minority Health and Health Dis-
23 parities shall expend amounts appropriated for ac-
24 tivities under such section 485E in accordance with
25 such section and other applicable law and in collabo-

1 ration with the Director of National Institutes of
2 Health and the directors of other institutes and cen-
3 ters of the National Institutes of Health.

4 (3) MANAGEMENT.—All amounts expended for
5 minority health and health disparities research ac-
6 tivities under this subsection shall be reported pro-
7 grammatically to and approved by the Director of
8 the National Center on Minority Health and Health
9 Disparities under such section 485E, in accordance
10 with the plan described under subsection (f)(1)(A) of
11 such section 485E.

12 **Subtitle B—Improving** 13 **Environmental Justice**

14 **SEC. 421. CODIFICATION OF EXECUTIVE ORDER 12898.**

15 (a) IN GENERAL.—The President of the United
16 States is authorized and directed to execute, administer,
17 and enforce as a matter of Federal law the provisions of
18 Executive Order 12898, dated February 11, 1994, (“Fed-
19 eral Actions To Address Environmental Justice In Minor-
20 ity Populations and Low-Income Populations”) with such
21 modifications as are provided in this section.

22 (b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For
23 purposes of carrying out the provisions of Executive Order
24 12898, the following definitions shall apply:

1 (1) The term “environmental justice” means
2 the fair treatment and meaningful involvement of all
3 people regardless of race, color, national origin, edu-
4 cational level, or income with respect to the develop-
5 ment, implementation, and enforcement of environ-
6 mental laws and regulations in order to ensure
7 that—

8 (A) minority and low-income communities
9 have access to public information relating to
10 human health and environmental planning, reg-
11 ulations, and enforcement; and

12 (B) no minority or low-income population
13 is forced to shoulder a disproportionate burden
14 of the negative human health and environ-
15 mental impacts of pollution or other environ-
16 mental hazard.

17 (2) The term “fair treatment” means policies
18 and practices that ensure that no group of people,
19 including racial, ethnic, or socioeconomic groups
20 bear disproportionately high and adverse human
21 health or environmental effects resulting from Fed-
22 eral agency programs, policies, and activities.

23 (c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—
24 The provisions of section 6–609 of Executive Order 12898
25 shall not apply for purposes of this Act.

1 **SEC. 422. IMPLEMENTATION OF RECOMMENDATIONS BY**
2 **ENVIRONMENTAL PROTECTION AGENCY.**

3 (a) INSPECTOR GENERAL RECOMMENDATIONS.—The
4 Administrator of the Environmental Protection Agency
5 shall, as promptly as practicable, carry out each of the
6 following recommendations of the Inspector General of the
7 agency as set forth in Report No. 2006–P-00034 entitled
8 “EPA needs to conduct environmental justice reviews of
9 its programs, policies and activities”:

10 (1) The recommendation that the Agency’s pro-
11 gram and regional offices identify which programs,
12 policies, and activities need environmental justice re-
13 views and require these offices to establish a plan to
14 complete the necessary reviews.

15 (2) The recommendation that the Administrator
16 of the Agency ensure that these reviews determine
17 whether the programs, policies, and activities may
18 have a disproportionately high and adverse health or
19 environmental impact on minority and low-income
20 populations.

21 (3) The recommendation that each program
22 and regional office develop specific environmental
23 justice review guidance for conducting environmental
24 justice reviews.

25 (4) The recommendation that the Administrator
26 designate a responsible office to compile results of

1 environmental justice reviews and recommend appro-
2 priate actions.

3 (b) GAO RECOMMENDATIONS.—In developing rules
4 under laws administered by the Environmental Protection
5 Agency, the Administrator of the Agency shall, as prompt-
6 ly as practicable, carry out each of the following rec-
7 ommendations of the Comptroller General of the United
8 States as set forth in GAO Report numbered GAO–05-
9 289 entitled “EPA Should Devote More Attention to En-
10 vironmental Justice when Developing Clean Air Rules”:

11 (1) The recommendation that the Administrator
12 ensure that workgroups involved in developing a rule
13 devote attention to environmental justice while draft-
14 ing and finalizing the rule.

15 (2) The recommendation that the Administrator
16 enhance the ability of such workgroups to identify
17 potential environmental justice issues through such
18 steps as providing workgroup members with guid-
19 ance and training to helping them identify potential
20 environmental justice problems and involving envi-
21 ronmental justice coordinators in the workgroups
22 when appropriate.

23 (3) The recommendation that the Administrator
24 improve assessments of potential environmental jus-
25 tice impacts in economic reviews by identifying the

1 data and developing the modeling techniques needed
2 to assess such impacts.

3 (4) The recommendation that the Administrator
4 direct appropriate Agency officers and employees to
5 respond fully when feasible to public comments on
6 environmental justice, including improving the Agen-
7 cy's explanation of the basis for its conclusions, to-
8 gether with supporting data.

9 (c) 2004 INSPECTOR GENERAL REPORT.—The Ad-
10 ministrator of the Environmental Protection Agency shall,
11 as promptly as practicable, carry out each of the following
12 recommendations of the Inspector General of the Agency
13 as set forth in the report entitled “EPA Needs to Consist-
14 ently Implement the Intent of the Executive Order on En-
15 vironmental Justice” (Report No. 2004–P–00007):

16 (1) The recommendation that the Agency clear-
17 ly define the mission of the Office of Environmental
18 Justice (OEJ) and provide Agency staff with an un-
19 derstanding of the roles and responsibilities of the
20 Office.

21 (2) The recommendation that the Agency estab-
22 lish (through issuing guidance or a policy statement
23 from the Administrator) specific time frames for the
24 development of definitions, goals, and measurements
25 regarding environmental justice and provide the re-

1 regions and program offices a standard and consistent
2 definition for a minority and low-income community,
3 with instructions on how the Agency will implement
4 and operationalize environmental justice into the
5 Agency's daily activities.

6 (3) The recommendation that the Agency en-
7 sure the comprehensive training program currently
8 under development includes standard and consistent
9 definitions of the key environmental justice concepts
10 (such as "low-income", "minority", and "dispropor-
11 tionately impacted") and instructions for implemen-
12 tation of those concepts.

13 (d) REPORT.—The Administrator shall submit an ini-
14 tial report to Congress within 6 months after the enact-
15 ment of this Act regarding the Administrator's strategy
16 for implementing the recommendations referred to in sub-
17 sections (a), (b), and (c). Thereafter, the Administrator
18 shall provide semi-annual reports to Congress regarding
19 the Administrator's progress in implementing such rec-
20 ommendations and modifying the Administrator's emer-
21 gency management procedures to incorporate environ-
22 mental justice in the Agency's Incident Command Struc-
23 ture (in accordance with the December 18, 2006, letter
24 from the Deputy Administrator to the Acting Inspector
25 General of the agency).

1 **SEC. 423. GRANT PROGRAM.**

2 (a) DEFINITIONS.—In this section:

3 (1) DIRECTOR.—The term “Director” means
4 the Director of the Centers for Disease Control and
5 Prevention, acting in collaboration with the Adminis-
6 trator of the Environmental Protection Agency and
7 the Director of the National Institute of Environ-
8 mental Health Sciences.

9 (2) ELIGIBLE ENTITY.—The term “eligible enti-
10 ty” means a State or local community that—

11 (A) bears a disproportionate burden of ex-
12 posure to environmental health hazards;

13 (B) has established a coalition—

14 (i) with not less than 1 community-
15 based organization; and

16 (ii) with not less than 1—

17 (I) public health entity;

18 (II) health care provider organi-
19 zation; or

20 (III) academic institution, includ-
21 ing any minority-serving institution
22 (including an Hispanic-serving institu-
23 tion, a historically Black college or
24 university, and a tribal college or uni-
25 versity);

1 (C) ensures planned activities and funding
2 streams are coordinated to improve community
3 health; and

4 (D) submits an application in accordance
5 with subsection (c).

6 (b) ESTABLISHMENT.—The Director shall establish a
7 grant program under which eligible entities shall receive
8 grants to conduct environmental health improvement ac-
9 tivities.

10 (c) APPLICATION.—To receive a grant under this sec-
11 tion, an eligible entity shall submit an application to the
12 Director at such time, in such manner, and accompanied
13 by such information as the Director may require.

14 (d) COOPERATIVE AGREEMENTS.—An eligible entity
15 may use a grant under this section—

16 (1) to promote environmental health; and

17 (2) to address environmental health disparities.

18 (e) AMOUNT OF COOPERATIVE AGREEMENT.—

19 (1) IN GENERAL.—The Director shall award
20 grants to eligible entities at the 2 different funding
21 levels described in this subsection.

22 (2) LEVEL 1 COOPERATIVE AGREEMENTS.—

23 (A) IN GENERAL.—An eligible entity
24 awarded a grant under this paragraph shall use

1 the funds to identify environmental health prob-
2 lems and solutions by—

3 (i) establishing a planning and
4 prioritizing council in accordance with sub-
5 paragraph (B); and

6 (ii) conducting an environmental
7 health assessment in accordance with sub-
8 paragraph (C).

9 (B) PLANNING AND PRIORITIZING COUN-
10 CIL.—

11 (i) IN GENERAL.—A prioritizing and
12 planning council established under sub-
13 paragraph (A)(i) (referred to in this para-
14 graph as a “PPC”) shall assist the envi-
15 ronmental health assessment process and
16 environmental health promotion activities
17 of the eligible entity.

18 (ii) MEMBERSHIP.—Membership of a
19 PPC shall consist of representatives from
20 various organizations within public health,
21 planning, development, and environmental
22 services and shall include stakeholders
23 from vulnerable groups such as children,
24 the elderly, disabled, and minority ethnic
25 groups that are often not actively involved

1 in democratic or decision-making proc-
2 esses.

3 (iii) DUTIES.—A PPC shall—

4 (I) identify key stakeholders and
5 engage and coordinate potential part-
6 ners in the planning process;

7 (II) establish a formal advisory
8 group to plan for the establishment of
9 services;

10 (III) conduct an in-depth review
11 of the nature and extent of the need
12 for an environmental health assess-
13 ment, including a local epidemiological
14 profile, an evaluation of the service
15 provider capacity of the community,
16 and a profile of any target popu-
17 lations; and

18 (IV) define the components of
19 care and form essential programmatic
20 linkages with related providers in the
21 community.

22 (C) ENVIRONMENTAL HEALTH ASSESS-
23 MENT.—

1 (i) IN GENERAL.—A PPC shall carry
2 out an environmental health assessment to
3 identify environmental health concerns.

4 (ii) ASSESSMENT PROCESS.—The
5 PPC shall—

6 (I) define the goals of the assess-
7 ment;

8 (II) generate the environmental
9 health issue list;

10 (III) analyze issues with a sys-
11 tems framework;

12 (IV) develop appropriate commu-
13 nity environmental health indicators;

14 (V) rank the environmental
15 health issues;

16 (VI) set priorities for action;

17 (VII) develop an action plan;

18 (VIII) implement the plan; and

19 (IX) evaluate progress and plan-
20 ning for the future.

21 (D) EVALUATION.—Each eligible entity
22 that receives a grant under this paragraph shall
23 evaluate, report, and disseminate program find-
24 ings and outcomes.

1 (E) TECHNICAL ASSISTANCE.—The Direc-
2 tor may provide such technical and other non-
3 financial assistance to eligible entities as the
4 Director determines to be necessary.

5 (3) LEVEL 2 COOPERATIVE AGREEMENTS.—

6 (A) ELIGIBILITY.—

7 (i) IN GENERAL.—The Director shall
8 award grants under this paragraph to eli-
9 gible entities that have already—

10 (I) established broad-based col-
11 laborative partnerships; and

12 (II) completed environmental as-
13 sessments.

14 (ii) NO LEVEL 1 REQUIREMENT.—To
15 be eligible to receive a grant under this
16 paragraph, an eligible entity is not re-
17 quired to have successfully completed a
18 Level 1 Cooperative Agreement (as de-
19 scribed in paragraph (2)).

20 (B) USE OF GRANT FUNDS.—An eligible
21 entity awarded a grant under this paragraph
22 shall use the funds to further activities to carry
23 out environmental health improvement activi-
24 ties, including—

1 (i) addressing community environ-
2 mental health priorities in accordance with
3 paragraph (2)(C)(ii), including—

4 (I) air quality;

5 (II) water quality;

6 (III) solid waste;

7 (IV) land use;

8 (V) housing;

9 (VI) food safety;

10 (VII) crime;

11 (VIII) injuries; and

12 (IX) healthcare services;

13 (ii) building partnerships between
14 planning, public health, and other sectors,
15 to address how the built environment im-
16 pacts food availability and access and
17 physical activity to promote healthy behav-
18 iors and lifestyles and reduce overweight
19 and obesity, asthma, respiratory condi-
20 tions, dental, oral and mental health condi-
21 tions, and related co-morbidities;

22 (iii) establishing programs to ad-
23 dress—

24 (I) how environmental and social
25 conditions of work and living choices

1 influence physical activity and dietary
2 intake; or

3 (II) how those conditions influ-
4 ence the concerns and needs of people
5 who have impaired mobility and use
6 assistance devices, including wheel-
7 chairs and lower limb prostheses; and

8 (iv) convening intervention programs
9 that examine the role of the social environ-
10 ment in connection with the physical and
11 chemical environment in—

12 (I) determining access to nutri-
13 tional food; and

14 (II) improving physical activity to
15 reduce morbidity and increase quality
16 of life.

17 (f) AUTHORIZATION OF APPROPRIATIONS.—There
18 are authorized to be appropriated to carry out this sec-
19 tion—

20 (1) \$25,000,000 for fiscal year 2008; and

21 (2) such sums as may be necessary for fiscal
22 years 2009 through 2012.

1 **SEC. 424. ADDITIONAL RESEARCH ON THE RELATIONSHIP**
2 **BETWEEN THE BUILT ENVIRONMENT AND**
3 **THE HEALTH OF COMMUNITY RESIDENTS.**

4 (a) DEFINITION OF ELIGIBLE INSTITUTION.—In this
5 section, the term “eligible institution” means a public or
6 private nonprofit institution that submits to the Secretary
7 of Health and Human Services (in this section referred
8 to as the “Secretary”) and the Administrator of the Envi-
9 ronmental Protection Agency (in this section referred to
10 as the “Administrator”) an application for a grant under
11 the grant program authorized under subsection (b)(2) at
12 such time, in such manner, and containing such agree-
13 ments, assurances, and information as the Secretary and
14 Administrator may require.

15 (b) RESEARCH GRANT PROGRAM.—

16 (1) DEFINITION OF HEALTH.—In this section,
17 the term “health” includes—

18 (A) levels of physical activity;

19 (B) consumption of nutritional foods;

20 (C) rates of crime;

21 (D) air, water, and soil quality;

22 (E) risk of injury;

23 (F) accessibility to healthcare services; and

24 (G) other indicators as determined appro-
25 priate by the Secretary.

1 (2) GRANTS.—The Secretary, in collaboration
2 with the Administrator, shall provide grants to eligi-
3 ble institutions to conduct and coordinate research
4 on the built environment and its influence on indi-
5 vidual and population-based health.

6 (3) RESEARCH.—The Secretary shall support
7 research that—

8 (A) investigates and defines the causal
9 links between all aspects of the built environ-
10 ment and the health of residents;

11 (B) examines—

12 (i) the extent of the impact of the
13 built environment (including the various
14 characteristics of the built environment) on
15 the health of residents;

16 (ii) the variance in the health of resi-
17 dents by—

18 (I) location (such as inner cities,
19 inner suburbs, and outer suburbs);
20 and

21 (II) population subgroup (such as
22 children, the elderly, the disadvan-
23 tagged); or

24 (iii) the importance of the built envi-
25 ronment to the total health of residents,

1 which is the primary variable of interest
2 from a public health perspective;

3 (C) is used to develop—

4 (i) measures to address health and the
5 connection of health to the built environ-
6 ment; and

7 (ii) efforts to link the measures to
8 travel and health databases; and

9 (D) distinguishes carefully between per-
10 sonal attitudes and choices and external influ-
11 ences on observed behavior to determine how
12 much an observed association between the built
13 environment and the health of residents, versus
14 the lifestyle preferences of the people that
15 choose to live in the neighborhood, reflects the
16 physical characteristics of the neighborhood;
17 and

18 (E)(i) identifies or develops effective inter-
19 vention strategies to promote better health
20 among residents with a focus on behavioral
21 interventions and enhancements of the built en-
22 vironment that promote increased use by resi-
23 dents; and

24 (ii) in developing the intervention strate-
25 gies under clause (i), ensures that the interven-

1 tion strategies will reach out to high-risk popu-
2 lations, including racial and ethnic minorities
3 and low-income urban and rural communities.

4 (4) PRIORITY.—In providing assistance under
5 the grant program authorized under paragraph (2),
6 the Secretary and the Administrator shall give pri-
7 ority to research that incorporates—

8 (A) Minority-serving institutions as grant-
9 ees;

10 (B) interdisciplinary approaches; or

11 (C) the expertise of the public health,
12 physical activity, urban planning, and transpor-
13 tation research communities in the United
14 States and abroad.

15 **TITLE V—IMPROVEMENT OF** 16 **HEALTH CARE SERVICES**

17 **SEC. 501. HEALTH EMPOWERMENT ZONES.**

18 (a) HEALTH EMPOWERMENT ZONE PROGRAMS.—

19 (1) GRANTS.—The Secretary, acting through
20 the Administrator of the Health Resources and Serv-
21 ices Administration and the Deputy Assistant Sec-
22 retary for Minority Health, and in cooperation with
23 the Director of the Office of Community Services
24 and the Director of the National Center for Minority
25 Health and Health Disparities, shall make grants to

1 partnerships of private and public entities to estab-
2 lish health empowerment zone programs in commu-
3 nities that disproportionately experience disparities
4 in health status and health care for the purpose de-
5 scribed in paragraph (2).

6 (2) USE OF FUNDS.—

7 (A) IN GENERAL.—Subject to subpara-
8 graph (B), the purpose of a health empower-
9 ment zone program under this section shall be
10 to assist individuals, businesses, schools, minor-
11 ity health associations, non-profit organizations,
12 community-based organizations, hospitals,
13 health care clinics, foundations, and other enti-
14 ties in communities that disproportionately ex-
15 perience disparities in health status and health
16 care which are seeking—

17 (i) to improve the health or environ-
18 ment of minority individuals in the com-
19 munity and to reduce disparities in health
20 status and health care by assisting individ-
21 uals in accessing Federal programs;

22 (ii) to coordinate the efforts of gov-
23 ernmental and private entities regarding
24 the elimination of racial and ethnic dispari-
25 ties in health status and health care; and

1 (iii) to increase the adoption and use
2 of health information technology by pro-
3 viders in racial and ethnic minority and
4 rural communities to improve quality of
5 care; enhance minority and rural consumer
6 awareness; understand, adopt, and use
7 health information technology to improve
8 health literacy and health self-manage-
9 ment; and foster improved coordination of
10 health services and care quality.

11 (B) MEDICARE AND MEDICAID.—A health
12 empowerment zone program under this section
13 shall not provide any assistance (other than re-
14 ferral and follow-up services) that is duplicative
15 of programs under title XVIII or XIX of the
16 Social Security Act (42 U.S.C. 1395 and 1396
17 et seq.).

18 (3) DISTRIBUTION.—The Secretary shall make
19 at least 1 grant per Health and Human Services re-
20 gion under this section to a partnership for a health
21 empowerment zone program in communities that
22 disproportionately experience disparities in health
23 status and health care that is located in a territory
24 or possession of the United States.

1 (4) APPLICATION.—To obtain a grant under
2 this section, a partnership shall submit to the Sec-
3 retary an application in such form and in such man-
4 ner as the Secretary may require. An application
5 under this paragraph shall—

6 (A) demonstrate that the communities to
7 be served by the health empowerment zone pro-
8 gram are those that disproportionately experi-
9 ence disparities in health status and health
10 care;

11 (B) set forth a strategic plan for accom-
12 plishing the purpose described in paragraph (2),
13 by—

14 (i) describing the coordinated health,
15 economic, human, community, and physical
16 development plan and related activities
17 proposed for the community;

18 (ii) describing the extent to which
19 local institutions and organizations have
20 contributed and will contribute to the plan-
21 ning process and implementation;

22 (iii) identifying the projected amount
23 of Federal, State, local, and private re-
24 sources that will be available in the area
25 and the private and public partnerships to

1 be used (including any participation by or
2 cooperation with universities, colleges,
3 foundations, non-profit organizations, med-
4 ical centers, hospitals, health clinics, school
5 districts, or other private and public enti-
6 ties);

7 (iv) identifying the funding requested
8 under any Federal program in support of
9 the proposed activities;

10 (v) identifying benchmarks for meas-
11 uring the success of carrying out the stra-
12 tegic plan;

13 (vi) demonstrating the ability to reach
14 and service the targeted underserved mi-
15 nority community populations in a cul-
16 turally appropriate and linguistically re-
17 sponsive manner; and

18 (vii) demonstrating a capacity and in-
19 frastructure to provide long-term commu-
20 nity response that is culturally appropriate
21 and linguistically responsive to commu-
22 nities that disproportionately experience
23 disparities in health and health care; and

24 (C) include such other information as the

25 Secretary may require.

1 (5) PREFERENCE.—In awarding grants under
2 this subsection, the Secretary shall give preference
3 to proposals from indigenous community entities
4 that have an expertise in providing culturally appro-
5 priate and linguistically responsive services to com-
6 munities that disproportionately experience dispari-
7 ties in health and health care.

8 (b) FEDERAL ASSISTANCE FOR HEALTH EMPOWER-
9 MENT ZONE GRANT PROGRAMS.—The Secretary, the Ad-
10 ministrators of the Small Business Administration, the
11 Secretary of Agriculture, the Secretary of Education, the
12 Secretary of Labor, and the Secretary of Housing and
13 Urban Development shall each—

14 (1) where appropriate, provide entity-specific
15 technical assistance and evidence-based strategies to
16 communities that disproportionately experience dis-
17 parities in health status and health care to further
18 the purposes served by a health empowerment zone
19 program established with a grant under subsection
20 (a);

21 (2) identify all programs administered by the
22 Department of Health and Human Services, Small
23 Business Administration, Department of Agri-
24 culture, Department of Education, Department of
25 Labor, and the Department of Housing and Urban

1 Development, respectively, that may be used to fur-
2 ther the purpose of a health empowerment zone pro-
3 gram established with a grant under subsection (a);
4 and

5 (3) in administering any program identified
6 under paragraph (2), consider the appropriateness of
7 giving priority to any individual or entity located in
8 communities that disproportionately experience dis-
9 parities in health status and health care served by
10 a health empowerment zone program established
11 with a grant under subsection (a), if such priority
12 would further the purpose of the health empower-
13 ment zone program.

14 (c) HEALTH EMPOWERMENT ZONE COORDINATING
15 COMMITTEE.—

16 (1) ESTABLISHMENT.—For each health em-
17 powerment zone program established with a grant
18 under subsection (a), the Secretary acting through
19 the Director of Office of Minority Health and the
20 Administrator of the Health Resources and Services
21 Administration shall establish a health empowerment
22 zone coordinating committee.

23 (2) DUTIES.—Each coordinating committee es-
24 tablished, in coordination with the Deputy Assistant
25 Secretary for Minority Health and the Administrator

1 of the Health Resources and Services Administra-
2 tion, shall provide technical assistance and evidence-
3 based strategies to the grant recipient involved, in-
4 cluding providing guidance on research, strategies,
5 health outcomes, program goals, management, im-
6 plementation, monitoring, assessment, and evalua-
7 tion processes.

8 (3) MEMBERSHIP.—

9 (A) APPOINTMENT.—The Deputy Assist-
10 ant Secretary for Minority Health and the Ad-
11 ministrator of the Health Resources and Serv-
12 ices Administration, in consultation with the re-
13 spective grant recipient shall appoint the mem-
14 bers of each coordinating committee.

15 (B) COMPOSITION.—The Deputy Assistant
16 Secretary for Minority Health, and the Admin-
17 istrator of the Health Resources and Services
18 Administration shall ensure that each coordi-
19 nating committee established—

20 (i) has not more than 20 members;

21 (ii) includes individuals from commu-
22 nities that disproportionately experience
23 disparities in health status and health
24 care;

1 (iii) includes community leaders and
2 leaders of community-based organizations;

3 (iv) includes representatives of aca-
4 demia and lay and professional organiza-
5 tions and associations including those hav-
6 ing expertise in medicine (including dental
7 and oral medicine), technical, social, and
8 behavioral science, health policy, health in-
9 formation technology, advocacy, cultural
10 and linguistic competency, research man-
11 agement, and organization; and

12 (v) represents a reasonable cross-sec-
13 tion of knowledge, views, and application
14 of expertise on societal, ethical, behavioral,
15 educational, policy, legal, cultural, lin-
16 guistic, and technological workforce issues
17 related to eliminating disparities in health
18 and health care.

19 (C) INDIVIDUAL QUALIFICATIONS.—The
20 Deputy Assistant Secretary for Minority Health
21 and the Administrator of the Health Resources
22 and Services Administration may not appoint
23 an individual to serve on a coordinating com-
24 mittee unless the individual meets the following
25 qualifications:

1 (i) The individual is not employed by
2 the Federal Government.

3 (ii) The individual has appropriate ex-
4 perience, including experience in the areas
5 of community development, cultural and
6 linguistic competency, reducing and elimi-
7 nating racial and ethnic disparities in
8 health and health care, or minority health.

9 (D) SELECTION.—In selecting individuals
10 to serve on a coordinating committee, the Dep-
11 uty Assistant Secretary for Minority Health
12 and the Administrator Health Resources and
13 Services Administration shall give due consider-
14 ation to the recommendations of the Congress,
15 industry leaders, the scientific community (in-
16 cluding the Institute of Medicine), academia,
17 community based non-profit organizations, mi-
18 nority health and related organizations, the
19 education community, State and local govern-
20 ments, and other appropriate organizations.

21 (E) CHAIRPERSON.—The Deputy Assistant
22 Secretary for Minority Health and the Adminis-
23 trator of the Health Resources and Services Ad-
24 ministration, in consultation with the members
25 of the coordinating committee involved, shall

1 designate a chairperson of the coordinating
2 committee, who shall serve for a term of 3
3 years and who may be reappointed at the expi-
4 ration of each such term.

5 (F) TERMS.—Each member of a coordi-
6 nating committee shall be appointed for a term
7 of 1 to 3 years in overlapping staggered terms,
8 as determined by the Deputy Assistant Sec-
9 retary for Minority Health and the Adminis-
10 trator of the Health Resources and Services Ad-
11 ministration at the time of appointment, and
12 may be reappointed at the expiration of each
13 such term.

14 (G) VACANCIES.—A vacancy on a coordi-
15 nating committee shall be filled in the same
16 manner in which the original appointment was
17 made.

18 (4) MEETINGS.—A coordinating committee
19 shall meet at least twice each year, at the call of the
20 coordinating committee's chairperson and in con-
21 sultation with the Deputy Assistant Secretary for
22 Minority Health and the Administrator Health Re-
23 sources and Services Administration.

24 (5) REPORT.—Each coordinating committee
25 shall transmit to the Congress an annual report

1 that, with respect to the health empowerment zone
2 program involved, includes the following:

3 (A) A review of the program's effectiveness
4 in achieving stated goals and outcomes.

5 (B) A review of the program's manage-
6 ment and the coordination of the entities in-
7 volved, including the representation and involve-
8 ment of communities experiencing health dis-
9 parities.

10 (C) A review of the activities in the pro-
11 gram's portfolio and components.

12 (D) An identification of policy issues raised
13 by the program.

14 (E) An assessment of the program's capac-
15 ity, infrastructure, and number of underserved
16 minority communities engaged.

17 (F) Recommendations for new program
18 goals, research areas, enhanced approaches,
19 partnerships, coordination and management
20 mechanisms, and projects to be established to
21 achieve the program's stated goals, to improve
22 outcomes, monitoring, and evaluation.

23 (G) A review of the degree of minority en-
24 tity participation in the program, and an identi-

1 fication of a strategy to increase such participa-
2 tion.

3 (H) Any other reviews or recommendations
4 determined to be appropriate by the coordi-
5 nating committee.

6 (d) REPORT.—The Deputy Assistant Secretary for
7 Minority Health and the Administrator of the Health Re-
8 sources and Services Administration shall submit a joint
9 annual report to the appropriate committees of Congress
10 on the results of the implementation of programs under
11 this section.

12 (e) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section,
14 such sums as may be necessary for each of fiscal years
15 2008 through 2013.

16 **SEC. 502. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
17 **ACT.**

18 Title XXX of the Public Health Service Act, as
19 amended by titles II, III, and IV of this Act, is further
20 amended by adding at the end the following:

1 **“Subtitle D—Reconstruction and**
2 **Improvement Grants for Public**
3 **Health Care Facilities Serving**
4 **Pacific Islanders and the Insu-**
5 **lar Areas**

6 **“SEC. 3051. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
7 **INITIATIVES.**

8 “(a) IN GENERAL.—The Secretary, in collaboration
9 with the Administrator of the Health Resources and Serv-
10 ices Administration, the Director of the Agency for
11 Healthcare Research and Quality, and the Administrator
12 of the Centers for Medicare & Medicaid Services, shall
13 award grants to eligible entities for the conduct of dem-
14 onstration projects to improve the quality of and access
15 to health care.

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

18 “(1) be a health center, hospital, health plan,
19 health system, community clinic, or other health en-
20 tity determined appropriate by the Secretary—

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

24 “(B) that provides care or treatment for a
25 substantial number of patients who are unin-

1 sured, are receiving assistance under a State
2 program under title XIX of the Social Security
3 Act, or are members of vulnerable populations,
4 as determined by the Secretary; and

5 “(C)(i) with respect to which, not less than
6 50 percent of the entity’s patient population is
7 made up of racial and ethnic minorities; or

8 “(ii) that—

9 “(I) serves a disproportionate percent-
10 age of local, minority racial and ethnic pa-
11 tients, or that has a patient population, at
12 least 50 percent of which is limited English
13 proficient; and

14 “(II) provides an assurance that
15 amounts received under the grant will be
16 used only to support quality improvement
17 activities in the racial and ethnic popu-
18 lation served; and

19 “(2) prepare and submit to the Secretary an
20 application at such time, in such manner, and con-
21 taining such information as the Secretary may re-
22 quire.

23 “(c) PRIORITY.—In awarding grants under sub-
24 section (a), the Secretary shall give priority to applicants
25 under subsection (b)(2) that—

1 “(1) demonstrate an intent to operate as part
2 of a health care partnership, network, collaborative,
3 coalition, or alliance where each member entity con-
4 tributes to the design, implementation, and evalua-
5 tion of the proposed intervention; or

6 “(2) intend to use funds to carry out system-
7 wide changes with respect to health care quality im-
8 provement, including—

9 “(A) improved systems for data collection
10 and reporting;

11 “(B) innovative collaborative or similar
12 processes;

13 “(C) group programs with behavioral or
14 self-management interventions;

15 “(D) case management services;

16 “(E) physician or patient reminder sys-
17 tems;

18 “(F) educational interventions; or

19 “(G) other activities determined appro-
20 priate by the Secretary.

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

1 “(1) with respect to health care systems, activi-
2 ties relating to improving—

3 “(A) patient safety;

4 “(B) timeliness of care;

5 “(C) effectiveness of care;

6 “(D) efficiency of care;

7 “(E) patient centeredness; and

8 “(F) health information technology; and

9 “(2) with respect to patients, activities relating
10 to—

11 “(A) staying healthy;

12 “(B) getting well;

13 “(C) living with illness or disability; and

14 “(D) coping with end of life issues.

15 “(e) COMMON DATA SYSTEMS.—The Secretary shall
16 provide financial and other technical assistance to grant-
17 ees under this section for the development of common data
18 systems.

19 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated to carry out this section,
21 such sums as may be necessary for each of fiscal years
22 2008 through 2013.

23 **“SEC. 3052. CENTERS OF EXCELLENCE.**

24 “(a) IN GENERAL.—The Secretary, acting through
25 the Administrator of the Health Resources and Services

1 Administration, shall designate centers of excellence at
2 public hospitals, and other health systems serving large
3 numbers of minority patients, that—

4 “(1) meet the requirements of section
5 3051(b)(1);

6 “(2) demonstrate excellence in providing care to
7 minority populations; and

8 “(3) demonstrate excellence in reducing dispari-
9 ties in health and health care.

10 “(b) REQUIREMENTS.—A hospital or health system
11 that serves as a Center of Excellence under subsection (a)
12 shall—

13 “(1) design, implement, and evaluate programs
14 and policies relating to the delivery of care in ra-
15 cially, ethnically, and linguistically diverse popu-
16 lations;

17 “(2) provide training and technical assistance
18 to other hospitals and health systems relating to the
19 provision of quality health care to minority popu-
20 lations; and

21 “(3) develop activities for graduate or con-
22 tinuing medical education that institutionalize a
23 focus on cultural competence training for health care
24 providers.

1 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
2 is authorized to be appropriated to carry out this section,
3 such sums as may be necessary for each of fiscal years
4 2008 through 2013.

5 **“SEC. 3053. RECONSTRUCTION AND IMPROVEMENT GRANTS**
6 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
7 **ING PACIFIC ISLANDERS AND THE INSULAR**
8 **AREAS.**

9 “(a) IN GENERAL.—The Secretary shall provide di-
10 rect financial assistance to designated health care pro-
11 viders and community health centers in American Samoa,
12 Guam, the Commonwealth of the Northern Mariana Is-
13 lands, the United States Virgin Islands, Puerto Rico, and
14 Hawaii for the purposes of reconstructing and improving
15 health care facilities and services.

16 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
17 nancial assistance under subsection (a), an entity shall be
18 a public health facility or community health center located
19 in American Samoa, Guam, or the Commonwealth of the
20 Northern Mariana Islands, the United States Virgin Is-
21 lands, Puerto Rico, and Hawaii that—

22 “(1) is owned or operated by—

23 “(A) the government of American Samoa,
24 Guam, or the Commonwealth of the Northern
25 Mariana Islands, the United States Virgin Is-

1 lands, Puerto Rico, and Hawaii or a unit of
2 local government; or

3 “(B) a nonprofit organization; and

4 “(2)(A) provides care or treatment for a sub-
5 stantial number of patients who are uninsured, re-
6 ceiving assistance under a State program under a
7 title XVIII of the Social Security Act, or a State
8 program under title XIX of such Act, or who are
9 members of a vulnerable population, as determined
10 by the Secretary; or

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

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

22 “(1) consult with and obtain information on all
23 health care facilities needs from the entities de-
24 scribed in subsection (b); and

1 431(c) of such Act) and who are otherwise eligible for such
2 assistance, within either or both of the following eligibility
3 categories:

4 “(i) PREGNANT WOMEN.—Women during preg-
5 nancy (and during the 60-day period beginning on
6 the last day of the pregnancy).

7 “(ii) CHILDREN.—Individuals under 21 years of
8 age, including optional targeted low-income children
9 described in section 1905(u)(2)(B).

10 “(B) In the case of a State that has elected to provide
11 medical assistance to a category of undocumented resi-
12 dents under subparagraph (A), no debt shall accrue under
13 an affidavit of support against any sponsor of such an un-
14 documented resident on the basis of provision of assistance
15 to such category and the cost of such assistance shall not
16 be considered as an unreimbursed cost.”.

17 (b) SCHIP.—Section 2107(e)(1) of such Act (42
18 U.S.C. 1397gg(e)(1)) is amended by redesignating sub-
19 paragraphs (C) and (D) as subparagraph (D) and (E),
20 respectively, and by inserting after subparagraph (B) the
21 following new subparagraph:

22 “(C) Section 1903(v)(4) (relating to op-
23 tional coverage of categories of lawfully residing
24 immigrant children), but only if the State has

1 elected to apply such section to the category of
2 children under title XIX.”.

3 (c) **EFFECTIVE DATE.**—The amendments made by
4 this section take effect on October 1, 2007, and apply to
5 medical assistance and child health assistance furnished
6 on or after such date.

7 **SEC. 504. BORDER HEALTH GRANTS.**

8 (a) **ELIGIBLE ENTITY DEFINED.**—In this section,
9 the term “eligible entity” means a State, public institution
10 of higher education, local government, tribal government,
11 nonprofit health organization, community health center, or
12 community clinic receiving assistance under section 330
13 of the Public Health Service Act (42 U.S.C. 254b), that
14 is located in the border area.

15 (b) **AUTHORIZATION.**—From funds appropriated
16 under subsection (f), the Secretary of Health and Human
17 Services (in this section referred to as the “Secretary”),
18 acting through the United States members of the United
19 States-Mexico Border Health Commission, shall award
20 grants to eligible entities to address priorities and rec-
21 ommendations to improve the health of border area resi-
22 dents that are established by—

23 (1) the United States members of the United
24 States-Mexico Border Health Commission;

25 (2) the State border health offices; and

1 (3) the Secretary.

2 (c) APPLICATION.—An eligible entity that desires a
3 grant under subsection (b) shall submit an application to
4 the Secretary at such time, in such manner, and con-
5 taining such information as the Secretary may require.

6 (d) USE OF FUNDS.—An eligible entity that receives
7 a grant under subsection (b) shall use the grant funds
8 for—

9 (1) programs relating to—

10 (A) maternal and child health;

11 (B) primary care and preventative health;

12 (C) public health and public health infra-
13 structure;

14 (D) health education and promotion;

15 (E) oral health;

16 (F) mental and behavioral health;

17 (G) substance abuse;

18 (H) health conditions that have a high
19 prevalence in the border area;

20 (I) medical and health services research;

21 (J) workforce training and development;

22 (K) community health workers or
23 promotoras;

1 (L) health care infrastructure problems in
2 the border area (including planning and con-
3 struction grants);

4 (M) health disparities in the border area;

5 (N) environmental health; and

6 (O) outreach and enrollment services with
7 respect to Federal programs (including pro-
8 grams authorized under titles XIX and XXI of
9 the Social Security Act (42 U.S.C. 1396 and
10 1397aa)); and

11 (2) other programs determined appropriate by
12 the Secretary.

13 (e) SUPPLEMENT, NOT SUPPLANT.—Amounts pro-
14 vided to an eligible entity awarded a grant under sub-
15 section (b) shall be used to supplement and not supplant
16 other funds available to the eligible entity to carry out the
17 activities described in subsection (d).

18 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
19 authorized to be appropriated to carry out this section,
20 \$200,000,000 for fiscal year 2008, and such sums as may
21 be necessary for each succeeding fiscal year.

22 **SEC. 505. CANCER PREVENTION AND TREATMENT DEM-**
23 **ONSTRATION FOR ETHNIC AND RACIAL MI-**
24 **NORITIES.**

25 (a) DEMONSTRATION.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (in this section referred to as the
3 “Secretary”) shall conduct demonstration projects
4 (in this section referred to as “demonstration
5 projects”) for the purpose of developing models and
6 evaluating methods that—

7 (A) improve the quality of items and serv-
8 ices provided to target individuals in order to
9 facilitate reduced disparities in early detection
10 and treatment of cancer;

11 (B) improve clinical outcomes, satisfaction,
12 quality of life, and appropriate use of Medicare-
13 covered services and referral patterns among
14 those target individuals with cancer;

15 (C) eliminate disparities in the rate of pre-
16 ventive cancer screening measures, such as pap
17 smears, prostate cancer screenings, and CT
18 scans for lung cancer among target individuals;
19 and

20 (D) promote collaboration with community-
21 based organizations to ensure cultural com-
22 petency of health care professionals and lin-
23 guistic access for persons with limited English
24 proficiency.

1 (2) TARGET INDIVIDUAL DEFINED.—In this
2 section, the term “target individual” means an indi-
3 vidual of a racial and ethnic minority group, as de-
4 fined by section 1707 of the Public Health Service
5 Act (42 U.S.C. 300u–6) who is entitled to benefits
6 under part A, and enrolled under part B, of title
7 XVIII of the Social Security Act.

8 (b) PROGRAM DESIGN.—

9 (1) INITIAL DESIGN.—Not later than 1 year
10 after the date of the enactment of this Act, the Sec-
11 retary shall evaluate best practices in the private
12 sector, community programs, and academic research
13 of methods that reduce disparities among individuals
14 of racial and ethnic minority groups in the preven-
15 tion and treatment of cancer and shall design the
16 demonstration projects based on such evaluation.

17 (2) NUMBER AND PROJECT AREAS.—Not later
18 than 2 years after the date of the enactment of this
19 Act, the Secretary shall implement at least nine
20 demonstration projects, including the following:

21 (A) Two projects for each of the four fol-
22 lowing major racial and ethnic minority groups:

23 (i) American Indians and Alaska Na-
24 tives, Eskimos and Aleuts.

25 (ii) Asian Americans.

- 1 (iii) Blacks/African Americans.
2 (iv) Hispanic/Latino Americans.
3 (v) Native Hawaiians and other Pa-
4 cific Islanders.

5 The two projects must target different ethnic
6 subpopulations.

7 (B) One project within the Pacific Islands
8 or United States insular areas.

9 (C) At least one project each in a rural
10 area and inner-city area.

11 (3) EXPANSION OF PROJECTS; IMPLEMENTA-
12 TION OF DEMONSTRATION PROJECT RESULTS.—If
13 the initial report under subsection (c) contains an
14 evaluation that demonstration projects—

15 (A) reduce expenditures under the Medi-
16 care program under title XVIII of the Social
17 Security Act; or

18 (B) do not increase expenditures under the
19 Medicare program and reduce racial and ethnic
20 health disparities in the quality of health care
21 services provided to target individuals and in-
22 crease satisfaction of beneficiaries and health
23 care providers;

1 the Secretary shall continue the existing demonstra-
2 tion projects and may expand the number of dem-
3 onstration projects.

4 (c) REPORT TO CONGRESS.—

5 (1) IN GENERAL.—Not later than 2 years after
6 the date the Secretary implements the initial dem-
7 onstration projects, and biannually thereafter, the
8 Secretary shall submit to Congress a report regard-
9 ing the demonstration projects.

10 (2) CONTENTS OF REPORT.—Each report under
11 paragraph (1) shall include the following:

12 (A) A description of the demonstration
13 projects.

14 (B) An evaluation of—

15 (i) the cost-effectiveness of the dem-
16 onstration projects;

17 (ii) the quality of the health care serv-
18 ices provided to target individuals under
19 the demonstration projects; and

20 (iii) beneficiary and health care pro-
21 vider satisfaction under the demonstration
22 projects.

23 (C) Any other information regarding the
24 demonstration projects that the Secretary de-
25 termines to be appropriate.

1 (d) WAIVER AUTHORITY.—The Secretary shall waive
2 compliance with the requirements of title XVIII of the So-
3 cial Security Act to such extent and for such period as
4 the Secretary determines is necessary to conduct dem-
5 onstration projects.

6 **SEC. 506. GRANTS TO PROMOTE POSITIVE HEALTH BEHAV-**
7 **IORES IN WOMEN AND CHILDREN.**

8 Part P of title III of the Public Health Service Act
9 (42 U.S.C. 280g et seq.) is amended by adding at the end
10 the following:

11 **“SEC. 399R. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
12 **HAVIORS IN WOMEN AND CHILDREN.**

13 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
14 laboration with the Director of the Centers for Disease
15 Control and Prevention and other Federal officials deter-
16 mined appropriate by the Secretary, is authorized to
17 award grants to eligible entities to promote positive health
18 behaviors for women and children in target populations,
19 especially racial and ethnic minority women and children
20 in medically underserved communities.

21 “(b) USE OF FUNDS.—Grants awarded pursuant to
22 subsection (a) may be used to support community health
23 workers—

24 “(1) to educate and provide outreach regarding
25 enrollment in health insurance including the State

1 Children’s Health Insurance Program under title
2 XXI of the Social Security Act, Medicare under title
3 XVIII of such Act, and Medicaid under title XIX of
4 such Act;

5 “(2) to educate, guide, and provide outreach in
6 a community setting regarding health problems prev-
7 alent among women and children and especially
8 among racial and ethnic minority women and chil-
9 dren;

10 “(3) to educate, guide, and provide experiential
11 learning opportunities that target behavioral risk
12 factors including—

13 “(A) poor nutrition;

14 “(B) physical inactivity;

15 “(C) being overweight or obese;

16 “(D) tobacco use;

17 “(E) alcohol and substance use;

18 “(F) injury and violence;

19 “(G) risky sexual behavior;

20 “(H) mental health problems;

21 “(I) dental and oral health problems; and

22 “(J) understanding informed consent;

23 “(4) to educate and guide regarding effective
24 strategies to promote positive health behaviors with-
25 in the family;

1 “(5) to promote community wellness and aware-
2 ness; and

3 “(6) to educate and refer target populations to
4 appropriate health care agencies and community-
5 based programs and organizations in order to in-
6 crease access to quality health care services, includ-
7 ing preventive health services.

8 “(c) APPLICATION.—

9 “(1) IN GENERAL.—Each eligible entity that
10 desires to receive a grant under subsection (a) shall
11 submit an application to the Secretary, at such time,
12 in such manner, and accompanied by such additional
13 information as the Secretary may require.

14 “(2) CONTENTS.—Each application submitted
15 pursuant to paragraph (1) shall—

16 “(A) describe the activities for which as-
17 sistance under this section is sought;

18 “(B) contain an assurance that with re-
19 spect to each community health worker pro-
20 gram receiving funds under the grant awarded,
21 such program provides training and supervision
22 to community health workers to enable such
23 workers to provide authorized program services;

24 “(C) contain an assurance that the appli-
25 cant will evaluate the effectiveness of commu-

1 nity health worker programs receiving funds
2 under the grant;

3 “(D) contain an assurance that each com-
4 munity health worker program receiving funds
5 under the grant will provide services in the cul-
6 tural context most appropriate for the individ-
7 uals served by the program;

8 “(E) contain a plan to document and dis-
9 seminate project description and results to
10 other States and organizations as identified by
11 the Secretary; and

12 “(F) describe plans to enhance the capac-
13 ity of individuals to utilize health services and
14 health-related social services under Federal,
15 State, and local programs by—

16 “(i) assisting individuals in estab-
17 lishing eligibility under the programs and
18 in receiving the services or other benefits
19 of the programs; and

20 “(ii) providing other services as the
21 Secretary determines to be appropriate,
22 that may include transportation and trans-
23 lation services.

1 “(d) PRIORITY.—In awarding grants under sub-
2 section (a), the Secretary shall give priority to those appli-
3 cants—

4 “(1) who propose to target geographic areas—

5 “(A) with a high percentage of residents
6 who are eligible for health insurance but are
7 uninsured or underinsured; and

8 “(B) with a high percentage of families for
9 whom English is not their primary language.

10 “(2) with experience in providing health or
11 health-related social services to individuals who are
12 underserved with respect to such services; and

13 “(3) with documented community activity and
14 experience with community health workers.

15 “(e) COLLABORATION WITH ACADEMIC INSTITU-
16 TIONS.—The Secretary shall encourage community health
17 worker programs receiving funds under this section to col-
18 laborate with academic institutions, including minority-
19 serving institutions. Nothing in this section shall be con-
20 strued to require such collaboration.

21 “(f) QUALITY ASSURANCE AND COST-EFFECTIVE-
22 NESS.—The Secretary shall establish guidelines for assur-
23 ing the quality of the training and supervision of commu-
24 nity health workers under the programs funded under this

1 section and for assuring the cost-effectiveness of such pro-
2 grams.

3 “(g) MONITORING.—The Secretary shall monitor
4 community health worker programs identified in approved
5 applications and shall determine whether such programs
6 are in compliance with the guidelines established under
7 subsection (f).

8 “(h) TECHNICAL ASSISTANCE.—The Secretary may
9 provide technical assistance to community health worker
10 programs identified in approved applications with respect
11 to planning, developing, and operating programs under the
12 grant.

13 “(i) REPORT TO CONGRESS.—

14 “(1) IN GENERAL.—Not later than 4 years
15 after the date on which the Secretary first awards
16 grants under subsection (a), the Secretary shall sub-
17 mit to Congress a report regarding the grant
18 project.

19 “(2) CONTENTS.—The report required under
20 paragraph (1) shall include the following:

21 “(A) A description of the programs for
22 which grant funds were used.

23 “(B) The number of individuals served.

24 “(C) An evaluation of—

1 “(i) the effectiveness of these pro-
2 grams;

3 “(ii) the cost of these programs; and

4 “(iii) the impact of the project on the
5 health outcomes of the community resi-
6 dents.

7 “(D) Recommendations for sustaining the
8 community health worker programs developed
9 or assisted under this section.

10 “(E) Recommendations regarding training
11 to enhance career opportunities for community
12 health workers.

13 “(j) DEFINITIONS.—In this section:

14 “(1) COMMUNITY HEALTH WORKER.—The term
15 ‘community health worker’ means an individual who
16 promotes health or nutrition within the community
17 in which the individual resides—

18 “(A) by serving as a liaison between com-
19 munities and health care agencies;

20 “(B) by providing guidance and social as-
21 sistance to community residents;

22 “(C) by enhancing community residents’
23 ability to effectively communicate with health
24 care providers;

1 “(D) by providing culturally and linguis-
2 tically appropriate health or nutrition edu-
3 cation;

4 “(E) by advocating for individual and com-
5 munity health, including dental, oral, mental,
6 and environmental health, or nutrition needs;
7 and

8 “(F) by providing referral and followup
9 services.

10 “(2) COMMUNITY SETTING.—The term ‘commu-
11 nity setting’ means a home or a community organi-
12 zation located in the neighborhood in which a partic-
13 ipant resides.

14 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
15 tity’ means—

16 “(A) a unit of State, territorial, local, or
17 tribal government (including a federally recog-
18 nized tribe or Alaska native villages); or

19 “(B) a community-based organization.

20 “(4) MEDICALLY UNDERSERVED COMMUNITY.—

21 The term ‘medically underserved community’ means
22 a community—

23 “(A) that has a substantial number of in-
24 dividuals who are members of a medically un-

1 “(M) EXCEPTION FOR CITIZENS OF FREE-
2 LY ASSOCIATED STATES.—With respect to eligi-
3 bility for benefits for the specified Federal pro-
4 grams described in paragraph (3), paragraph
5 (1) shall not apply to any individual who law-
6 fully resides in the United States (including ter-
7 ritories and possessions of the United States) in
8 accordance with—

9 “(i) section 141 of the Compact of
10 Free Association between the Government
11 of the United States and the Government
12 of the Federated States of Micronesia, ap-
13 proved by Congress in the Compact of
14 Free Association Amendments Act of
15 2003;

16 “(ii) section 141 of the Compact of
17 Free Association between the Government
18 of the United States and the Government
19 of the Republic of the Marshall Islands,
20 approved by Congress in the Compact of
21 Free Association Amendments Act of
22 2003; or

23 “(iii) section 141 of the Compact of
24 Free Association between the Government
25 of the United States and the Government

1 of Palau, approved by Congress in Public
2 Law 99–658 (100 Stat. 3672).”.

3 (b) **MEDICAID EXCEPTION.**—Section 402(b)(2) of the
4 Personal Responsibility and Work Opportunity Reconcili-
5 ation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by
6 adding at the end the following:

7 “(G) **MEDICAID EXCEPTIONS FOR CITI-**
8 **ZENS OF FREELY ASSOCIATED STATES.**—With
9 respect to eligibility for benefits for the pro-
10 grams defined in subparagraphs (A) and (C) of
11 paragraph (3) (relating to Medicaid), paragraph
12 (1) shall not apply to any individual who law-
13 fully resides in the United States (including ter-
14 ritories and possessions of the United States) in
15 accordance with a Compact of Free Association
16 referred to in subsection (a)(2)(M).”.

17 (c) **QUALIFIED ALIEN.**—Section 431(b) of the Per-
18 sonal Responsibility and Work Opportunity Reconciliation
19 Act of 1996 (8 U.S.C. 1641(b)) is amended—

20 (1) in paragraph (6), by striking “or” at the
21 end;

22 (2) in paragraph (7), by striking the period at
23 the end and inserting “; or”; and

24 (3) by adding at the end the following:

1 “(8) an individual who lawfully resides in the
2 United States (including territories and possessions
3 of the United States) in accordance with a Compact
4 of Free Association referred to in section
5 402(a)(2)(M).”.

6 (d) FINANCIAL TREATMENT UNDER MEDICAID.—
7 Section 1108 of the Social Security Act (42 U.S.C. 1308)
8 is amended—

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

11 (2) by adding at the end the following new sub-
12 section:

13 “(h) The limitations of subsections (f) and (g) shall
14 not apply with respect to medical assistance provided to
15 an individual described in section 431(b)(8) of the Per-
16 sonal Responsibility and Work Opportunity Reconciliation
17 Act of 1996.”.

18 (e) INCREASED FMAP.—The third sentence of sec-
19 tion 1905(b) of the Social Security Act (42 U.S.C.
20 1396d(b)) is amended by inserting before the period at
21 the end the following: “and for services furnished to indi-
22 viduals described in section 431(b)(8) of the Personal Re-
23 sponsibility and Work Opportunity Reconciliation Act of
24 1996”.

1 **SEC. 508. MEDICARE GRADUATE MEDICAL EDUCATION.**

2 (a) CLARIFICATION OF CONGRESSIONAL INTENT RE-
3 GARDING THE COUNTING OF RESIDENTS IN A NONHOS-
4 PITAL SETTING.—

5 (1) D-GME.—Section 1886(h)(4)(E) of the So-
6 cial Security Act (42 U.S.C. 1395ww(h)(4)(E)) is
7 amended by adding at the end the following new
8 sentences: “For purposes of the preceding sentence,
9 the term ‘all, or substantially all, of the costs for the
10 training program’ means the stipends and benefits
11 provided to the resident and other amounts, if any,
12 as determined by the hospital and the entity oper-
13 ating the nonhospital setting. The hospital is not re-
14 quired to pay the entity any amounts other than
15 those determined by the hospital and the entity in
16 order for the hospital to be considered to have in-
17 curred all, or substantially all, of the costs for the
18 training program in that setting.”.

19 (2) IME.—Section 1886(d)(5)(B)(iv) of the So-
20 cial Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is
21 amended by adding at the end the following new
22 sentences: “For purposes of the preceding sentence,
23 the term ‘all, or substantially all, of the costs for the
24 training program’ means the stipends and benefits
25 provided to the resident and other amounts, if any,
26 as determined by the hospital and the entity oper-

1 ating the nonhospital setting. The hospital is not re-
2 quired to pay the entity any amounts other than
3 those determined by the hospital and the entity in
4 order for the hospital to be considered to have in-
5 curred all, or substantially all, of the costs for the
6 training program in that setting.”.

7 (3) EFFECTIVE DATE.—The amendments made
8 by this subsection shall take effect on January 1,
9 2008.

10 (b) CLARIFICATION OF ELIGIBILITY OF A NONRURAL
11 HOSPITAL THAT HAS A TRAINING PROGRAM WITH AN
12 INTEGRATED RURAL TRACK.—

13 (1) IN GENERAL.—Section 1886(h)(4)(H) of
14 the Social Security Act (42 U.S.C.
15 1395ww(h)(4)(H)) is amended—

16 (A) in clause (iv), by inserting “(as defined
17 in clause (v))” after “an integrated rural
18 track”; and

19 (B) by adding at the end the following new
20 clause:

21 “(v) DEFINITION OF ACCREDITED
22 TRAINING PROGRAM WITH AN INTEGRATED
23 RURAL TRACK.—For purposes of clause
24 (iv), the term ‘accredited training program
25 with an integrated rural track’ means an

1 accredited medical residency training pro-
2 gram located in an urban area which offers
3 a curriculum for all residents in the pro-
4 gram that includes the following character-
5 istics:

6 “(I) A minimum of 3 block
7 months of rural rotations. During
8 such 3 block months, the resident is
9 in a rural area for 4 weeks or a
10 month.

11 “(II) A stated mission for train-
12 ing rural physicians.

13 “(III) A minimum of 3 months of
14 obstetrical training, or an equivalent
15 longitudinal experience.

16 “(IV) A minimum of 4 months of
17 pediatric training that includes neo-
18 natal, ambulatory, inpatient, and
19 emergency experiences through rota-
20 tions, or an equivalent longitudinal ex-
21 perience.

22 “(V) A minimum of 2 months of
23 emergency medicine rotations, or an
24 equivalent longitudinal experience.”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection apply with respect to—

3 (A) payments to hospitals under section
4 1886(h) of the Social Security Act (42 U.S.C.
5 1395ww(h)) for cost reporting periods begin-
6 ning on or after January 1, 2008; and

7 (B) payments to hospitals under section
8 1886(d)(5)(B)(v) of such Act (42 U.S.C.
9 1395ww(d)(5)(B)(v)) for discharges occurring
10 on or after January 1, 2008.

11 **SEC. 509. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MI-**
12 **NORITY COMMUNITIES.**

13 (a) EXPANDED FUNDING.—The Secretary, in col-
14 laboration with the Director of the Office of Minority
15 Health, the Director of the Centers for Disease Control
16 and Prevention, the Administrator of the Health Re-
17 sources and Services Administration, and the Adminis-
18 trator of the Substance Abuse and Mental Health Services
19 Administration, shall provide funds and carry out activi-
20 ties to expand the Minority HIV/AIDS Initiative.

21 (b) USE OF FUNDS.—The additional funds made
22 available under this section may be used, through the Mi-
23 nority AIDS Initiative, to support the following activities:

1 (1) Providing technical assistance and infra-
2 structure support to reduce HIV/AIDS in minority
3 populations.

4 (2) Increasing minority populations' access to
5 HIV/AIDS prevention and care services.

6 (3) Building strong community programs and
7 partnerships to address HIV prevention and the
8 health care needs of specific racial and ethnic minor-
9 ity populations.

10 (c) PRIORITY INTERVENTIONS.—Within the racial
11 and ethnic minority populations referred to in subsection
12 (b), priority in conducting intervention services shall be
13 given to—

14 (1) women;

15 (2) youth;

16 (3) men who engage in homosexual activity;

17 (4) persons who engage in intravenous drug
18 abuse;

19 (5) homeless individuals; and

20 (6) individuals incarcerated or in the penal sys-
21 tem.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—For car-
23 rying out this section, there are authorized to be appro-
24 priated \$610,000,000 for fiscal year 2008 and such sums

1 as may be necessary for each of fiscal years 2009 through
2 2012.

3 **SEC. 510. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
4 **TO COMMUNITY HEALTH.**

5 (a) **PURPOSE.**—It is the purpose of this section to
6 provide for the awarding of grants to assist communities
7 in mobilizing and organizing resources in support of effec-
8 tive and sustainable programs that will reduce or eliminate
9 disparities in health and health care experienced by racial
10 and ethnic minority individuals.

11 (b) **AUTHORITY.**—The Secretary, acting through the
12 Director of the Centers for Disease Control and Preven-
13 tion, in consultation with the Office of Minority Health,
14 shall award grants to eligible entities to assist in design-
15 ing, implementing, and evaluating culturally and linguis-
16 tically appropriate, evidence-based, and community-driven
17 sustainable strategies to eliminate racial and ethnic health
18 and health care disparities.

19 (c) **ELIGIBLE ENTITIES.**—To be eligible to receive a
20 grant under this section, an entity shall—

21 (1) represent a coalition—

22 (A) whose principal purpose is to develop
23 and implement interventions to reduce or elimi-
24 nate a health or health care disparity in a tar-

1 geted racial or ethnic minority group in the
2 community served by the coalition; and

3 (B) that includes—

4 (i) at least 3 members selected from
5 among—

6 (I) public health departments;

7 (II) community-based organiza-
8 tions;

9 (III) university and research or-
10 ganizations;

11 (IV) Indian tribes, tribal organi-
12 zations, urban Indian organizations,
13 national or regional Indian organiza-
14 tions, or the Indian Health Service;

15 (V) organizations serving Native
16 Hawaiians;

17 (VI) organizations serving Pacific
18 Islanders; and

19 (VII) interested public or private
20 health care providers or organizations
21 as deemed appropriate by the Sec-
22 retary; and

23 (ii) at least 1 member from a commu-
24 nity-based organization that represents the

1 targeted racial or ethnic minority group;
2 and

3 (2) submit to the Secretary an application at
4 such time, in such manner, and containing such in-
5 formation as the Secretary may require, which shall
6 include—

7 (A) a description of the targeted racial or
8 ethnic populations in the community to be
9 served under the grant;

10 (B) a description of at least 1 health dis-
11 parity that exists in the racial or ethnic tar-
12 geted populations, including infant mortality,
13 breast and cervical cancer screening and man-
14 agement, cardiovascular disease, diabetes, child
15 and adult immunization levels, HIV/AIDS, hep-
16 atitis B, tuberculosis, or asthma, or other
17 health priority areas as designated by the Sec-
18 retary; and

19 (C) a demonstration of a proven record of
20 accomplishment of the coalition members in
21 serving and working with the targeted commu-
22 nity.

23 (d) SUSTAINABILITY.—The Secretary shall give pri-
24 ority to an eligible entity under this section if the entity
25 agrees that, with respect to the costs to be incurred by

1 the entity in carrying out the activities for which the grant
2 was awarded, the entity (and each of the participating
3 partners in the coalition represented by the entity) will
4 maintain its expenditures of non-Federal funds for such
5 activities at a level that is not less than the level of such
6 expenditures during the fiscal year immediately preceding
7 the first fiscal year for which the grant is awarded.

8 (e) NONDUPLICATION.—Funds provided through this
9 grant program should supplement, not supplant, existing
10 Federal funding, and the funds should not be used to du-
11 plicate the activities of the other health disparity grant
12 programs in this Act.

13 (f) TECHNICAL ASSISTANCE.—The Secretary may,
14 either directly or by grant or contract, provide any entity
15 that receives a grant under this section with technical and
16 other non-financial assistance necessary to meet the re-
17 quirements of this section.

18 (g) DISSEMINATION.—The Secretary shall encourage
19 and enable grantees to share best practices, evaluation re-
20 sults, and reports using the Internet, conferences, and
21 other pertinent information regarding the projects funded
22 by this section, including the outreach efforts of the Office
23 of Minority Health and the Centers for Disease Control
24 and Prevention. Such information shall be publicly avail-

1 able, and posted on the Internet website of relevant Gov-
2 ernment agencies.

3 (h) ADMINISTRATIVE BURDENS.—The Secretary
4 shall make every effort to minimize duplicative or unneces-
5 sary administrative burdens on grantees.

6 **SEC. 511. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

7 (a) CLARIFICATION OF PAYMENT FOR CLINICAL
8 LABORATORY TESTS FURNISHED BY CRITICAL ACCESS
9 HOSPITALS.—

10 (1) IN GENERAL.—Section 1834(g)(4) of the
11 Social Security Act (42 U.S.C. 1395m(g)(4)) is
12 amended—

13 (A) in the heading, by striking “NO BENE-
14 FICIARY COST-SHARING” and inserting “TREAT-
15 MENT OF”; and

16 (B) by adding at the end the following new
17 sentence: “For purposes of the preceding sen-
18 tence and section 1861(mm)(3), clinical diag-
19 nostic laboratory services furnished by a critical
20 access hospital shall be treated as being fur-
21 nished as part of outpatient critical access serv-
22 ices without regard to whether—

23 “(A) the individual with respect to whom
24 such services are furnished is physically present

1 in the critical access hospital at the time the
2 specimen is collected;

3 “(B) such individual is registered as an
4 outpatient on the records of, and receives such
5 services directly from, the critical access hos-
6 pital; or

7 “(C) payment is (or, but for this sub-
8 section, would be) available for such services
9 under the fee schedule established under section
10 1833(h).”.

11 (2) EFFECTIVE DATE.—The amendments made
12 by paragraph (1) shall apply to cost reporting peri-
13 ods beginning on or after October 1, 2008.

14 (b) ELIMINATION OF ISOLATION TEST FOR COST-
15 BASED AMBULANCE REIMBURSEMENT.—

16 (1) IN GENERAL.—Section 1834(l)(8) of the
17 Social Security Act (42 U.S.C. 1395m(l)(8)) is
18 amended—

19 (A) in subparagraph (B)—

20 (i) by striking “owned and”; and

21 (ii) by inserting “(including when
22 such services are provided by the entity
23 under an arrangement with the hospital)”
24 after “hospital”; and

1 (B) by striking the comma at the end of
2 subparagraph (B) and all that follows and in-
3 serting a period.

4 (2) EFFECTIVE DATE.—The amendments made
5 by this subsection shall apply to services furnished
6 on or after January 1, 2008.

7 (c) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
8 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
9 REQUIREMENT.—

10 (1) IN GENERAL.—Section 1820(c)(2) of the
11 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
12 amended—

13 (A) in subparagraph (B)(iii), by striking
14 “provides not more than” and inserting “sub-
15 ject to subparagraph (F), provides not more
16 than”; and

17 (B) by adding at the end the following new
18 subparagraph:

19 “(F) ALTERNATIVE TO 25 INPATIENT BED
20 LIMIT REQUIREMENT.—

21 “(i) IN GENERAL.—A State may elect
22 to treat a facility, with respect to the des-
23 ignation of the facility for a cost reporting
24 period, as satisfying the requirement of
25 subparagraph (B)(iii) relating to a max-

1 imum number of acute care inpatient beds
2 if the facility elects, in accordance with a
3 method specified by the Secretary and be-
4 fore the beginning of the cost reporting pe-
5 riod, to meet the requirement under clause
6 (ii).

7 “(ii) ALTERNATE REQUIREMENT.—
8 The requirement under this clause, with
9 respect to a facility and a cost reporting
10 period, is that the total number of inpa-
11 tient bed days described in subparagraph
12 (B)(iii) during such period will not exceed
13 7,300. For purposes of this subparagraph,
14 an individual who is an inpatient in a bed
15 in the facility for a single day shall be
16 counted as one inpatient bed day.

17 “(iii) WITHDRAWAL OF ELECTION.—
18 The option described in clause (i) shall not
19 apply to a facility for a cost reporting pe-
20 riod if the facility (for any two consecutive
21 cost reporting periods during the previous
22 5 cost reporting periods) was treated under
23 such option and had a total number of in-
24 patient bed days for each of such two cost

1 reporting periods that exceeded the num-
2 ber specified in such clause.”.

3 (2) EFFECTIVE DATE.—The amendments made
4 by paragraph (1) shall apply to cost reporting peri-
5 ods beginning on or after the date of the enactment
6 of this Act.

7 **SEC. 512. COVERAGE OF MARRIAGE AND FAMILY THERA-**
8 **PIST SERVICES AND MENTAL HEALTH COUN-**
9 **SELOR SERVICES UNDER PART B OF THE**
10 **MEDICARE PROGRAM.**

11 (a) COVERAGE OF SERVICES.—

12 (1) IN GENERAL.—Section 1861(s)(2) of the
13 Social Security Act (42 U.S.C. 1395x(s)(2)) is
14 amended—

15 (A) in subparagraph (Z), by striking
16 “and” at the end;

17 (B) in subparagraph (AA), by inserting
18 “and” at the end; and

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

21 “(BB) marriage and family therapist services
22 (as defined in subsection (ccc)(1)) and mental health
23 counselor services (as defined in subsection
24 (ccc)(3));”.

1 (2) DEFINITIONS.—Section 1861 of such Act
2 (42 U.S.C. 1395x) is amended by adding at the end
3 the following new subsection:

4 “Marriage and Family Therapist Services; Marriage and
5 Family Therapist; Mental Health Counselor Serv-
6 ices; Mental Health Counselor

7 “(ccc)(1) The term ‘marriage and family therapist
8 services’ means services performed by a marriage and
9 family therapist (as defined in paragraph (2)) for the diag-
10 nosis and treatment of mental illnesses, which the mar-
11 riage and family therapist is legally authorized to perform
12 under State law (or the State regulatory mechanism pro-
13 vided by State law) of the State in which such services
14 are performed, as would otherwise be covered if furnished
15 by a physician or as an incident to a physician’s profes-
16 sional service, but only if no facility or other provider
17 charges or is paid any amounts with respect to the fur-
18 nishing of such services.

19 “(2) The term ‘marriage and family therapist’ means
20 an individual who—

21 “(A) possesses a master’s or doctoral degree
22 which qualifies for licensure or certification as a
23 marriage and family therapist pursuant to State
24 law;

1 “(B) after obtaining such degree has performed
2 at least 2 years of clinical supervised experience in
3 marriage and family therapy; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of marriage and family therapists, is li-
7 censed or certified as a marriage and family thera-
8 pist in such State.

9 “(3) The term ‘mental health counselor services’
10 means services performed by a mental health counselor (as
11 defined in paragraph (4)) for the diagnosis and treatment
12 of mental illnesses which the mental health counselor is
13 legally authorized to perform under State law (or the
14 State regulatory mechanism provided by the State law) of
15 the State in which such services are performed, as would
16 otherwise be covered if furnished by a physician or as inci-
17 dent to a physician’s professional service, but only if no
18 facility or other provider charges or is paid any amounts
19 with respect to the furnishing of such services.

20 “(4) The term ‘mental health counselor’ means an
21 individual who—

22 “(A) possesses a master’s or doctor’s degree in
23 mental health counseling or a related field;

1 “(B) after obtaining such a degree has per-
2 formed at least 2 years of supervised mental health
3 counselor practice; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of mental health counselors or professional
7 counselors, is licensed or certified as a mental health
8 counselor or professional counselor in such State.”.

9 (3) PROVISION FOR PAYMENT UNDER PART
10 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.
11 1395k(a)(2)(B)) is amended by adding at the end
12 the following new clause:

13 “(v) marriage and family therapist
14 services and mental health counselor serv-
15 ices;”.

16 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
17 of such Act (42 U.S.C. 1395l(a)(1)) is amended—

18 (A) by striking “and (V)” and inserting
19 “(V)”; and

20 (B) by inserting before the semicolon at
21 the end the following: “, and (W) with respect
22 to marriage and family therapist services and
23 mental health counselor services under section
24 1861(s)(2)(BB), the amounts paid shall be 80
25 percent of the lesser of the actual charge for

1 the services or 75 percent of the amount deter-
2 mined for payment of a psychologist under sub-
3 paragraph (L)”.

4 (5) EXCLUSION OF MARRIAGE AND FAMILY
5 THERAPIST SERVICES AND MENTAL HEALTH COUN-
6 SELOR SERVICES FROM SKILLED NURSING FACILITY
7 PROSPECTIVE PAYMENT SYSTEM.—Section
8 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
9 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
10 riage and family therapist services (as defined in
11 section 1861(ccc)(1)), mental health counselor serv-
12 ices (as defined in section 1861(ccc)(3)),” after
13 “qualified psychologist services,”.

14 (6) INCLUSION OF MARRIAGE AND FAMILY
15 THERAPISTS AND MENTAL HEALTH COUNSELORS AS
16 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-
17 tion 1842(b)(18)(C) of such Act (42 U.S.C.
18 1395u(b)(18)(C)) is amended by adding at the end
19 the following new clauses:

20 “(vii) A marriage and family therapist (as de-
21 fined in section 1861(ccc)(2)).

22 “(viii) A mental health counselor (as defined in
23 section 1861(ccc)(4)).”.

24 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
25 ICES PROVIDED IN CERTAIN SETTINGS.—

1 (1) RURAL HEALTH CLINICS AND FEDERALLY
2 QUALIFIED HEALTH CENTERS.—Section
3 1861(aa)(1)(B) of the Social Security Act (42
4 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
5 by a clinical social worker (as defined in subsection
6 (hh)(1)),” and inserting “, by a clinical social worker
7 (as defined in subsection (hh)(1)), by a marriage
8 and family therapist (as defined in subsection
9 (ccc)(2)), or by a mental health counselor (as de-
10 fined in subsection (ccc)(4)),”.

11 (2) HOSPICE PROGRAMS.—Section
12 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.
13 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or
14 one marriage and family therapist (as defined in
15 subsection (ccc)(2))” after “social worker”.

16 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
17 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-
18 HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the So-
19 cial Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended
20 by inserting “marriage and family therapist (as defined
21 in subsection (ccc)(2)),” after “social worker,”.

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section shall apply with respect to services furnished
24 on or after January 1, 2008.

1 **SEC. 513. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
2 **PITAL (RCH) PROGRAM.**

3 (a) IN GENERAL.—Section 1861 of the Social Secu-
4 rity Act (42 U.S.C. 1395x), as amended by section 512,
5 is amended by adding at the end of the following new sub-
6 section:

7 “Rural Community Hospital; Rural Community Hospital
8 Services

9 “(ddd)(1) The term ‘rural community hospital’
10 means a hospital (as defined in subsection (e)) that—

11 “(A) is located in a rural area (as defined in
12 section 1886(d)(2)(D)) or treated as being so lo-
13 cated pursuant to section 1886(d)(8)(E);

14 “(B) subject to paragraph (2), has less than 51
15 acute care inpatient beds, as reported in its most re-
16 cent cost report;

17 “(C) makes available 24-hour emergency care
18 services;

19 “(D) subject to paragraph (3), has a provider
20 agreement in effect with the Secretary and is open
21 to the public as of January 1, 2008; and

22 “(E) applies to the Secretary for such designa-
23 tion.

24 “(2) For purposes of paragraph (1)(B), beds in a
25 psychiatric or rehabilitation unit of the hospital which is
26 a distinct part of the hospital shall not be counted.

1 “(3) Subparagraph (1)(D) shall not be construed to
2 prohibit any of the following from qualifying as a rural
3 community hospital:

4 “(A) A replacement facility (as defined by the
5 Secretary in regulations in effect on January 1,
6 2008) with the same service area (as defined by the
7 Secretary in regulations in effect on such date).

8 “(B) A facility obtaining a new provider num-
9 ber pursuant to a change of ownership.

10 “(C) A facility which has a binding written
11 agreement with an outside, unrelated party for the
12 construction, reconstruction, lease, rental, or financ-
13 ing of a building as of January 1, 2008.

14 “(4) Nothing in this subsection shall be construed as
15 prohibiting a critical access hospital from qualifying as a
16 rural community hospital if the critical access hospital
17 meets the conditions otherwise applicable to hospitals
18 under subsection (e) and section 1866.

19 “(5) Nothing in this subsection shall be construed as
20 prohibiting a rural community hospital participating in
21 the demonstration program under Section 410A of the
22 Medicare Prescription Drug, Improvement, and Mod-
23 ernization Act of 2003 (Public Law 108–173; 117 Stat.
24 2313) from qualifying as a rural community hospital if
25 the rural community hospital meets the conditions other-

1 wise applicable to hospitals under subsection (e) and sec-
2 tion 1866.”.

3 (b) PAYMENT.—

4 (1) INPATIENT HOSPITAL SERVICES.—Section
5 1814 of the Social Security Act (42 U.S.C. 1395f)
6 is amended by adding at the end the following new
7 subsection:

8 “Payment for Inpatient Services Furnished in Rural
9 Community Hospitals

10 “(m) The amount of payment under this part for in-
11 patient hospital services furnished in a rural community
12 hospital, other than such services furnished in a psy-
13 chiatric or rehabilitation unit of the hospital which is a
14 distinct part, is, at the election of the hospital in the appli-
15 cation referred to in section 1861(ddd)(1)(E)—

16 “(1) 101 percent of the reasonable costs of pro-
17 viding such services, without regard to the amount
18 of the customary or other charge, or

19 “(2) the amount of payment provided for under
20 the prospective payment system for inpatient hos-
21 pital services under section 1886(d).”.

22 (2) OUTPATIENT SERVICES.—Section 1834 of
23 such Act (42 U.S.C. 1395m) is amended by adding
24 at the end the following new subsection:

1 “(n) PAYMENT FOR OUTPATIENT SERVICES FUR-
2 NISHED IN RURAL COMMUNITY HOSPITALS.—The
3 amount of payment under this part for outpatient services
4 furnished in a rural community hospital is, at the election
5 of the hospital in the application referred to in section
6 1861(ddd)(1)(E)—

7 “(1) 101 percent of the reasonable costs of pro-
8 viding such services, without regard to the amount
9 of the customary or other charge and any limitation
10 under section 1861(v)(1)(U), or

11 “(2) the amount of payment provided for under
12 the prospective payment system for covered OPD
13 services under section 1833(t).”.

14 (3) EXEMPTION FROM 30-PERCENT REDUCTION
15 IN REIMBURSEMENT FOR BAD DEBT.—Section
16 1861(v)(1)(T) of such Act (42 U.S.C.
17 1395x(v)(1)(T)) is amended by inserting “(other
18 than for a rural community hospital)” after “In de-
19 termining such reasonable costs for hospitals”.

20 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
21 SERVICES.—Section 1834(n) of such Act (as added by
22 subsection (b)(2)) is amended—

23 (1) by redesignating paragraphs (1) and (2) as
24 subparagraphs (A) and (B), respectively;

25 (2) by inserting “(1)” after “(n)”; and

1 (3) by adding at the end the following:

2 “(2) The amounts of beneficiary cost-sharing for out-
3 patient services furnished in a rural community hospital
4 under this part shall be as follows:

5 “(A) For items and services that would have
6 been paid under section 1833(t) if provided by a
7 hospital, the amount of cost-sharing determined
8 under paragraph (8) of such section.

9 “(B) For items and services that would have
10 been paid under section 1833(h) if furnished by a
11 provider or supplier, no cost-sharing shall apply.

12 “(C) For all other items and services, the
13 amount of cost-sharing that would apply to the item
14 or service under the methodology that would be used
15 to determine payment for such item or service if pro-
16 vided by a physician, provider, or supplier, as the
17 case may be.”.

18 (d) CONFORMING AMENDMENTS.—

19 (1) PART A PAYMENT.—Section 1814(b) of
20 such Act (42 U.S.C. 1395f(b)) is amended in the
21 matter preceding paragraph (1) by inserting “other
22 than inpatient hospital services furnished by a rural
23 community hospital,” after “critical access hospital
24 services,”.

1 (2) PART B PAYMENT.—Section 1833(a) of
2 such Act (42 U.S.C. 1395l(a)) is amended—

3 (A) in paragraph (2), in the matter before
4 subparagraph (A), by striking “and (I)” and in-
5 serting “(I), and (K)”;

6 (B) by striking “and” at the end of para-
7 graph (8);

8 (C) by striking the period at the end of
9 paragraph (9) and inserting “; and”; and

10 (D) by adding at the end the following:

11 “(10) in the case of outpatient services fur-
12 nished by a rural community hospital, the amounts
13 described in section 1834(n).”.

14 (3) TECHNICAL AMENDMENTS.—

15 (A) CONSULTATION WITH STATE AGEN-
16 CIES.—Section 1863 of such Act (42 U.S.C.
17 1395z) is amended by striking “and (dd)(2)”
18 and inserting “(dd)(2), (mm)(1), and
19 (ddd)(1)”.

20 (B) PROVIDER AGREEMENTS.—Section
21 1866(a)(2)(A) of such Act (42 U.S.C.
22 1395cc(a)(2)(A)) is amended by inserting “sec-
23 tion 1834(n)(2),” after “section 1833(b),”.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to items and services furnished on
3 or after October 1, 2007.

4 **SEC. 514. MEDICARE REMOTE MONITORING PILOT**
5 **PROJECTS.**

6 (a) PILOT PROJECTS.—

7 (1) IN GENERAL.—Not later than 9 months
8 after the date of enactment of this Act, the Sec-
9 retary of Health and Human Services (in this sec-
10 tion referred to as the “Secretary”) shall conduct
11 pilot projects under title XVIII of the Social Secu-
12 rity Act for the purpose of providing incentives to
13 home health agencies to utilize home monitoring and
14 communications technologies that—

15 (A) enhance health outcomes for Medicare
16 beneficiaries; and

17 (B) reduce expenditures under such title.

18 (2) SITE REQUIREMENTS.—

19 (A) URBAN AND RURAL.—The Secretary
20 shall conduct the pilot projects under this sec-
21 tion in both urban and rural areas.

22 (B) SITE IN A SMALL STATE.—The Sec-
23 retary shall conduct at least 3 of the pilot
24 projects in a State with a population of less
25 than 1,000,000.

1 (3) DEFINITION OF HOME HEALTH AGENCY.—

2 In this section, the term “home health agency” has
3 the meaning given that term in section 1861(o) of
4 the Social Security Act (42 U.S.C. 1395x(o)).

5 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
6 OF PROJECTS.—The Secretary shall specify the criteria
7 for identifying those Medicare beneficiaries who shall be
8 considered within the scope of the pilot projects under this
9 section for purposes of the application of subsection (c)
10 and for the assessment of the effectiveness of the home
11 health agency in achieving the objectives of this section.
12 Such criteria may provide for the inclusion in the projects
13 of Medicare beneficiaries who begin receiving home health
14 services under title XVIII of the Social Security Act after
15 the date of the implementation of the projects.

16 (c) INCENTIVES.—

17 (1) PERFORMANCE TARGETS.—The Secretary
18 shall establish for each home health agency partici-
19 pating in a pilot project under this section a per-
20 formance target using one of the following meth-
21 odologies, as determined appropriate by the Sec-
22 retary:

23 (A) ADJUSTED HISTORICAL PERFORMANCE
24 TARGET.—The Secretary shall establish for the
25 agency—

1 (i) a base expenditure amount equal
2 to the average total payments made to the
3 agency under parts A and B of title XVIII
4 of the Social Security Act for Medicare
5 beneficiaries determined to be within the
6 scope of the pilot project in a base period
7 determined by the Secretary; and

8 (ii) an annual per capita expenditure
9 target for such beneficiaries, reflecting the
10 base expenditure amount adjusted for risk
11 and adjusted growth rates.

12 (B) COMPARATIVE PERFORMANCE TAR-
13 GET.—The Secretary shall establish for the
14 agency a comparative performance target equal
15 to the average total payments under such parts
16 A and B during the pilot project for comparable
17 individuals in the same geographic area that
18 are not determined to be within the scope of the
19 pilot project.

20 (2) INCENTIVE.—Subject to paragraph (3), the
21 Secretary shall pay to each participating home care
22 agency an incentive payment for each year under the
23 pilot project equal to a portion of the Medicare sav-
24 ings realized for such year relative to the perform-
25 ance target under paragraph (1).

1 (3) LIMITATION ON EXPENDITURES.—The Sec-
2 retary shall limit incentive payments under this sec-
3 tion in order to ensure that the aggregate expendi-
4 tures under title XVIII of the Social Security Act
5 (including incentive payments under this subsection)
6 do not exceed the amount that the Secretary esti-
7 mates would have been expended if the pilot projects
8 under this section had not been implemented.

9 (d) WAIVER AUTHORITY.—The Secretary may waive
10 such provisions of titles XI and XVIII of the Social Secu-
11 rity Act as the Secretary determines to be appropriate for
12 the conduct of the pilot projects under this section.

13 (e) REPORT TO CONGRESS.—Not later than 5 years
14 after the date that the first pilot project under this section
15 is implemented, the Secretary shall submit to Congress a
16 report on the pilot projects. Such report shall contain a
17 detailed description of issues related to the expansion of
18 the projects under subsection (f) and recommendations for
19 such legislation and administrative actions as the Sec-
20 retary considers appropriate.

21 (f) EXPANSION.—If the Secretary determines that
22 any of the pilot projects under this section enhance health
23 outcomes for Medicare beneficiaries and reduce expendi-
24 tures under title XVIII of the Social Security Act, the Sec-

1 retary may initiate comparable projects in additional
2 areas.

3 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
4 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
5 tive payment under this section—

6 (1) shall be in addition to the payments that a
7 home health agency would otherwise receive under
8 title XVIII of the Social Security Act for the provi-
9 sion of home health services; and

10 (2) shall have no effect on the amount of such
11 payments.

12 **SEC. 515. RURAL HEALTH QUALITY ADVISORY COMMISSION**
13 **AND DEMONSTRATION PROJECTS.**

14 (a) RURAL HEALTH QUALITY ADVISORY COMMIS-
15 SION.—

16 (1) ESTABLISHMENT.—Not later than 6
17 months after the date of the enactment of this sec-
18 tion, the Secretary of Health and Human Services
19 (in this section referred to as the “Secretary”) shall
20 establish a commission to be known as the Rural
21 Health Quality Advisory Commission (in this section
22 referred to as the “Commission”).

23 (2) DUTIES OF COMMISSION.—

24 (A) NATIONAL PLAN.—The Commission
25 shall develop, coordinate, and facilitate imple-

1 mentation of a national plan for rural health
2 quality improvement. The national plan shall—

3 (i) identify objectives for rural health
4 quality improvement;

5 (ii) identify strategies to eliminate
6 known gaps in rural health system capacity
7 and improve rural health quality; and

8 (iii) provide for Federal programs to
9 identify opportunities for strengthening
10 and aligning policies and programs to im-
11 prove rural health quality.

12 (B) DEMONSTRATION PROJECTS.—The
13 Commission shall design demonstration projects
14 to test alternative models for rural health qual-
15 ity improvement, including with respect to both
16 personal and population health.

17 (C) MONITORING.—The Commission shall
18 monitor progress toward the objectives identi-
19 fied pursuant to paragraph (1)(A).

20 (3) MEMBERSHIP.—

21 (A) NUMBER.—The Commission shall be
22 composed of 11 members appointed by the Sec-
23 retary.

24 (B) SELECTION.—The Secretary shall se-
25 lect the members of the Commission from

1 among individuals with significant rural health
2 care and health care quality expertise, including
3 expertise in clinical health care, health care
4 quality research, population or public health, or
5 purchaser organizations.

6 (4) CONTRACTING AUTHORITY.—Subject to the
7 availability of funds, the Commission may enter into
8 contracts and make other arrangements, as may be
9 necessary to carry out the duties described in para-
10 graph (2).

11 (5) STAFF.—Upon the request of the Commis-
12 sion, the Secretary may detail, on a reimbursable
13 basis, any of the personnel of the Office of Rural
14 Health Policy of the Health Resources and Services
15 Administration, the Agency for Health Care Quality
16 and Research, or the Centers for Medicare & Medicaid
17 Services to the Commission to assist in
18 carrying out this subsection.

19 (6) REPORTS TO CONGRESS.—Not later than 1
20 year after the establishment of the Commission, and
21 annually thereafter, the Commission shall submit a
22 report to the Congress on rural health quality. Each
23 such report shall include the following:

1 (A) An inventory of relevant programs and
2 recommendations for improved coordination and
3 integration of policy and programs.

4 (B) An assessment of achievement of the
5 objectives identified in the national plan devel-
6 oped under paragraph (2) and recommenda-
7 tions for realizing such objectives.

8 (C) Recommendations on Federal legisla-
9 tion, regulations, or administrative policies to
10 enhance rural health quality and outcomes.

11 (b) RURAL HEALTH QUALITY DEMONSTRATION
12 PROJECTS.—

13 (1) IN GENERAL.—Not later than 270 days
14 after the date of the enactment of this section, the
15 Secretary, in consultation with the Rural Health
16 Quality Advisory Commission, the Office of Rural
17 Health Policy of the Health Resources and Services
18 Administration, the Agency for Healthcare Research
19 and Quality, and the Centers for Medicare &
20 Medicaid Services, shall make grants to eligible enti-
21 ties for 5 demonstration projects to implement and
22 evaluate methods for improving the quality of health
23 care in rural communities. Each such demonstration
24 project shall include—

25 (A) alternative community models that—

1 (i) will achieve greater integration of
2 personal and population health services;
3 and

4 (ii) address safety, effectiveness,
5 patient- or community-centeredness, timeli-
6 ness, efficiency, and equity (the six aims
7 identified by the Institute of Medicine of
8 the National Academies in its report enti-
9 tled “Crossing the Quality Chasm: A New
10 Health System for the 21st Century” re-
11 leased on March 1, 2001);

12 (B) innovative approaches to the financing
13 and delivery of health services to achieve rural
14 health quality goals; and

15 (C) development of quality improvement
16 support structures to assist rural health sys-
17 tems and professionals (such as workforce sup-
18 port structures, quality monitoring and report-
19 ing, clinical care protocols, and information
20 technology applications).

21 (2) ELIGIBLE ENTITIES.—In this subsection,
22 the term “eligible entity” means a consortium
23 that—

24 (A) shall include—

1 (i) at least one health care provider or
2 health care delivery system located in a
3 rural area; and

4 (ii) at least one organization rep-
5 resenting multiple community stakeholders;
6 and

7 (B) may include other partners such as
8 rural research centers.

9 (3) CONSULTATION.—In developing the pro-
10 gram for awarding grants under this subsection, the
11 Secretary shall consult with the Administrator of the
12 Agency for Healthcare Research and Quality, rural
13 health care providers, rural health care researchers,
14 and private and non-profit groups (including na-
15 tional associations) which are undertaking similar
16 efforts.

17 (4) EXPEDITED WAIVERS.—The Secretary shall
18 expedite the processing of any waiver that—

19 (A) is authorized under title XVIII or XIX
20 of the Social Security Act (42 U.S.C. 1395 et
21 seq.); and

22 (B) is necessary to carry out a demonstra-
23 tion project under this subsection.

24 (5) DEMONSTRATION PROJECT SITES.—The
25 Secretary shall ensure that the 5 demonstration

1 projects funded under this subsection are conducted
2 at a variety of sites representing the diversity of
3 rural communities in the Nation.

4 (6) DURATION.—Each demonstration project
5 under this subsection shall be for a period of 4
6 years.

7 (7) INDEPENDENT EVALUATION.—The Sec-
8 retary shall enter into an arrangement with an enti-
9 ty that has experience working directly with rural
10 health systems for the conduct of an independent
11 evaluation of the program carried out under this
12 subsection.

13 (8) REPORT.—Not later than one year after the
14 conclusion of all of the demonstration projects fund-
15 ed under this subsection, the Secretary shall submit
16 a report to the Congress on the results of such
17 projects. The report shall include—

18 (A) an evaluation of patient access to care,
19 patient outcomes, and an analysis of the cost
20 effectiveness of each such project; and

21 (B) recommendations on Federal legisla-
22 tion, regulations, or administrative policies to
23 enhance rural health quality and outcomes.

24 (c) APPROPRIATION.—

1 (1) IN GENERAL.—Out of funds in the Treas-
2 ury not otherwise appropriated, there are appro-
3 priated to the Secretary to carry out this section
4 \$30,000,000 for the period of fiscal years 2008
5 through 2012.

6 (2) AVAILABILITY.—

7 (A) IN GENERAL.—Funds appropriated
8 under paragraph (1) shall remain available for
9 expenditure through fiscal year 2012.

10 (B) REPORT.—For purposes of carrying
11 out subsection (b)(8), funds appropriated under
12 paragraph (1) shall remain available for ex-
13 penditure through fiscal year 2013.

14 (3) RESERVATION.—Of the amount appro-
15 priated under paragraph (1), the Secretary shall re-
16 serve—

17 (A) \$5,000,000 to carry out subsection (a);

18 and

19 (B) \$25,000,000 to carry out subsection

20 (b), of which—

21 (i) 2 percent shall be for the provision
22 of technical assistance to grant recipients;

23 and

24 (ii) 5 percent shall be for independent
25 evaluation under subsection (b)(7).

1 **SEC. 516. RURAL HEALTH CARE SERVICES.**

2 Section 330A of the Public Health Service Act (42
3 U.S.C. 254c) is amended to read as follows:

4 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
5 **RURAL HEALTH NETWORK DEVELOPMENT,**
6 **DELTA RURAL DISPARITIES AND HEALTH**
7 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
8 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
9 **MENT GRANT PROGRAMS.**

10 “(a) PURPOSE.—The purpose of this section is to
11 provide for grants—

12 “(1) under subsection (b), to promote rural
13 health care services outreach;

14 “(2) under subsection (c), to provide for the
15 planning and implementation of integrated health
16 care networks in rural areas;

17 “(3) under subsection (d), to assist rural com-
18 munities in the Delta Region to reduce health dis-
19 parities and to promote and enhance health system
20 development; and

21 “(4) under subsection (e), to provide for the
22 planning and implementation of small rural health
23 care provider quality improvement activities.

24 “(b) RURAL HEALTH CARE SERVICES OUTREACH
25 GRANTS.—

1 “(1) GRANTS.—The Director of the Office of
2 Rural Health Policy of the Health Resources and
3 Services Administration may award grants to eligible
4 entities to promote rural health care services out-
5 reach by expanding the delivery of health care serv-
6 ices to include new and enhanced services in rural
7 areas. The Director may award the grants for peri-
8 ods of not more than 3 years.

9 “(2) ELIGIBILITY.—To be eligible to receive a
10 grant under this subsection for a project, an enti-
11 ty—

12 “(A) shall be a rural public or rural non-
13 profit private entity, a facility that qualifies as
14 a rural health clinic under title XVIII of the
15 Social Security Act, a public or nonprofit entity
16 existing exclusively to provide services to mi-
17 grant and seasonal farm workers in rural areas,
18 or a tribal government whose grant-funded ac-
19 tivities will be conducted within federally recog-
20 nized tribal areas;

21 “(B) shall represent a consortium com-
22 posed of members—

23 “(i) that include 3 or more independ-
24 ently-owned health care entities; and

1 “(ii) that may be nonprofit or for-
2 profit entities; and

3 “(C) shall not previously have received a
4 grant under this subsection for the same or a
5 similar project, unless the entity is proposing to
6 expand the scope of the project or the area that
7 will be served through the project.

8 “(3) APPLICATIONS.—To be eligible to receive a
9 grant under this subsection, an eligible entity shall
10 prepare and submit to the Director an application at
11 such time, in such manner, and containing such in-
12 formation as the Director may require, including—

13 “(A) a description of the project that the
14 eligible entity will carry out using the funds
15 provided under the grant;

16 “(B) a description of the manner in which
17 the project funded under the grant will meet
18 the health care needs of rural populations in
19 the local community or region to be served;

20 “(C) a plan for quantifying how health
21 care needs will be met through identification of
22 the target population and benchmarks of service
23 delivery or health status, such as—

1 “(i) quantifiable measurements of
2 health status improvement for projects fo-
3 cusing on health promotion; or

4 “(ii) benchmarks of increased access
5 to primary care, including tracking factors
6 such as the number and type of primary
7 care visits, identification of a medical
8 home, or other general measures of such
9 access;

10 “(D) a description of how the local com-
11 munity or region to be served will be involved
12 in the development and ongoing operations of
13 the project;

14 “(E) a plan for sustaining the project after
15 Federal support for the project has ended;

16 “(F) a description of how the project will
17 be evaluated;

18 “(G) the administrative capacity to submit
19 annual performance data electronically as speci-
20 fied by the Director; and

21 “(H) other such information as the Direc-
22 tor determines to be appropriate.

23 “(c) RURAL HEALTH NETWORK DEVELOPMENT
24 GRANTS.—

25 “(1) GRANTS.—

1 “(A) IN GENERAL.—The Director may
2 award rural health network development grants
3 to eligible entities to promote, through planning
4 and implementation, the development of inte-
5 grated health care networks that have combined
6 the functions of the entities participating in the
7 networks in order to—

8 “(i) achieve efficiencies and economies
9 of scale;

10 “(ii) expand access to, coordinate, and
11 improve the quality of the health care de-
12 livery system through development of orga-
13 nizational efficiencies;

14 “(iii) implement health information
15 technology to achieve efficiencies, reduce
16 medical errors, and improve quality;

17 “(iv) coordinate care and manage
18 chronic illness; and

19 “(v) strengthen the rural health care
20 system as a whole in such a manner as to
21 show a quantifiable return on investment
22 to the participants in the network.

23 “(B) GRANT PERIODS.—The Director may
24 award such a rural health network development
25 grant—

1 “(i) for a period of 3 years for imple-
2 mentation activities; or

3 “(ii) for a period of 1 year for plan-
4 ning activities to assist in the initial devel-
5 opment of an integrated health care net-
6 work, if the proposed participants in the
7 network do not have a history of collabo-
8 rative efforts and a 3-year grant would be
9 inappropriate.

10 “(2) ELIGIBILITY.—To be eligible to receive a
11 grant under this subsection, an entity—

12 “(A) shall be a rural public or rural non-
13 profit private entity, a facility that qualifies as
14 a rural health clinic under title XVIII of the
15 Social Security Act, a public or nonprofit entity
16 existing exclusively to provide services to mi-
17 grant and seasonal farm workers in rural areas,
18 or a tribal government whose grant-funded ac-
19 tivities will be conducted within federally recog-
20 nized tribal areas;

21 “(B) shall represent a network composed
22 of participants—

23 “(i) that include 3 or more independ-
24 ently-owned health care entities; and

1 “(ii) that may be nonprofit or for-
2 profit entities; and

3 “(C) shall not previously have received a
4 grant under this subsection (other than a 1-
5 year grant for planning activities) for the same
6 or a similar project.

7 “(3) APPLICATIONS.—To be eligible to receive a
8 grant under this subsection, an eligible entity, in
9 consultation with the appropriate State office of
10 rural health or another appropriate State entity,
11 shall prepare and submit to the Director an applica-
12 tion at such time, in such manner, and containing
13 such information as the Director may require, in-
14 cluding—

15 “(A) a description of the project that the
16 eligible entity will carry out using the funds
17 provided under the grant;

18 “(B) an explanation of the reasons why
19 Federal assistance is required to carry out the
20 project;

21 “(C) a description of—

22 “(i) the history of collaborative activi-
23 ties carried out by the participants in the
24 network;

1 “(ii) the degree to which the partici-
2 pants are ready to integrate their func-
3 tions; and

4 “(iii) how the local community or re-
5 gion to be served will benefit from and be
6 involved in the activities carried out by the
7 network;

8 “(D) a description of how the local com-
9 munity or region to be served will experience in-
10 creased access to quality health care services
11 across the continuum of care as a result of the
12 integration activities carried out by the net-
13 work, including a description of—

14 “(i) return on investment for the com-
15 munity and the network members; and

16 “(ii) other quantifiable performance
17 measures that show the benefit of the net-
18 work activities;

19 “(E) a plan for sustaining the project after
20 Federal support for the project has ended;

21 “(F) a description of how the project will
22 be evaluated;

23 “(G) the administrative capacity to submit
24 annual performance data electronically as speci-
25 fied by the Director; and

1 “(H) other such information as the Direc-
2 tor determines to be appropriate.

3 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
4 TEMS DEVELOPMENT GRANTS.—

5 “(1) GRANTS.—The Director may award grants
6 to eligible entities to support reduction of health dis-
7 parities, improve access to health care, and enhance
8 rural health system development in the Delta Re-
9 gion.

10 “(2) ELIGIBILITY.—To be eligible to receive a
11 grant under this subsection, an entity shall be a
12 rural public or rural nonprofit private entity, a facil-
13 ity that qualifies as a rural health clinic under title
14 XVIII of the Social Security Act, a public or non-
15 profit entity existing exclusively to provide services
16 to migrant and seasonal farm workers in rural
17 areas, or a tribal government whose grant-funded
18 activities will be conducted within federally recog-
19 nized tribal areas.

20 “(3) APPLICATIONS.—To be eligible to receive a
21 grant under this subsection, an eligible entity shall
22 prepare and submit to the Director an application at
23 such time, in such manner, and containing such in-
24 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of the manner in which
8 the project funded under the grant will meet
9 the health care needs of the Delta Region;

10 “(D) a description of how the local com-
11 munity or region to be served will experience in-
12 creased access to quality health care services as
13 a result of the activities carried out by the enti-
14 ty;

15 “(E) a description of how health dispari-
16 ties will be reduced or the health system will be
17 improved;

18 “(F) a plan for sustaining the project after
19 Federal support for the project has ended;

20 “(G) a description of how the project will
21 be evaluated including process and outcome
22 measures related to the quality of care provided
23 or how the health care system improves its per-
24 formance;

1 “(H) a description of how the grantee will
2 develop an advisory group made up of rep-
3 resentatives of the communities to be served to
4 provide guidance to the grantee to best meet
5 community need; and

6 “(I) other such information as the Director
7 determines to be appropriate.

8 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
9 ITY IMPROVEMENT GRANTS.—

10 “(1) GRANTS.—The Director may award grants
11 to provide for the planning and implementation of
12 small rural health care provider quality improvement
13 activities. The Director may award the grants for
14 periods of 1 to 3 years.

15 “(2) ELIGIBILITY.—To be eligible for a grant
16 under this subsection, an entity—

17 “(A) shall be—

18 “(i) a rural public or rural nonprofit
19 private health care provider or provider of
20 health care services, such as a rural health
21 clinic; or

22 “(ii) another rural provider or net-
23 work of small rural providers identified by
24 the Director as a key source of local care;
25 and

1 “(B) shall not previously have received a
2 grant under this subsection for the same or a
3 similar project.

4 “(3) PREFERENCE.—In awarding grants under
5 this subsection, the Director shall give preference to
6 facilities that qualify as rural health clinics under
7 title XVIII of the Social Security Act.

8 “(4) APPLICATIONS.—To be eligible to receive a
9 grant under this subsection, an eligible entity shall
10 prepare and submit to the Director an application at
11 such time, in such manner, and containing such in-
12 formation as the Director may require, including—

13 “(A) a description of the project that the
14 eligible entity will carry out using the funds
15 provided under the grant;

16 “(B) an explanation of the reasons why
17 Federal assistance is required to carry out the
18 project;

19 “(C) a description of the manner in which
20 the project funded under the grant will assure
21 continuous quality improvement in the provision
22 of services by the entity;

23 “(D) a description of how the local com-
24 munity or region to be served will experience in-
25 creased access to quality health care services as

1 a result of the activities carried out by the enti-
2 ty;

3 “(E) a plan for sustaining the project after
4 Federal support for the project has ended;

5 “(F) a description of how the project will
6 be evaluated including process and outcome
7 measures related to the quality of care pro-
8 vided; and

9 “(G) other such information as the Direc-
10 tor determines to be appropriate.

11 “(f) GENERAL REQUIREMENTS.—

12 “(1) PROHIBITED USES OF FUNDS.—An entity
13 that receives a grant under this section may not use
14 funds provided through the grant—

15 “(A) to build or acquire real property; or

16 “(B) for construction.

17 “(2) COORDINATION WITH OTHER AGENCIES.—

18 The Director shall coordinate activities carried out
19 under grant programs described in this section, to
20 the extent practicable, with Federal and State agen-
21 cies and nonprofit organizations that are operating
22 similar grant programs, to maximize the effect of
23 public dollars in funding meritorious proposals.

24 “(g) REPORT.—Not later than September 30, 2010,
25 the Secretary shall prepare and submit to the appropriate

1 committees of Congress a report on the progress and ac-
2 complishments of the grant programs described in sub-
3 sections (b), (c), (d), and (e).

4 “(h) DEFINITIONS.—In this section:

5 “(1) The term ‘Delta Region’ has the meaning
6 given to the term ‘region’ in section 382A of the
7 Consolidated Farm and Rural Development Act (7
8 U.S.C. 2009aa).

9 “(2) The term ‘Director’ means the Director of
10 the Office of Rural Health Policy of the Health Re-
11 sources and Services Administration.

12 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this section
14 \$40,000,000 for fiscal year 2008, and such sums as may
15 be necessary for each of fiscal years 2009 through 2012.”.

16 **SEC. 517. COMMUNITY HEALTH CENTER COLLABORATIVE**
17 **ACCESS EXPANSION.**

18 Section 330 of the Public Health Service Act (42
19 U.S.C. 254b) is amended by adding at the end the fol-
20 lowing:

21 “(s) MISCELLANEOUS PROVISIONS.—

22 “(1) RULE OF CONSTRUCTION WITH RESPECT
23 TO RURAL HEALTH CLINICS.—

24 “(A) IN GENERAL.—Nothing in this sec-
25 tion shall be construed to prevent a community

1 health center from contracting with a federally
2 certified rural health clinic (as defined by sec-
3 tion 1861(aa)(2) of the Social Security Act) for
4 the delivery of primary health care services that
5 are available at the rural health clinic to indi-
6 viduals who would otherwise be eligible for free
7 or reduced cost care if that individual were able
8 to obtain that care at the community health
9 center. Such services may be limited in scope to
10 those primary health care services available in
11 that rural health clinic.

12 “(B) ASSURANCES.—In order for a rural
13 health clinic to receive funds under this section
14 through a contract with a community health
15 center under paragraph (1), such rural health
16 clinic shall establish policies to ensure—

17 “(i) nondiscrimination based upon the
18 ability of a patient to pay; and

19 “(ii) the establishment of a sliding fee
20 scale for low-income patients.”.

21 **SEC. 518. FACILITATING THE PROVISION OF TELEHEALTH**
22 **SERVICES ACROSS STATE LINES.**

23 (a) IN GENERAL.—For purposes of expediting the
24 provision of telehealth services, for which payment is made
25 under the Medicare program, across State lines, the Sec-

1 retary of Health and Human Services shall, in consulta-
2 tion with representatives of States, physicians, health care
3 practitioners, and patient advocates, encourage and facili-
4 tate the adoption of provisions allowing for multistate
5 practitioner practice across State lines.

6 (b) DEFINITIONS.—In subsection (a):

7 (1) TELEHEALTH SERVICE.—The term “tele-
8 health service” has the meaning given that term in
9 subparagraph (F) of section 1834(m)(4) of the So-
10 cial Security Act (42 U.S.C. 1395m(m)(4)).

11 (2) PHYSICIAN, PRACTITIONER.—The terms
12 “physician” and “practitioner” have the meaning
13 given those terms in subparagraphs (D) and (E), re-
14 spectively, of such section.

15 (3) MEDICARE PROGRAM.—The term “Medicare
16 program” means the program of health insurance
17 administered by the Secretary of Health and Human
18 Services under title XVIII of the Social Security Act
19 (42 U.S.C. 1395 et seq.).

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