

116TH CONGRESS
2D SESSION

H. R. 8200

To improve the health of minority individuals during the COVID–19
pandemic, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 11, 2020

Ms. KELLY of Illinois (for herself, Ms. BASS, Mr. CASTRO of Texas, Ms. JUDY CHU of California, Mr. GARCÍA of Illinois, Ms. HAALAND, Ms. LEE of California, Mr. SOTO, Ms. SEWELL of Alabama, Mr. BUTTERFIELD, Mr. SABLAN, Ms. BARRAGÁN, Ms. CLARKE of New York, Mr. CÁRDENAS, Mr. SARBANES, Ms. PRESSLEY, Mr. THOMPSON of Mississippi, Ms. ESCOBAR, Mr. BRENDAN F. BOYLE of Pennsylvania, Mr. CARSON of Indiana, Mr. CLAY, Mrs. BEATTY, Mr. KHANNA, Ms. GARCIA of Texas, Mr. SAN NICOLAS, Mr. ESPAILLAT, Ms. JAYAPAL, Mrs. DEMINGS, Mr. HASTINGS, Mrs. WATSON COLEMAN, Ms. JOHNSON of Texas, Mr. GRIJALVA, Ms. BONAMICI, and Mr. LYNCH) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, the Judiciary, Transportation and Infrastructure, Education and Labor, Agriculture, Natural Resources, House Administration, Oversight and Reform, the Budget, and Small Business, 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 during the
COVID–19 pandemic, 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,*

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Ending Health Dis-
3 parities During COVID–19 Act of 2020” or the “EHDC
4 Act of 2020”.

5 SEC. 2. TABLE OF CONTENTS.

Sec. 1. Short title.

Sec. 2. Table of contents.

TITLE I—RACIAL AND ETHNICITY DATA COLLECTION

Subtitle A—Collection and Reporting

Sec. 101. Equitable data collection and disclosure on COVID–19 Act.

Sec. 102. COVID–19 reporting portal.

Sec. 103. Regular CDC reporting on demographic data.

Sec. 104. Amendment to the Public Health Service Act.

Sec. 105. Elimination of prerequisite of direct appropriations for data collection
and analysis.

Sec. 106. Collection of data for the Medicare program.

Sec. 107. Revision of HIPAA claims standards.

Sec. 108. Disparities data collected by the Federal Government.

Sec. 109. Standards for measuring sexual orientation, gender identity, and so-
cioeconomic status in collection of health data.

Sec. 110. Improving health data regarding Native Hawaiians and other Pacific
Islanders.

Subtitle B—Improvements and Modernization

Sec. 121. Federal modernization for health inequities data.

Sec. 122. Modernization of State and local health inequities data.

Sec. 123. Additional reporting to Congress on the race and ethnicity rates of
COVID–19 testing, hospitalizations, and mortalities.

TITLE II—EQUITABLE TESTING AND TRACING

Subtitle A—Free Testing for Patients

Sec. 201. Sooner coverage of testing for COVID–19.

Subtitle B—National Testing Strategy

Sec. 211. COVID–19 testing strategy.

Sec. 212. Coronavirus immigrant families protection.

Sec. 213. ICE detention.

Subtitle C—Contact Tracing

Sec. 221. COVID–19 Testing, reaching, and contacting everyone.

Sec. 222. National system for COVID–19 testing, contact tracing, surveillance,
containment, and mitigation.

Sec. 223. Grants.

Sec. 224. Grants to State and Tribal workforce agencies.

TITLE III—FREE TREATMENT FOR ALL AMERICANS

- Sec. 301. Coverage at no cost sharing of COVID–19 vaccine and treatment.
- Sec. 302. Optional coverage at no cost sharing of COVID–19 treatment and vaccines under Medicaid for uninsured individuals.
- Sec. 303. Coverage of treatments for COVID–19 at no cost sharing under the Medicare Advantage program.
- Sec. 304. Requiring coverage under Medicare PDPS and MA–PD plans, without the imposition of cost sharing or utilization management requirements, of drugs intended to treat COVID–19 during certain emergencies.
- Sec. 305. Coverage of COVID–19 related treatment at no cost sharing.
- Sec. 306. Reimbursement for additional health services relating to coronavirus.

TITLE IV—FEDERAL HEALTH EQUITY OVERSIGHT

- Sec. 401. COVID-19 Racial and Ethnic Disparities Task Force Act of 2020.
- Sec. 402. Protection of the HHS Offices of Minority Health.
- Sec. 403. Establish an interagency counsel and grant programs on social determinants of health.
- Sec. 404. Accountability and transparency within the Department of Health and Human Services.

TITLE V—EXPANDED INSURANCE ACCESS

- Sec. 501. Medicare special enrollment period for individuals residing in COVID–19 emergency areas.
- Sec. 502. Special enrollment period through exchanges; Federal exchange outreach and educational activities.
- Sec. 503. MOMMA’s Act.
- Sec. 504. Allowing for medical assistance under Medicaid for inmates during 30-day period preceding release.
- Sec. 505. Providing for immediate Medicaid eligibility for former foster youth.
- Sec. 506. Expanded coverage for former foster youth.
- Sec. 507. Removing citizenship and immigration barriers to access to affordable health care under ACA.
- Sec. 508. Medicaid in the territories.
- Sec. 509. Removing Medicare barrier to health care.
- Sec. 510. Removing barriers to health care and nutrition assistance for children, pregnant persons, and lawfully present individuals.
- Sec. 511. Repeal of requirement for documentation evidencing citizenship or nationality under the Medicaid program.

TITLE VI—COMMUNITY BASED GRANTS

- Sec. 601. Grants for racial and ethnic approaches to community health.
- Sec. 602. Grants to promote health for underserved communities.
- Sec. 603. Addressing COVID–19 health inequities and improving health equity.
- Sec. 604. Improving social determinants of health.
- Sec. 605. Funding to States, localities, and community-based organizations for emergency aid and services.
- Sec. 606. Supplemental nutrition assistance program.

TITLE VII—CULTURALLY AND LINGUISTICALLY COMPETENT CARE

- Sec. 701. Ensuring standards for culturally and linguistically appropriate services in health care.
- Sec. 702. Culturally and linguistically appropriate health care in the Public Health Service Act.
- Sec. 703. Training tomorrow's doctors for culturally and linguistically appropriate care: graduate medical education.
- Sec. 704. Federal reimbursement for culturally and linguistically appropriate services under the Medicare, Medicaid, and State Children's Health Insurance Programs.
- Sec. 705. Requirements for health programs or activities receiving Federal funds.
- Sec. 706. Report on Federal efforts to provide culturally and linguistically appropriate health care services.
- Sec. 707. Health professions competencies to address racial and ethnic mental health disparities.
- Sec. 708. Study on the uninsured.

TITLE VIII—AID TO PROVIDERS SERVING MINORITY COMMUNITIES

- Sec. 801. Temporary increase in Medicaid DSH allotments.
- Sec. 802. COVID-19-related temporary increase of Medicaid FMAP.
- Sec. 803. Appropriation for primary health care.
- Sec. 804. Amendment to the Public Health Service Act.
- Sec. 805. Pandemic premium pay for essential workers.
- Sec. 806. COVID-19 Heroes Fund grants.
- Sec. 807. Enforcement and outreach.

TITLE IX—HEALTH IT AND BRIDGING THE DIGITAL DIVIDE IN HEALTH CARE

- Sec. 901. HRSA assistance to health centers for promotion of Health IT.
- Sec. 902. Assessment of impact of Health IT on racial and ethnic minority communities; outreach and adoption of Health IT in such communities.
- Sec. 903. Extending funding to strengthen the Health IT infrastructure in racial and ethnic minority communities.
- Sec. 904. Extending competitive grants for the development of loan programs to facilitate adoption of certified EHR technology by providers serving racial and ethnic minority groups.
- Sec. 905. Authorization of appropriations.
- Sec. 906. Data collection and assessments conducted in coordination with minority-serving institutions.
- Sec. 907. Study of health information technology in medically underserved communities.
- Sec. 908. Study on the effects of changes to telehealth under the Medicare and Medicaid programs during the COVID-19 emergency.
- Sec. 909. COVID-19 designation of immediate special authority of spectrum for Tribes' emergency response in Indian Country.
- Sec. 910. Facilitating the provision of telehealth services across State lines.

TITLE X—PUBLIC AWARENESS

- Sec. 1001. Awareness campaigns.
- Sec. 1002. Increasing understanding of and improving health literacy.
- Sec. 1003. English for speakers of other languages.

Sec. 1004. Influenza, COVID–19, and pneumonia vaccination campaign.

TITLE XI—RESEARCH

- Sec. 1101. Research and development.
- Sec. 1102. CDC field studies pertaining to specific health inequities.
- Sec. 1103. Expanding capacity for health outcomes.
- Sec. 1104. Data collection and analysis grants to minority-serving institutions.
- Sec. 1105. Safety and effectiveness of drugs with respect to racial and ethnic background.
- Sec. 1106. GAO and NIH reports.
- Sec. 1107. Health impact assessments.
- Sec. 1108. Tribal funding to research health inequities including COVID–19.
- Sec. 1109. Research endowments at both current and former centers of excellence.

TITLE XII—EDUCATION

- Sec. 1201. Grants for schools of medicine in diverse and underserved areas.
- Sec. 1202. Amendment to the Public Health Service Act.
- Sec. 1203. Hispanic-serving institutions, Historically Black Colleges and Universities, Asian American and Native American Pacific Islander-serving institutions, Tribal colleges, regional community-based organizations, and national minority medical associations.
- Sec. 1204. Loan repayment program of Centers for Disease Control and Prevention.
- Sec. 1205. Study and report on strategies for increasing diversity.
- Sec. 1206. Amendments to the Pandemic EBT Act.

TITLE XIII—PUBLIC HEALTH ASSISTANCE TO TRIBES

- Sec. 1301. Appropriations for the Indian Health Service.
- Sec. 1302. Improving State, local, and Tribal public health security.
- Sec. 1303. Provision of items to Indian programs and facilities.
- Sec. 1304. Health care access for urban native veterans.
- Sec. 1305. Proper and reimbursed care for native veterans.

- 1 **TITLE I—RACIAL AND**
- 2 **ETHNICITY DATA COLLECTION**
- 3 **Subtitle A—Collection and**
- 4 **Reporting**
- 5 **SEC. 101. EQUITABLE DATA COLLECTION AND DISCLOSURE**
- 6 **ON COVID–19 ACT.**
- 7 (a) FINDINGS.—Congress makes the following find-
- 8 ings:

1 (1) The World Health Organization (WHO) de-
2 clared COVID–19 a “Public Health Emergency of
3 International Concern” on January 30, 2020. By
4 late March 2020, there have been over 470,000 con-
5 firmed cases of, and 20,000 deaths associated with,
6 COVID–19 worldwide.

7 (2) In the United States, cases of COVID–19
8 have quickly surpassed those across the world, and
9 as of April 12, 2020, over 500,000 cases and 20,000
10 deaths have been reported in the United States
11 alone.

12 (3) Early reporting on racial inequities in
13 COVID–19 testing and treatment have renewed calls
14 for the Centers for Disease Control and Prevention
15 and other relevant subagencies within the Depart-
16 ment of Health and Human Services to publicly re-
17 lease racial and demographic information to better
18 inform the pandemic response, specifically in com-
19 munities of color and in Limited English Proficient
20 (LEP) communities.

21 (4) The burden of morbidity and mortality in
22 the United States has historically fallen dispropor-
23 tionately on marginalized communities (those who
24 suffer the most from great public health needs and
25 are the most medically underserved).

1 (5) Historically, structures and systems, such
2 as racism, ableism and class oppression, have ren-
3 dered affected individuals more vulnerable to inequi-
4 ties and have prevented people from achieving their
5 optimal health even when there is not a crisis of
6 pandemic proportions.

7 (6) Significant differences in access to health
8 care, specifically to primary health care providers,
9 health care information, and greater perceived dis-
10 crimination in health care place communities of
11 color, individuals with disabilities, and LEP individ-
12 uals at greater risk of receiving delayed, and per-
13 haps poorer, health care.

14 (7) Stark racial inequities across the United
15 States, including unequal access to stable housing,
16 quality education, and decent employment signifi-
17 cantly impact the ability of individuals to take care
18 of their most basic health needs. Communities of
19 color are more likely to experience homelessness and
20 struggle with low-paying jobs or unemployment. To
21 date, experts have cited that 2 in 5 Latino residents
22 in New York City, the current epicenter of the
23 COVID–19 pandemic, are recently unemployed as a
24 direct consequence of COVID–19. And at a time
25 when sheltering in place will save lives, less than 1

1 in 5 Black workers and roughly 1 in 6 Latino work-
2 ers are able to work from home.

3 (8) Communities of color experience higher
4 rates of chronic disease and disabilities, such as dia-
5 betes, hypertension, and asthma, than non-Hispanic
6 White communities, which predisposes them to
7 greater risk of complications and mortality should
8 they contract COVID–19.

9 (9) Such communities are made even more vul-
10 nerable to the uncertainty of the preparation, re-
11 sponse, and events surrounding the pandemic public
12 health crisis, COVID–19. For instance, in the recent
13 past, multiple epidemiologic studies and reviews have
14 reported higher rates of hospitalization due to the
15 2009 H1N1 pandemic among the poor, individuals
16 with disabilities and preexisting conditions, those liv-
17 ing in impoverished neighborhoods, and individuals
18 of color and ethnic backgrounds in the United
19 States. These findings highlight the urgency to
20 adapt the COVID–19 response to monitor and act
21 on these inequities via data collection and research
22 by race and ethnicity.

23 (10) Research experts recognize that there are
24 underlying differences in illness and death when
25 each of these factors are examined through socio-

1 economic and racial or ethnic lenses. These socially
2 determinant factors of health accelerate disease and
3 degradation.

4 (11) Language barriers are highly correlated
5 with medication noncompliance and inconsistent en-
6 gagement with health systems. Without language ac-
7 cessibility data and research around COVID–19,
8 these communities are less likely to receive critical
9 testing and preventive health services. Yet, to date,
10 the Centers for Disease Control and Prevention do
11 not disseminate COVID–19 messaging in critical
12 languages, including Mandarin Chinese, Spanish,
13 and Korean within the same timeframe as informa-
14 tion in English despite requirements to ensure lim-
15 ited English proficient populations are not discrimi-
16 nated against under title VI of the Civil Rights Act
17 of 1964 and subsequent laws and Federal policies.

18 (12) Further, it is critical to disaggregate data
19 further by ancestry to address disparities among
20 Asian American, Native Hawaiian, and Pacific Is-
21 lander groups. According to the National Equity
22 Atlas, while 13 percent of the Asian population over-
23 all lived in poverty in 2015, 39 percent of Burmese
24 people, 29 percent of Hmong people, and 21 percent
25 of Pacific Islanders lived in poverty.

1 (13) Utilizing disaggregation of enrollment in
2 Affordable Care Act-sponsored health insurance, the
3 Asian and Pacific Islander American Health Forum
4 found that prior to the passage of the Patient Pro-
5 tection and Affordable Care Act (Public Law 111–
6 148), Korean Americans had a high uninsured rate
7 of 23 percent, compared to just 12 percent for all
8 Asian Americans. Developing targeted outreach ef-
9 forts assisted 1,000,000 people and resulted in a 56-
10 percent decrease in the uninsured among the Asian,
11 Native Hawaiian, and Pacific Islander population.
12 Such efforts show that disaggregated data is essen-
13 tial to public health mobilizations efforts.

14 (14) Without clear understanding of how
15 COVID–19 impacts marginalized racial and ethnic
16 communities, there will be exacerbated risk of en-
17 dangering the most historically vulnerable of our
18 Nation.

19 (15) The consequences of misunderstanding the
20 racial and ethnic impact of COVID–19 expound be-
21 yond communities of color such that it would impact
22 all.

23 (16) Race and ethnicity are valuable research
24 and practice variables when used and interpreted ap-
25 propriately. Health data collected on patients by

1 race and ethnicity will boost and more efficiently di-
2 rect critical resources and inform risk communica-
3 tion development in languages and at appropriate
4 health literacy levels, which resonate with historically
5 vulnerable communities of color.

6 (17) To date, there is no public standardized
7 and comprehensive race and ethnicity data reposi-
8 tory of COVID–19 testing, hospitalizations, or mor-
9 tality. The inconsistency of data collection by Fed-
10 eral, State, and local health authorities, and the in-
11 ability to access data by public research institutions
12 and academic organizations, poses a threat to anal-
13 ysis and synthesis of the pandemic impact on com-
14 munities of color. However, research and medical ex-
15 perts of Historically Black Colleges and Universities,
16 academic health care institutions which are histori-
17 cally and geographically embedded in minoritized
18 and marginalized communities, generally also pos-
19 sess rapport with the communities they serve. They
20 are well-positioned, as trusted thought leaders and
21 health care service providers, to collect data and con-
22 duct research toward creating holistic solutions to
23 remedy the inequitable impact of this and future
24 public health crises.

1 (18) Well-designed, ethically sound research
2 aligns with the goals of medicine, addresses ques-
3 tions relevant to the population among whom the
4 study will be carried out, balances the potential for
5 benefit against the potential for harm, employs
6 study designs that will yield scientifically valid and
7 significant data, and generates useful knowledge.

8 (19) The dearth of racially and ethnically
9 disaggregated data reflecting the health of commu-
10 nities of color underlies the challenges of a fully in-
11 formed public health response.

12 (20) Without collecting race and ethnicity data
13 associated with COVID–19 testing, hospitalizations,
14 morbidities, and mortalities, as well as publicly dis-
15 closing it, communities of color will remain at great-
16 er risk of disease and death.

17 (b) EMERGENCY FUNDING FOR FEDERAL DATA COL-
18 LECTION ON THE RACIAL, ETHNIC, AND OTHER DEMO-
19 GRAPHIC DISPARITIES OF COVID–19.—To conduct or
20 support data collection on the racial, ethnic, and other de-
21 mographic implications of COVID–19 in the United States
22 and its territories, including support to assist in the capac-
23 ity building for State and local public health departments
24 to collect and transmit racial, ethnic, and other demo-
25 graphic data to the relevant Department of Health and

1 Human Services agencies, there is authorized to be appro-
2 priated—

3 (1) to the Centers for Disease Control and Pre-
4 vention, \$12,000,000;

5 (2) to State, territorial, and Tribal public
6 health agencies, distributed proportionally based on
7 the total population of their residents who are en-
8 rolled in Medicaid or who have no health insurance,
9 \$15,000,000;

10 (3) to the Indian Health Service, Indian Tribes
11 and Tribal organizations (as defined in section 4 of
12 the Indian Self-Determination and Education Assist-
13 ance Act), and urban Indian organizations (as de-
14 fined in section 4 of the Indian Health Care Im-
15 provement Act), \$3,000,000;

16 (4) to the Centers for Medicare & Medicaid
17 Services, \$5,000,000;

18 (5) to the Food and Drug Administration,
19 \$5,000,000;

20 (6) to the Agency for Healthcare Research and
21 Quality, \$5,000,000; and

22 (7) to the Office of the National Coordinator
23 for Health Information Technology, \$5,000,000.

24 (c) COVID-19 DATA COLLECTION AND DISCLO-
25 SURE.—

1 (1) DATA COLLECTION.—The Secretary of
2 Health and Human Services (referred to in this sec-
3 tion as the “Secretary”), acting through the Direc-
4 tor of the Centers for Disease Control and Preven-
5 tion and the Administrator of the Centers for Medi-
6 care & Medicaid Services, shall make publicly avail-
7 able on the website of the Centers for Disease Con-
8 trol and Prevention data collected across all surveil-
9 lance systems relating to COVID–19, disaggregated
10 by race, ethnicity, sex, age, primary language, socio-
11 economic status, disability status, and county, in-
12 cluding the following:

13 (A) Data related to all COVID–19 testing,
14 including the number of individuals tested and
15 the number of tests that were positive.

16 (B) Data related to treatment for COVID–
17 19, including hospitalizations and intensive care
18 unit admissions.

19 (C) Data related to COVID–19 outcomes,
20 including total fatalities and case fatality rates
21 (expressed as the proportion of individuals who
22 were infected with COVID–19 and died from
23 the virus).

24 (2) APPLICATION OF STANDARDS.—To the ex-
25 tent practicable, data collection under this sub-

1 section shall follow standards developed by the De-
2 partment of Health and Human Services Office of
3 Minority Health and be collected, analyzed, and re-
4 ported in accordance with the standards promul-
5 gated by the Assistant Secretary for Planning and
6 Evaluation under title XXXI of the Public Health
7 Service Act (42 U.S.C. 300kk et seq.).

8 (3) **TIMELINE.**—The data made available under
9 this subsection shall be updated on a daily basis
10 throughout the public health emergency.

11 (4) **PRIVACY.**—In publishing data under this
12 subsection, the Secretary shall take all necessary
13 steps to protect the privacy of individuals whose in-
14 formation is included in such data, including—

15 (A) complying with privacy protections
16 provided under the regulations promulgated
17 under section 264(c) of the Health Insurance
18 Portability and Accountability Act of 1996; and

19 (B) protections from all inappropriate in-
20 ternal use by an entity that collects, stores, or
21 receives the data, including use of such data in
22 determinations of eligibility (or continued eligi-
23 bility) in health plans, and from inappropriate
24 uses.

1 (5) CONSULTATION WITH TRIBES.—The Indian
2 Health Service shall consult with Indian Tribes and
3 confer with urban Indian organizations on data col-
4 lection and reporting.

5 (6) REPORT.—Not later than 60 days after the
6 date on which the Secretary certifies that the public
7 health emergency related to COVID–19 has ended,
8 the Secretary shall make publicly available a sum-
9 mary of the final statistics related to COVID–19.

10 (7) REPORT.—Not later than 60 days after the
11 date on which the Secretary certifies that the public
12 health emergency related to COVID–19 has ended,
13 the Department of Health and Human Services shall
14 compile and submit to the Committee on Health,
15 Education, Labor, and Pensions and the Committee
16 on Finance of the Senate and the Committee on En-
17 ergy and Commerce and the Committee on Ways
18 and Means of the House of Representatives a pre-
19 liminary report—

20 (A) describing the testing, hospitalization,
21 mortality rates, and preferred language of pa-
22 tients associated with COVID–19 by race and
23 ethnicity; and

1 (B) proposing evidenced-based response
2 strategies to safeguard the health of these com-
3 munities in future pandemics.

4 (d) COMMISSION ON ENSURING HEALTH EQUITY
5 DURING THE COVID-19 PUBLIC HEALTH EMER-
6 GENCY.—

7 (1) IN GENERAL.—Not later than 30 days after
8 the date of enactment of this Act, the Secretary
9 shall establish a commission, to be known as the
10 “Commission on Ensuring Health Equity During
11 the COVID-19 Public Health Emergency” (referred
12 to in this subsection as the “Commission”) to pro-
13 vide clear and robust guidance on how to improve
14 the collection, analysis, and use of demographic data
15 in responding to future waves of the coronavirus.

16 (2) MEMBERSHIP AND CHAIRPERSON.—

17 (A) MEMBERSHIP.—The Commission shall
18 be composed of—

19 (i) the Director of the Centers for
20 Disease Control and Prevention;

21 (ii) the Director of the National Insti-
22 tutes of Health;

23 (iii) the Commissioner of Food and
24 Drugs;

1 (iv) the Administrator of the Federal
2 Emergency Management Agency;

3 (v) the Director of the National Insti-
4 tute on Minority Health and Health Dis-
5 parities;

6 (vi) the Director of the Indian Health
7 Service;

8 (vii) the Administrator of the Centers
9 for Medicare & Medicaid Services;

10 (viii) the Director of the Agency for
11 Healthcare Research and Quality;

12 (ix) the Surgeon General;

13 (x) the Administrator of the Health
14 Resources and Services Administration;

15 (xi) the Director of the Office of Mi-
16 nority Health;

17 (xii) the Director of the Office of
18 Women's Health;

19 (xiii) the Chairperson of the National
20 Council on Disability;

21 (xiv) at least 4 State, local, territorial,
22 and Tribal public health officials rep-
23 resenting departments of public health,
24 who shall represent jurisdictions from dif-
25 ferent regions of the United States with

1 relatively high concentrations of histori-
2 cally marginalized populations, to be ap-
3 pointed by the Secretary; and

4 (xv) racially and ethnically diverse
5 representation from at least 3 independent
6 experts with knowledge or field experience
7 with racial and ethnic disparities in public
8 health appointed by the Secretary.

9 (B) CHAIRPERSON.—The President of the
10 National Academies of Sciences, Engineering,
11 and Medicine, or designee, shall serve as the
12 chairperson of the Commission.

13 (3) DUTIES.—The Commission shall—

14 (A) examine barriers to collecting, ana-
15 lyzing, and using demographic data;

16 (B) determine how to best use such data
17 to promote health equity across the United
18 States and reduce racial, Tribal, and other de-
19 mographic disparities in COVID–19 prevalence
20 and outcomes;

21 (C) gather available data related to
22 COVID–19 treatment of individuals with dis-
23 abilities, including denial of treatment for pre-
24 existing conditions, removal or denial of dis-
25 ability related equipment (including ventilators

1 and CPAP), and data on completion of DNR
2 orders, and identify barriers to obtaining accu-
3 rate and timely data related to COVID–19
4 treatment of such individuals;

5 (D) solicit input from public health offi-
6 cials, community-connected organizations,
7 health care providers, State and local agency of-
8 ficials, and other experts on barriers to, and
9 best practices for, collecting demographic data;
10 and

11 (E) recommend policy changes that the
12 data indicates are necessary to reduce dispari-
13 ties.

14 (4) REPORT.—Not later than 60 days after the
15 date of enactment of this Act, and every 180 days
16 thereafter until the Secretary certifies that the pub-
17 lic health emergency related to COVID–19 has
18 ended, the Commission shall submit a written report
19 of its findings and recommendations to Congress
20 and post such report on a website of the Department
21 of Health and Human Services. Such reports shall
22 contain information concerning—

23 (A) how to enhance State, local, territorial,
24 and Tribal capacity to conduct public health re-
25 search on COVID–19, with a focus on expanded

1 capacity to analyze data on disparities cor-
2 related with race, ethnicity, income, sex, age,
3 disability status, specific geographic areas, and
4 other relevant demographic characteristics, and
5 an analysis of what demographic data is cur-
6 rently being collected about COVID–19, the ac-
7 curacy of that data and any gaps, how this data
8 is currently being used to inform efforts to com-
9 bat COVID–19, and what resources are needed
10 to supplement existing public health data collec-
11 tion;

12 (B) how to collect, process, and disclose to
13 the public the data described in subparagraph
14 (A) in a way that maintains individual privacy
15 while helping direct the State and local re-
16 sponse to the virus;

17 (C) how to improve demographic data col-
18 lection related to COVID–19 in the short- and
19 long-term, including how to continue to grow
20 and value the Tribal sovereignty of data and in-
21 formation concerning Tribal communities;

22 (D) to the extent possible, a preliminary
23 analysis of racial and other demographic dis-
24 parities in COVID–19 mortality, including an
25 analysis of comorbidities and case fatality rates;

1 (E) to the extent possible, a preliminary
2 analysis of sex, gender, sexual orientation, and
3 gender identity disparities in COVID–19 treat-
4 ment and mortality;

5 (F) an analysis of COVID–19 treatment of
6 individuals with disabilities, including equity of
7 access to treatment and equipment and inter-
8 sections of disability status with other demo-
9 graphic factors, including race, and rec-
10 ommendations for how to improve transparency
11 and equity of treatment for such individuals
12 during the COVID–19 public health emergency
13 and future emergencies;

14 (G) how to support State, local, and Tribal
15 capacity to eliminate barriers to COVID–19
16 testing and treatment; and

17 (H) to the extent possible, a preliminary
18 analysis of Federal Government policies that
19 disparately exacerbate the COVID–19 impact,
20 and recommendations to improve racial and
21 other demographic disparities in health out-
22 comes.

23 (5) AUTHORIZATION OF APPROPRIATIONS.—

24 There is authorized to be appropriated such sums as
25 may be necessary to carry out this subsection.

1 **SEC. 102. COVID-19 REPORTING PORTAL.**

2 (a) IN GENERAL.—Not later than 15 days after the
3 date of enactment of this Act, the Secretary of Health and
4 Human Services (referred to in this section as the “Sec-
5 retary”) shall establish and maintain an online portal for
6 use by eligible health care entities to track and transmit
7 data regarding their personal protective equipment and
8 medical supply inventory and capacity related to COVID–
9 19.

10 (b) ELIGIBLE HEALTH CARE ENTITIES.—In this sec-
11 tion, the term “eligible health care entity” means a li-
12 censed acute care hospital, hospital system, or long-term
13 care facility with confirmed cases of COVID–19.

14 (c) SUBMISSION.—An eligible health care entity shall
15 report using the portal under this section on a biweekly
16 basis in order to assist the Secretary in tracking usage
17 and need of COVID–related supplies and personnel in a
18 regular and real-time manner.

19 (d) INCLUDED INFORMATION.—The Secretary shall
20 design the portal under this section to include information
21 on personal protective equipment and medical supply in-
22 ventory and capacity related to COVID–19, including with
23 respect to the following:

24 (1) PERSONAL PROTECTIVE EQUIPMENT.—
25 Total personal protective equipment inventory, in-
26 cluding, in units, the numbers of N95 masks and

1 authorized equivalent respirator masks, surgical
2 masks, exam gloves, face shields, isolation gowns,
3 and coveralls.

4 (2) MEDICAL SUPPLY.—

5 (A) Total ventilator inventory, including, in
6 units, the number of universal, adult, pediatric,
7 and infant ventilators.

8 (B) Total diagnostic and serological test
9 inventory, including, in units, the number of
10 test platforms, tests, test kits, reagents, trans-
11 port media, swabs, and other materials or sup-
12 plies determined necessary by the Secretary.

13 (3) CAPACITY.—

14 (A) Case count measurements, including
15 confirmed positive cases and persons under in-
16 vestigation.

17 (B) Total number of staffed beds, includ-
18 ing medical surgical beds, intensive care beds,
19 and critical care beds.

20 (C) Available beds, including medical sur-
21 gical beds, intensive care beds, and critical care
22 beds.

23 (D) Total number of COVID–19 patients
24 currently utilizing a ventilator.

1 (E) Average number of days a COVID–19
2 patient is utilizing a ventilator.

3 (F) Total number of additionally needed
4 professionals in each of the following categories:
5 intensivists, critical care physicians, respiratory
6 therapists, registered nurses, certified registered
7 nurse anesthetists, and laboratory personnel.

8 (G) Total number of hospital personnel
9 currently not working due to self-isolation fol-
10 lowing a known or presumed COVID–19 expo-
11 sure.

12 (e) ACCESS TO INFORMATION RELATED TO INVEN-
13 TORY AND CAPACITY.—The Secretary shall ensure that
14 relevant agencies and officials, including the Centers for
15 Disease Control and Prevention, the Assistant Secretary
16 for Preparedness and Response, and the Federal Emer-
17 gency Management Agency, have access to information re-
18 lated to inventory and capacity submitted under this sec-
19 tion.

20 (f) WEEKLY REPORT TO CONGRESS.—On a weekly
21 basis, the Secretary shall transmit information related to
22 inventory and capacity submitted under this section to the
23 appropriate committees of the House and Senate.

1 **SEC. 103. REGULAR CDC REPORTING ON DEMOGRAPHIC**
2 **DATA.**

3 Not later than 14 days after the date of enactment
4 of this Act, the Secretary of Health and Human Services,
5 in coordination with the Director of the Centers for Dis-
6 ease Control and Prevention, shall amend the reporting
7 under the heading “Department of Health and Human
8 Services—Office of the Secretary—Public Health and So-
9 cial Service Emergency Fund” in title I of division B of
10 the Paycheck Protection Program and Health Care En-
11 hancement Act (Public Law 116–139; 134 Stat. 620, 626)
12 on the demographic characteristics, including race, eth-
13 nicity (including breakdowns of major ethnic groups and
14 Tribal affiliations within minority populations), age, sex,
15 gender, geographic region, primary written and spoken
16 language, disability status, sexual orientation, socio-
17 economic status, occupation, and other relevant factors of
18 individuals tested for or diagnosed with COVID–19, to in-
19 clude—

20 (1) providing technical assistance to State,
21 local, Tribal, and territorial health departments to
22 improve the collection and reporting of such demo-
23 graphic data;

24 (2) if such data is not so collected or reported,
25 the reason why the State, local, Tribal, or territorial

1 department of health has not been able to collect or
 2 provide such information; and

3 (3) making a copy of such report available pub-
 4 licly on the website of the Centers for Disease Con-
 5 trol and Prevention.

6 **SEC. 104. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
 7 **ACT.**

8 (a) PURPOSE.—It is the purpose of the amendment
 9 made by this section to promote data collection, analysis,
 10 and reporting by race, ethnicity, sex, primary language,
 11 sexual orientation, disability status, gender identity, age,
 12 and socioeconomic status among federally supported
 13 health programs.

14 (b) AMENDMENT.—The Public Health Service Act is
 15 amended by adding at the end the following:

16 **“TITLE XXXIV—STRENGTHENING**
 17 **DATA COLLECTION, IMPROV-**
 18 **ING DATA ANALYSIS, AND EX-**
 19 **PANDING DATA REPORTING**

20 **“SEC. 3400. HEALTH DISPARITY DATA.**

21 **“(a) REQUIREMENTS.—**

22 **“(1) IN GENERAL.—**Each health-related pro-
 23 gram shall—

24 **“(A)** require the collection, by the agency
 25 or program involved, of data on the race, eth-

1 nicity, sex, primary language, sexual orienta-
2 tion, disability status, gender identity, age, and
3 socioeconomic status of each applicant for and
4 recipient of health-related assistance under such
5 program, including—

6 “(i) using, at a minimum, standards
7 for data collection on race, ethnicity, sex,
8 primary language, sexual orientation, gen-
9 der identity, age, socioeconomic status, and
10 disability status as each are developed
11 under section 3101;

12 “(ii) collecting data for additional
13 population groups if such groups can be
14 aggregated into the race and ethnicity cat-
15 egories outlined by standards developed
16 under section 3101;

17 “(iii) using, where practicable, the
18 standards developed by the Health and
19 Medicine Division of the National Acad-
20 emies of Sciences, Engineering, and Medi-
21 cine (formerly known as the ‘Institute of
22 Medicine’) in the 2009 publication, entitled
23 ‘Race, Ethnicity, and Language Data:
24 Standardization for Health Care Quality
25 Improvement’; and

1 “(iv) where practicable, collecting
2 such data through self-reporting;

3 “(B) with respect to the collection of the
4 data described in subparagraph (A), for appli-
5 cants and recipients who are minors, require
6 communication assistance in speech or writing,
7 and for applicants and recipients who are other-
8 wise legally incapacitated, require that—

9 “(i) such data be collected from the
10 parent or legal guardian of such an appli-
11 cant or recipient; and

12 “(ii) the primary language of the par-
13 ent or legal guardian of such an applicant
14 or recipient be collected;

15 “(C) systematically analyze such data
16 using the smallest appropriate units of analysis
17 feasible to detect racial and ethnic disparities,
18 as well as disparities along the lines of primary
19 language, sex, disability status, sexual orienta-
20 tion, gender identity, age, and socioeconomic
21 status in health and health care, and report the
22 results of such analysis to the Secretary, the
23 Director of the Office for Civil Rights, each
24 agency listed in section 3101(c)(1), the Com-
25 mittee on Health, Education, Labor, and Pen-

sions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

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

“(E) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, primary language, sex, sexual orientation, disability status, gender identity, age, and socioeconomic status data.

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

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

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

“(3) NO COMPELLED DISCLOSURE OF DATA.—

This title does not authorize any health care pro-

1 vider, Federal official, or other entity to compel the
2 disclosure of any data collected under this title. The
3 disclosure of any such data by an individual pursu-
4 ant to this title shall be strictly voluntary.

5 “(b) PROTECTION OF DATA.—The Secretary shall
6 ensure (through the promulgation of regulations or other-
7 wise) that all data collected pursuant to subsection (a) are
8 protected—

9 “(1) under the same privacy protections as the
10 Secretary applies to other health data under the reg-
11 ulations promulgated under section 264(c) of the
12 Health Insurance Portability and Accountability Act
13 of 1996 relating to the privacy of individually identi-
14 fiable health information and other protections; and

15 “(2) from all inappropriate internal use by any
16 entity that collects, stores, or receives the data, in-
17 cluding use of such data in determinations of eligi-
18 bility (or continued eligibility) in health plans, and
19 from other inappropriate uses, as defined by the
20 Secretary.

21 “(c) NATIONAL PLAN OF THE DATA COUNCIL.—The
22 Secretary shall develop and implement a national plan to
23 ensure the collection of data in a culturally and linguis-
24 tically appropriate manner, to improve the collection, anal-
25 ysis, and reporting of racial, ethnic, sex, primary lan-

1 guage, sexual orientation, disability status, gender iden-
2 tity, age, and socioeconomic status data at the Federal,
3 State, territorial, Tribal, and local levels, including data
4 to be collected under subsection (a), and to ensure that
5 data collection activities carried out under this section are
6 in compliance with standards developed under section
7 3101. The Data Council of the Department of Health and
8 Human Services, in consultation with the National Com-
9 mittee on Vital Health Statistics, the Office of Minority
10 Health, Office on Women’s Health, and other appropriate
11 public and private entities, shall make recommendations
12 to the Secretary concerning the development, implementa-
13 tion, and revision of the national plan. Such plan shall
14 include recommendations on how to—

15 “(1) implement subsection (a) while minimizing
16 the cost and administrative burdens of data collec-
17 tion and reporting;

18 “(2) expand knowledge among Federal agen-
19 cies, States, territories, Indian Tribes, counties, mu-
20 nicipalities, health providers, health plans, and the
21 general public that data collection, analysis, and re-
22 porting by race, ethnicity, sex, primary language,
23 sexual orientation, gender identity, age, socio-
24 economic status, and disability status is legal and

1 necessary to assure equity and nondiscrimination in
2 the quality of health care services;

3 “(3) ensure that future patient record systems
4 follow Federal standards promulgated under the
5 Health Information Technology for Economic and
6 Clinical Health Act for the collection and meaningful
7 use of electronic health data on race, ethnicity, sex,
8 primary language, sexual orientation, gender iden-
9 tity, age, socioeconomic status, and disability status;

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

18 “(5) provide researchers with greater access to
19 racial, ethnic, primary language, sex, sexual orienta-
20 tion, gender identity, age, socioeconomic status data,
21 and disability status data, subject to all applicable
22 privacy and confidentiality requirements, including
23 HIPAA privacy and security law as defined in sec-
24 tion 3009; and

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

3 “(d) COMPLIANCE WITH STANDARDS.—Data col-
4 lected under subsection (a) shall be obtained, maintained,
5 and presented (including for reporting purposes) in ac-
6 cordance with standards developed under section 3101.

7 “(e) ANALYSIS OF HEALTH DISPARITY DATA.—The
8 Secretary, acting through the Director of the Agency for
9 Healthcare Research and Quality and in coordination with
10 the Assistant Secretary for Planning and Evaluation, the
11 Administrator of the Centers for Medicare & Medicaid
12 Services, the Director of the National Center for Health
13 Statistics, and the Director of the National Institutes of
14 Health, shall provide technical assistance to agencies of
15 the Department of Health and Human Services in meeting
16 Federal standards for health disparity data collection and
17 for analysis of racial, ethnic, and other disparities in
18 health and health care in programs conducted or sup-
19 ported by such agencies by—

20 “(1) identifying appropriate quality assurance
21 mechanisms to monitor for health disparities;

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

24 “(3) developing new quality measures relating
25 to racial and ethnic disparities and their overlap

1 with other disparity factors in health and health
2 care;

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

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

7 “(f) DEFINITIONS.—In this section—

8 “(1) the term ‘health-related program’ means a
9 program that is operated by the Secretary, or that
10 receives funding or reimbursement, in whole or in
11 part, either directly or indirectly from the Sec-
12 retary—

13 “(A) for activities under the Social Secu-
14 rity Act for health care services; or

15 “(B) for providing Federal financial assist-
16 ance for health care, biomedical research, or
17 health services research or for otherwise im-
18 proving the health of the public;

19 “(2) the term ‘primary language data’ includes
20 spoken and written primary language data; and

21 “(3) the term ‘primary language data collection
22 activities’ includes identifying, collecting, storing,
23 tracking, and analyzing primary language data and
24 information on the methods used to meet the lan-

1 guage access needs of individuals with limited
2 English proficiency.

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated to carry out this section
5 such sums as may be necessary for each of fiscal years
6 2021 through 2025.

7 **“SEC. 3401. ESTABLISHING GRANTS FOR DATA COLLECTION**
8 **IMPROVEMENT ACTIVITIES.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Director of the Agency for Healthcare Research and
11 Quality and in consultation with the Deputy Assistant
12 Secretary for Minority Health, the Director of the Na-
13 tional Institutes of Health, the Assistant Secretary for
14 Planning and Evaluation, and the Director of the National
15 Center for Health Statistics, shall establish a technical as-
16 sistance program under which the Secretary provides
17 grants to eligible entities to assist such entities in com-
18 plying with section 3431.

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

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

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

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

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

16 “(c) ELIGIBLE ENTITY.—To be eligible for grants
17 under this section, an entity shall be a State, territory,
18 Indian Tribe, municipality, county, health provider, health
19 care organization, or health plan making a demonstrated
20 effort to bring data collections into compliance with sec-
21 tion 3431.

22 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 such sums as may be necessary for each of fiscal years
25 2021 through 2025.

1 **“SEC. 3402. OVERSAMPLING OF UNDERREPRESENTED**
2 **GROUPS IN FEDERAL HEALTH SURVEYS.**

3 “(a) NATIONAL STRATEGY.—

4 “(1) IN GENERAL.—The Secretary, acting
5 through the Director of the National Center for
6 Health Statistics of the Centers for Disease Control
7 and Prevention, and other agencies within the De-
8 partment of Health and Human Services as the Sec-
9 retary determines appropriate, shall develop and im-
10 plement an ongoing and sustainable national strat-
11 egy for oversampling underrepresented populations
12 within the categories of race, ethnicity, sex, primary
13 language, sexual orientation, disability status, gen-
14 der identity, and socioeconomic status as determined
15 appropriate by the Secretary in Federal health sur-
16 veys and program data collections. Such national
17 strategy shall include a strategy for oversampling of
18 Native Americans, Asian Americans, Native Hawai-
19 ians, and Pacific Islanders.

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

24 “(A) consult with representatives of com-
25 munity groups, nonprofit organizations, non-
26 governmental organizations, and government

1 agencies working with underrepresented popu-
2 lations;

3 “(B) solicit the participation of representa-
4 tives from other Federal departments and agen-
5 cies, including subagencies of the Department
6 of Health and Human Services; and

7 “(C) consult on, and use as models, the
8 2014 National Health Interview Survey over-
9 sample of Native Hawaiian and Pacific Islander
10 populations and the 2017 Behavioral Risk Fac-
11 tor Surveillance System oversample of American
12 Indian and Alaska Native communities.

13 “(b) PROGRESS REPORT.—Not later than 2 years
14 after the date of the enactment of this section, the Sec-
15 retary shall submit to the Congress a progress report,
16 which shall include the national strategy described in sub-
17 section (a)(1).

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—To
19 carry out this section, there are authorized to be appro-
20 priated such sums as may be necessary for fiscal years
21 2021 through 2025.”.

1 **SEC. 105. ELIMINATION OF PREREQUISITE OF DIRECT AP-**
2 **PROPRIATIONS FOR DATA COLLECTION AND**
3 **ANALYSIS.**

4 Section 3101 of the Public Health Service Act (42
5 U.S.C. 300kk) is amended—

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

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

9 **SEC. 106. COLLECTION OF DATA FOR THE MEDICARE PRO-**
10 **GRAM.**

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

14 “COLLECTION OF DATA FOR THE MEDICARE PROGRAM

15 “SEC. 1150C.

16 “(a) REQUIREMENT.—

17 “(1) IN GENERAL.—The Commissioner of So-
18 cial Security, in consultation with the Administrator
19 of the Centers for Medicare & Medicaid Services,
20 shall collect data on the race, ethnicity, sex, primary
21 language, sexual orientation, gender identity, socio-
22 economic status, and disability status of all appli-
23 cants for Social Security benefits under title II or
24 Medicare benefits under title XVIII.

25 “(2) DATA COLLECTION STANDARDS.—In col-
26 lecting data under paragraph (1), the Commissioner

1 of Social Security shall at least use the standards
2 for data collection developed under section 3101 of
3 the Public Health Service Act or the standards de-
4 veloped by the Office of Management and Budget,
5 whichever is more disaggregated. In the event there
6 are no standards for the demographic groups listed
7 under paragraph (1), the Commissioner shall consult
8 with stakeholder groups representing the various
9 identities as well as with the Office of Minority
10 Health within the Centers for Medicare & Medicaid
11 Services to develop appropriate standards.

12 “(3) DATA FOR ADDITIONAL POPULATION
13 GROUPS.—Where practicable, the information col-
14 lected by the Commissioner of Social Security under
15 paragraph (1) shall include data for additional popu-
16 lation groups if such groups can be aggregated into
17 the race and ethnicity categories outlined by the
18 data collection standards described in paragraph (2).

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

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

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

6 “(5) QUALITY OF DATA.—The Commissioner of
7 Social Security shall periodically review the quality
8 and completeness of the data collected under para-
9 graph (1) and make adjustments as necessary to im-
10 prove both.

11 “(6) TRANSMISSION OF DATA.—Upon enroll-
12 ment in Medicare benefits under title XVIII, the
13 Commissioner of Social Security shall transmit an
14 individual’s demographic data as collected under
15 paragraph (1) to the Centers for Medicare and Med-
16 icaid Services.

17 “(7) ANALYSIS AND REPORTING OF DATA.—
18 With respect to data transmitted under paragraph
19 (5), the Administrator of the Centers for Medicare
20 and Medicaid Services, in consultation with the
21 Commissioner of Social Security shall—

22 “(A) require that such data be uniformly
23 analyzed and that such analysis be reported at
24 least annually to Congress;

1 “(B) incorporate such data in other anal-
2 ysis and reporting on health disparities as ap-
3 propriate;

4 “(C) make such data available to research-
5 ers, under the protections outlined in paragraph
6 (7);

7 “(D) provide opportunities to individuals
8 enrolled in Medicare to submit updated data;
9 and

10 “(E) ensure that the provision of assist-
11 ance or benefits to an applicant is not denied
12 or otherwise adversely affected because of the
13 failure of the applicant to provide any of the
14 data collected under paragraph (1).

15 “(8) PROTECTION OF DATA.—The Commis-
16 sioner of Social Security shall ensure (through the
17 promulgation of regulations or otherwise) that all
18 data collected pursuant to subsection (a) is pro-
19 tected—

20 “(A) under the same privacy protections as
21 the Secretary applies to health data under the
22 regulations promulgated under section 264(c) of
23 the Health Insurance Portability and Account-
24 ability Act of 1996 (relating to the privacy of

1 individually identifiable health information and
2 other protections); and

3 “(B) from all inappropriate internal use by
4 any entity that collects, stores, or receives the
5 data, including use of such data in determina-
6 tions of eligibility (or continued eligibility) in
7 health plans, and from other inappropriate
8 uses, as defined by the Secretary.

9 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
10 tion shall be construed to permit the use of information
11 collected under this section in a manner that would ad-
12 versely affect any individual providing any such informa-
13 tion.

14 “(c) TECHNICAL ASSISTANCE.—The Secretary may,
15 either directly or by grant or contract, provide technical
16 assistance to enable any entity to comply with the require-
17 ments of this section or with regulations implementing this
18 section.

19 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 \$500 million for 2020 and \$100 million for each fiscal
22 year thereafter.”.

23 **SEC. 107. REVISION OF HIPAA CLAIMS STANDARDS.**

24 (a) IN GENERAL.—Not later than 1 year after the
25 date of enactment of this Act, the Secretary of Health and

1 Human Services shall revise the regulations promulgated
2 under part C of title XI of the Social Security Act (42
3 U.S.C. 1320d et seq.), relating to the collection of data
4 on race, ethnicity, and primary language in a health-re-
5 lated transaction, to require—

6 (1) the use, at a minimum, of standards for
7 data collection on race, ethnicity, primary language,
8 disability, sex, sexual orientation, gender identity,
9 and socioeconomic status developed under section
10 3101 of the Public Health Service Act (42 U.S.C.
11 300kk); and

12 (2) in consultation with the Office of the Na-
13 tional Coordinator for Health Information Tech-
14 nology, the designation of the appropriate racial,
15 ethnic, primary language, disability, sex, and other
16 code sets as required for claims and enrollment data.

17 (b) DISSEMINATION.—The Secretary of Health and
18 Human Services shall disseminate the new standards de-
19 veloped under subsection (a) to all entities that are subject
20 to the regulations described in such subsection and provide
21 technical assistance with respect to the collection of the
22 data involved.

23 (c) COMPLIANCE.—The Secretary of Health and
24 Human Services shall require that entities comply with the
25 new standards developed under subsection (a) not later

1 than 2 years after the final promulgation of such stand-
2 ards.

3 **SEC. 108. DISPARITIES DATA COLLECTED BY THE FEDERAL**
4 **GOVERNMENT.**

5 (a) REPOSITORY OF GOVERNMENT DATA.—The Sec-
6 retary of Health and Human Services, in coordination
7 with the departments, agencies, or offices described in
8 subsection (b), shall establish a centralized electronic re-
9 pository of Government data on factors related to the
10 health and well-being of the population of the United
11 States.

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

21 (c) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—
22 Not later than April 30, 2021, and April 30 of each year
23 thereafter, the Secretary of Health and Human Services,
24 acting through the Assistant Secretary for Planning and
25 Evaluation, the Assistant Secretary for Health, the Direc-

1 tor of the Agency for Healthcare Research and Quality,
 2 the Director of the National Center for Health Statistics,
 3 the Administrator of the Centers for Medicare & Medicaid
 4 Services, the Director of the National Institute on Minor-
 5 ity Health and Health Disparities, and the Deputy Assist-
 6 ant Secretary for Minority Health, shall—

7 (1) prepare and make available datasets for
 8 public use that relate to disparities in health status,
 9 health care access, health care quality, health out-
 10 comes, public health, and other areas of health and
 11 well-being by factors that include race, ethnicity,
 12 sex, primary language, sexual orientation, disability
 13 status, gender identity, and socioeconomic status;

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

17 (3) submit a report to the Congress on the
 18 availability and use of such data by public stake-
 19 holders.

20 **SEC. 109. STANDARDS FOR MEASURING SEXUAL ORIENTA-**
 21 **TION, GENDER IDENTITY, AND SOCIO-**
 22 **ECONOMIC STATUS IN COLLECTION OF**
 23 **HEALTH DATA.**

24 Section 3101(a) of the Public Health Service Act (42
 25 U.S.C. 300kk(a)) is amended—

1 (1) in paragraph (1)(A), by inserting “sexual
2 orientation, gender identity, socioeconomic status,”
3 before “and disability status”;

4 (2) in paragraph (1)(C), by inserting “sexual
5 orientation, gender identity, socioeconomic status,”
6 before “and disability status”; and

7 (3) in paragraph (2)(B), by inserting “sexual
8 orientation, gender identity, socioeconomic status,”
9 before “and disability status”.

10 **SEC. 110. IMPROVING HEALTH DATA REGARDING NATIVE**
11 **HAWAIIANS AND OTHER PACIFIC ISLANDERS.**

12 Part B of title III of the Public Health Service Act
13 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
14 tion 317U the following:

15 **“SEC. 317V. NATIVE HAWAIIAN AND OTHER PACIFIC IS-**
16 **LANDER HEALTH DATA.**

17 “(a) DEFINITIONS.—In this section:

18 “(1) COMMUNITY GROUP.—The term ‘commu-
19 nity group’ means a group of NHOPI who are orga-
20 nized at the community level, and may include a
21 church group, social service group, national advocacy
22 organization, or cultural group.

23 “(2) NONPROFIT, NONGOVERNMENTAL ORGANI-
24 ZATION.—The term ‘nonprofit, nongovernmental or-
25 ganization’ means a group of NHOPI with a dem-

1 onstrated history of addressing NHOPI issues, in-
2 cluding a NHOPI coalition.

3 “(3) DESIGNATED ORGANIZATION.—The term
4 ‘designated organization’ means an entity estab-
5 lished to represent NHOPI populations and which
6 has statutory responsibilities to provide, or has com-
7 munity support for providing, health care.

8 “(4) GOVERNMENT REPRESENTATIVES OF
9 NHOPI POPULATIONS.—The term ‘government rep-
10 resentatives of NHOPI populations’ means rep-
11 resentatives from Hawaii, American Samoa, the
12 Commonwealth of the Northern Mariana Islands,
13 the Federated States of Micronesia, Guam, the Re-
14 public of Palau, and the Republic of the Marshall Is-
15 lands.

16 “(5) NATIVE HAWAIIANS AND OTHER PACIFIC
17 ISLANDERS (NHOPI).—The term ‘Native Hawaiians
18 and Other Pacific Islanders’ or ‘NHOPI’ means peo-
19 ple having origins in any of the original peoples of
20 American Samoa, the Commonwealth of the North-
21 ern Mariana Islands, the Federated States of Micro-
22 nesia, Guam, Hawaii, the Republic of the Marshall
23 Islands, the Republic of Palau, or any other Pacific
24 Island.

1 “(6) INSULAR AREA.—The term ‘insular area’
2 means Guam, the Commonwealth of Northern Mar-
3 iana Islands, American Samoa, the United States
4 Virgin Islands, the Federated States of Micronesia,
5 the Republic of Palau, or the Republic of the Mar-
6 shall Islands.

7 “(b) NATIONAL STRATEGY.—

8 “(1) IN GENERAL.—The Secretary, acting
9 through the Director of the National Center for
10 Health Statistics (referred to in this section as
11 ‘NCHS’) of the Centers for Disease Control and
12 Prevention, and other agencies within the Depart-
13 ment of Health and Human Services as the Sec-
14 retary determines appropriate, shall develop and im-
15 plement an ongoing and sustainable national strat-
16 egy for identifying and evaluating the health status
17 and health care needs of NHOPI populations living
18 in the continental United States, Hawaii, American
19 Samoa, the Commonwealth of the Northern Mariana
20 Islands, the Federated States of Micronesia, Guam,
21 the Republic of Palau, and the Republic of the Mar-
22 shall Islands.

23 “(2) CONSULTATION.—In developing and imple-
24 menting a national strategy, as described in para-
25 graph (1), not later than 180 days after the date of

1 enactment of the Ending Health Disparities During
2 COVID–19 Act of 2020, the Secretary—

3 “(A) shall consult with representatives of
4 community groups, designated organizations,
5 and nonprofit, nongovernmental organizations
6 and with government representatives of NHOPI
7 populations; and

8 “(B) may solicit the participation of rep-
9 resentatives from other Federal departments.

10 “(c) PRELIMINARY HEALTH SURVEY.—

11 “(1) IN GENERAL.—The Secretary, acting
12 through the Director of NCHS, shall conduct a pre-
13 liminary health survey in order to identify the major
14 areas and regions in the continental United States,
15 Hawaii, American Samoa, the Commonwealth of the
16 Northern Mariana Islands, the Federated States of
17 Micronesia, Guam, the Republic of Palau, and the
18 Republic of the Marshall Islands in which NHOPI
19 people reside.

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

23 “(A) useful in determining health status
24 and health care needs; or

1 “(B) required for developing or imple-
2 menting a national strategy.

3 “(3) METHODOLOGY.—Methodology for the
4 health survey described in paragraph (1), including
5 plans for designing questions, implementation, sam-
6 pling, and analysis, shall be developed in consulta-
7 tion with community groups, designated organiza-
8 tions, nonprofit, nongovernmental organizations, and
9 government representatives of NHOPI populations,
10 as determined by the Secretary.

11 “(4) TIMEFRAME.—The survey required under
12 this subsection shall be completed not later than 18
13 months after the date of enactment of the Ending
14 Health Disparities During COVID–19 Act of 2020.

15 “(d) PROGRESS REPORT.—Not later than 2 years
16 after the date of enactment of the Ending Health Dispari-
17 ties During COVID–19 Act of 2020, the Secretary shall
18 submit to Congress a progress report, which shall include
19 the national strategy described in subsection (b)(1).

20 “(e) STUDY AND REPORT BY THE HEALTH AND
21 MEDICINE DIVISION.—

22 “(1) IN GENERAL.—The Secretary shall enter
23 into an agreement with the Health and Medicine Di-
24 vision of the National Academies of Sciences, Engi-
25 neering, and Medicine to conduct a study, with input

1 from stakeholders in insular areas, on each of the
2 following:

3 “(A) The standards and definitions of
4 health care applied to health care systems in in-
5 sular areas and the appropriateness of such
6 standards and definitions.

7 “(B) The status and performance of health
8 care systems in insular areas, evaluated based
9 upon standards and definitions, as the Sec-
10 retary determines appropriate.

11 “(C) The effectiveness of donor aid in ad-
12 dressing health care needs and priorities in in-
13 sular areas.

14 “(D) The progress toward implementation
15 of recommendations of the Committee on
16 Health Care Services in the United States—As-
17 sociated Pacific Basin that are set forth in the
18 1998 report entitled ‘Pacific Partnerships for
19 Health: Charting a New Course’.

20 “(2) REPORT.—An agreement described in
21 paragraph (1) shall require the Health and Medicine
22 Division to submit to the Secretary and to Congress,
23 not later than 2 years after the date of the enact-
24 ment of the Ending Health Disparities During
25 COVID–19 Act of 2020, a report containing a de-

1 scription of the results of the study conducted under
2 paragraph (1), including the conclusions and rec-
3 ommendations of the Health and Medicine Division
4 for each of the items described in subparagraphs (A)
5 through (D) of such paragraph.

6 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there are authorized to be appro-
8 priated such sums as may be necessary for fiscal years
9 2021 through 2025.”.

10 **Subtitle B—Improvements and** 11 **Modernization**

12 **SEC. 121. FEDERAL MODERNIZATION FOR HEALTH INEQUI-** 13 **TIES DATA.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services shall work with covered agencies to sup-
16 port the modernization of data collection methods and in-
17 frastructure at such agencies for the purpose of increasing
18 data collection related to health inequities, such as racial,
19 ethnic (including breakdowns of major ethnic groups and
20 Tribal affiliations within minority populations), socio-
21 economic, sex, gender, age, geographic region, primary
22 written and spoken language, sexual orientation, occupa-
23 tion, and disability status disparities.

1 (b) COVERED AGENCY DEFINED.—In this section,
2 the term “covered agency” means each of the following
3 Federal agencies:

4 (1) The Agency for Healthcare Research and
5 Quality.

6 (2) The Centers for Disease Control and Pre-
7 vention.

8 (3) The Centers for Medicare & Medicaid Serv-
9 ices.

10 (4) The Food and Drug Administration.

11 (5) The Office of the National Coordinator for
12 Health Information Technology.

13 (6) The National Institutes of Health.

14 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to each covered agency to
16 carry out this section \$4,000,000, to remain available
17 until expended.

18 **SEC. 122. MODERNIZATION OF STATE AND LOCAL HEALTH**

19 **INEQUITIES DATA.**

20 (a) IN GENERAL.—Not later than 6 months after the
21 date of enactment of this Act, the Secretary of Health and
22 Human Services (referred to in this section as the “Sec-
23 retary”), acting through the Director of the Centers for
24 Disease Control and Prevention, shall award grants to
25 State, local, Tribal, and territorial health departments in

1 order to support the modernization of data collection
2 methods and infrastructure for the purposes of increasing
3 data related to health inequities, such as racial, ethnic (in-
4 cluding breakdowns of major ethnic groups and Tribal af-
5 filiations within minority populations), socioeconomic, sex,
6 gender, age, geographic region, primary written and spo-
7 ken language, sexual orientation, occupation, and dis-
8 ability status disparities. The Secretary shall—

9 (1) provide guidance, technical assistance, and
10 information to grantees under this section on best
11 practices regarding culturally competent, accurate,
12 and increased data collection and transmission; and

13 (2) track performance of grantees under this
14 section to help improve their health inequities data
15 collection by identifying gaps and taking effective
16 steps to support States, localities, and territories in
17 addressing the gaps.

18 (b) REPORT.—Not later than 1 year after the date
19 on which the first grant is awarded under this section,
20 the Secretary shall submit to the Committee on Energy
21 and Commerce of the House of Representatives and the
22 Committee on Health, Education, Labor, and Pensions of
23 the Senate an initial report detailing—

1 (1) nationwide best practices for ensuring
2 States and localities collect and transmit health in-
3 equities data;

4 (2) nationwide trends which hinder the collec-
5 tion and transmission of health inequities data;

6 (3) Federal best practices for working with
7 States and localities to ensure culturally competent,
8 accurate, and increased data collection and trans-
9 mission; and

10 (4) any recommended changes to legislative or
11 regulatory authority to help improve and increase
12 health inequities data collection.

13 (c) FINAL REPORT.—Not later than December 31,
14 2023, the Secretary shall—

15 (1) update and finalize the initial report under
16 subsection (b); and

17 (2) submit such final report to the committees
18 specified in such subsection.

19 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
20 authorized to be appropriated to carry out this section
21 \$100,000,000, to remain available until expended.

1 **SEC. 123. ADDITIONAL REPORTING TO CONGRESS ON THE**
2 **RACE AND ETHNICITY RATES OF COVID-19**
3 **TESTING, HOSPITALIZATIONS, AND MORTALI-**
4 **TIES.**

5 (a) IN GENERAL.—Not later than August 1, 2020,
6 the Secretary of Health and Human Services (referred to
7 in this section as the “Secretary”) shall submit to the
8 Committee on Appropriations and the Committee on En-
9 ergy and Commerce of the House of Representatives and
10 the Committee on Appropriations and the Committee on
11 Health, Education, Labor, and Pensions of the Senate an
12 initial report—

13 (1) describing the testing, positive diagnoses,
14 hospitalization, intensive care admissions, and mor-
15 tality rates associated with COVID-19,
16 disaggregated by race, ethnicity (including break-
17 downs of major ethnic groups and Tribal affiliations
18 within minority populations), age, sex, gender, geo-
19 graphic region, primary written and spoken lan-
20 guage, disability status, sexual orientation, socio-
21 economic status, occupation, and other relevant fac-
22 tors as determined by the Secretary;

23 (2) including an analysis of any variances of
24 testing, positive diagnoses, hospitalizations, and
25 deaths by demographic characteristics; and

1 (3) including proposals for evidenced-based re-
 2 response strategies to reduce disparities related to
 3 COVID–19.

4 (b) FINAL REPORT.—Not later than December 31,
 5 2024, the Secretary shall—

6 (1) update and finalize the initial report under
 7 subsection (a); and

8 (2) submit such final report to the committees
 9 specified in such subsection.

10 (c) COORDINATION.—In preparing the report sub-
 11 mitted under this section, the Secretary shall take into ac-
 12 count and otherwise coordinate such report with reporting
 13 required under section 103 and under the heading “De-
 14 partment of Health and Human Services—Office of the
 15 Secretary—Public Health and Social Service Emergency
 16 Fund” in title I of division B of the Paycheck Protection
 17 Program and Health Care Enhancement Act (Public Law
 18 116–139; 134 Stat. 620, 626).

19 **TITLE II—EQUITABLE TESTING**
 20 **AND TRACING**
 21 **Subtitle A—Free Testing for**
 22 **Patients**

23 **SEC. 201. SOONER COVERAGE OF TESTING FOR COVID–19.**

24 Section 6001(a) of division F of the Families First
 25 Coronavirus Response Act (42 U.S.C. 1320b–5 note) is

1 amended by striking “beginning on or after” and inserting
2 “beginning before, on, or after”.

3 **Subtitle B—National Testing**
4 **Strategy**

5 **SEC. 211. COVID-19 TESTING STRATEGY.**

6 (a) STRATEGY.—Not later than June 15, 2020, the
7 Secretary of Health and Human Services (referred to in
8 this section as the “Secretary”) shall update the COVID–
9 19 strategic testing plan under the heading “Department
10 of Health and Human Services—Office of the Secretary—
11 Public Health and Social Service Emergency Fund” in
12 title I of division B of the Paycheck Protection Program
13 and Health Care Enhancement Act (Public Law 116–139,
14 134 Stat. 620, 626–627) and submit to the appropriate
15 congressional committees such updated national plan iden-
16 tifying—

17 (1) what level of, types of, and approaches to
18 testing (including predicted numbers of tests, popu-
19 lations to be tested, and frequency of testing and the
20 appropriate setting whether a health care setting
21 (such as hospital-based, high-complexity laboratory,
22 point-of-care, mobile testing units, pharmacies or
23 community health centers) or non-health care setting
24 (such as workplaces, schools, or child care centers))
25 are necessary—

1 (A) to sufficiently monitor and contribute
2 to the control of the transmission of SARS-
3 CoV-2 in the United States;

4 (B) to ensure that any reduction in social
5 distancing efforts, when determined appropriate
6 by public health officials, can be undertaken in
7 a manner that optimizes the health and safety
8 of the people of the United States, and reduces
9 disparities (including disparities related to race,
10 ethnicity, sex, age, disability status, socio-
11 economic status, primary written and spoken
12 language, occupation, and geographic location)
13 in the prevalence of, incidence of, and health
14 outcomes with respect to, COVID-19; and

15 (C) to provide for ongoing surveillance suf-
16 ficient to support contact tracing, case identi-
17 fication, quarantine, and isolation to prevent fu-
18 ture outbreaks of COVID-19;

19 (2) specific plans and benchmarks, each with
20 clear timelines, to ensure—

21 (A) such level of, types of, and approaches
22 to testing as are described in paragraph (1),
23 with respect to optimizing health and safety;

24 (B) sufficient availability of all necessary
25 testing materials and supplies, including extrac-

tion and testing kits, reagents, transport media, swabs, instruments, analysis equipment, personal protective equipment if necessary for testing (including point-of-care testing), and other equipment;

(C) allocation of testing materials and supplies in a manner that optimizes public health, including by considering the variable impact of SARS-CoV-2 on specific States, territories, Indian Tribes, Tribal organizations, urban Indian organizations, communities, industries, and professions;

(D) sufficient evidence of validation for tests that are deployed as a part of such strategy;

(E) sufficient laboratory and analytical capacity, including target turnaround time for test results;

(F) sufficient personnel, including personnel to collect testing samples, conduct and analyze results, and conduct testing follow-up, including contact tracing, as appropriate; and

(G) enforcement of the Families First Coronavirus Response Act (Public Law 116–

1 127) to ensure patients who are tested are not
2 subject to cost sharing;

3 (3) specific plans to ensure adequate testing in
4 rural areas, frontier areas, health professional short-
5 age areas, and medically underserved areas (as de-
6 fined in section 330I(a) of the Public Health Service
7 Act (42 U.S.C. 254c–14(a))), and for underserved
8 populations, Native Americans (including Indian
9 Tribes, Tribal organizations, and urban Indian orga-
10 nizations), and populations at increased risk related
11 to COVID–19;

12 (4) specific plans to ensure accessibility of test-
13 ing to people with disabilities, older individuals, indi-
14 viduals with limited English proficiency, and individ-
15 uals with underlying health conditions or weakened
16 immune systems; and

17 (5) specific plans for broadly developing and
18 implementing testing for potential immunity in the
19 United States, as appropriate, in a manner suffi-
20 cient—

21 (A) to monitor and contribute to the con-
22 trol of SARS–CoV–2 in the United States;

23 (B) to ensure that any reduction in social
24 distancing efforts, when determined appropriate
25 by public health officials, can be undertaken in

1 a manner that optimizes the health and safety
2 of the people of the United States; and

3 (C) to reduce disparities (including dispari-
4 ties related to race, ethnicity, sex, age, dis-
5 ability status, socioeconomic status, primary
6 written and spoken language, occupation, and
7 geographic location) in the prevalence of, inci-
8 dence of, and health outcomes with respect to,
9 COVID-19.

10 (b) COORDINATION.—The Secretary shall carry out
11 this section—

12 (1) in coordination with the Administrator of
13 the Federal Emergency Management Agency;

14 (2) in collaboration with other agencies and de-
15 partments, as appropriate; and

16 (3) taking into consideration the State plans for
17 COVID-19 testing prepared as required under the
18 heading “Department of Health and Human Serv-
19 ices—Office of the Secretary—Public Health and
20 Social Service Emergency Fund” in title I of divi-
21 sion B of the Paycheck Protection Program and
22 Health Care Enhancement Act (Public Law 116–
23 139; 134 Stat. 620, 624).

24 (c) UPDATES.—

1 (1) FREQUENCY.—The updated national plan
2 under subsection (a) shall be updated every 30 days
3 until the end of the public health emergency first de-
4 clared by the Secretary under section 319 of the
5 Public Health Service Act (42 U.S.C. 247d) on Jan-
6 uary 31, 2020, with respect to COVID–19.

7 (2) RELATION TO OTHER LAW.—Paragraph (1)
8 applies in lieu of the requirement (for updates every
9 90 days until funds are expended) in the second to
10 last proviso under the heading “Department of
11 Health and Human Services—Office of the Sec-
12 retary—Public Health and Social Service Emergency
13 Fund” in title I of division B of the Paycheck Pro-
14 tection Program and Health Care Enhancement Act
15 (Public Law 116–139; 134 Stat. 620, 627).

16 (d) APPROPRIATE CONGRESSIONAL COMMITTEES.—
17 In this section, the term “appropriate congressional com-
18 mittees” means—

19 (1) the Committee on Appropriations and the
20 Committee on Energy and Commerce of the House
21 of Representatives; and

22 (2) the Committee on Appropriations and the
23 Committee on Health, Education, Labor, and Pen-
24 sions of the Senate.

1 **SEC. 212. CORONAVIRUS IMMIGRANT FAMILIES PROTEC-**
2 **TION.**

3 (a) DEFINITIONS.—In this section:

4 (1) CORONAVIRUS PUBLIC HEALTH EMER-
5 GENCY.—The term “coronavirus public health emer-
6 gency” means—

7 (A) an emergency involving Federal pri-
8 mary responsibility determined to exist by the
9 President under section 501(b) of the Robert T.
10 Stafford Disaster Relief and Emergency Assist-
11 ance Act (42 U.S.C. 5191(b)) with respect to
12 COVID–19 or any other coronavirus with pan-
13 demic potential;

14 (B) an emergency declared by a Federal
15 official with respect to coronavirus (as defined
16 in section 506 of the Coronavirus Preparedness
17 and Response Supplemental Appropriations
18 Act, 2020 (Public Law 116–123));

19 (C) a national emergency declared by the
20 President under the National Emergencies Act
21 (50 U.S.C. 1601 et seq.) with respect to
22 COVID–19 or any other coronavirus with pan-
23 demic potential; and

24 (D) a public health emergency declared by
25 the Secretary of Health and Human Services
26 pursuant to section 319 of the Public Health

1 Service Act (42 U.S.C. 247(d)) with respect to
2 COVID–19 or any other coronavirus with pan-
3 demic potential.

4 (2) CORONAVIRUS RESPONSE LAW.—The term
5 “coronavirus response law” means—

6 (A) the Coronavirus Preparedness and Re-
7 sponse Supplemental Appropriations Act, 2020
8 (Public Law 116–123);

9 (B) the Families First Coronavirus Re-
10 sponse Act (Public Law 116–127);

11 (C) the Coronavirus Aid, Relief, and Eco-
12 nomic Security Act (Public Law 116–136); and

13 (D) any subsequent law enacted as a re-
14 sponse to a coronavirus public health emer-
15 gency.

16 (3) COVID–19.—The term “COVID–19”
17 means the Coronavirus Disease 2019.

18 (4) ENFORCEMENT ACTION.—The term “en-
19 forcement action” means an apprehension, an arrest,
20 a search, an interview, a request for identification,
21 or surveillance for the purposes of immigration en-
22 forcement.

23 (5) SENSITIVE LOCATION.—The term “sensitive
24 location” means all physical space located within
25 1,000 feet of—

1 (A) a medical treatment or health care fa-
2 cility, including a hospital, an office of a health
3 care practitioner, an accredited health clinic, an
4 alcohol or drug treatment center, an emergent
5 or urgent care facility, and a community health
6 center;

7 (B) a location at which emergency service
8 providers distribute food or provide shelter;

9 (C) an organization that provides—

10 (i) disaster or emergency social serv-
11 ices and assistance;

12 (ii) services for individuals experi-
13 encing homelessness, including food banks
14 and shelters; or

15 (iii) assistance for children, pregnant
16 women, victims of crime or abuse, or indi-
17 viduals with significant mental or physical
18 disabilities;

19 (D) a public assistance office, including
20 any Federal, State, or municipal location at
21 which individuals may apply for or receive un-
22 employment compensation or report violations
23 of labor and employment laws;

1 (E) a Federal, State, or local courthouse,
2 including the office of the legal counsel or rep-
3 resentative of an individual;

4 (F) a domestic violence shelter, rape crisis
5 center, supervised visitation center, family jus-
6 tice center, or victim services provider;

7 (G) an office of the Social Security Admin-
8 istration;

9 (H) a childcare facility or a school, includ-
10 ing a preschool, primary school, secondary
11 school, post-secondary school up to and includ-
12 ing a college or university, and any other insti-
13 tution of learning such as a vocational or trade
14 school;

15 (I) a church, synagogue, mosque or any
16 other institution of worship, such as a building
17 rented for the purpose of a religious service;

18 (J) the site of a funeral, wedding, or any
19 other public religious ceremony;

20 (K) in the case of a jurisdiction in which
21 a shelter-in-place order is in effect during a
22 coronavirus public health emergency, any busi-
23 ness location considered to provide an essential
24 service, such as a pharmacy or a grocery store;
25 and

1 (L) any other location specified by the Sec-
2 retary of Homeland Security.

3 (b) SUSPENSION OF ADVERSE IMMIGRATION AC-
4 TIONS THAT DETER IMMIGRANT COMMUNITIES FROM
5 SEEKING HEALTH SERVICES IN A PUBLIC HEALTH
6 EMERGENCY.—

7 (1) IN GENERAL.—Beginning on the date on
8 which a coronavirus public health emergency is de-
9 clared and ending on the date that is 60 days after
10 the date on which the coronavirus public health
11 emergency expires—

12 (A) the Secretary of Homeland Security,
13 the Secretary of State, and the Attorney Gen-
14 eral shall not—

15 (i) implement the final rule of the De-
16 partment of Homeland Security entitled
17 “Inadmissibility on Public Charge
18 Grounds” (84 Fed. Reg. 41292 (August
19 14, 2019));

20 (ii) implement the interim final rule of
21 the Department of State entitled “Visas:
22 Ineligibility Based on Public Charge
23 Grounds” (84 Fed. Reg. 54996 (October
24 11, 2019));

1 (iii) implement the proposed rule of
2 the Department of Justice entitled “Inad-
3 missibility on Public Charge Grounds”
4 published in the Fall 2018 Uniform Regu-
5 latory Agenda;

6 (iv) conduct any enforcement action
7 against an individual at, or in transit to or
8 from, a sensitive location unless the en-
9 forcement action is conducted pursuant to
10 a valid judicial warrant;

11 (v) detain or remove—

12 (I) a survivor of domestic vio-
13 lence, sexual assault, or human traf-
14 ficking, or any other individual, who
15 has a pending application under sec-
16 tion 101(a)(15)(T), 101(a)(15)(U),
17 106, 240A(b)(2) of the Immigration
18 and Nationality Act (8 U.S.C.
19 1101(a)(15)(T), 1101(a)(15)(U),
20 1105a, 1229b(b)(2)) or section
21 244(a)(3) of that Act (as in effect on
22 March 31, 1997); or

23 (II) a VAWA self-petitioner de-
24 scribed in section 101(a)(51) of that

1 Act (8 U.S.C. 1101(a)(51)) who has a
2 pending application for relief under—

3 (aa) a provision referred to
4 in any of subparagraphs (A)
5 through (G) of that section; or

6 (bb) section 101(a)(27)(J)
7 of that Act (8 U.S.C.
8 1101(a)(27)(J)); and

9 (vi) require an individual subject to
10 supervision by U.S. Immigration and Cus-
11 toms Enforcement to report in person.

12 (B) The Attorney General shall conduct
13 fully telephonic bond hearings and allow sup-
14 porting documents to be faxed and emailed to
15 the appropriate clerk.

16 (C) The Secretary of Homeland Security,
17 to the extent practicable, shall stipulate to bond
18 determinations on written motions.

19 (2) USE OF BENEFITS FUNDED BY
20 CORONAVIRUS RESPONSE LAW.—The Secretary of
21 Homeland Security, the Secretary of State, and the
22 Attorney General shall not consider in any deter-
23 mination affecting the current or future immigration
24 status of any individual the use of any benefit of any
25 program or activity funded in whole or in part by

1 amounts made available under a coronavirus re-
2 sponse law.

3 (c) ACCESS TO COVID-19 TESTING AND TREAT-
4 MENT FOR ALL COMMUNITIES.—

5 (1) CLARIFICATION REGARDING EMERGENCY
6 SERVICES FOR CERTAIN INDIVIDUALS.—Section
7 1903(v)(2) of the Social Security Act (42 U.S.C.
8 1396b(v)(2)) is amended by adding at the end the
9 following flush sentence:

10 “For purposes of subparagraph (A), care and services
11 described in such subparagraph include any in vitro diag-
12 nostic product described in section 1905(a)(3)(B) that is
13 administered during any portion of the emergency period
14 described in such section beginning on or after the date
15 of the enactment of this sentence (and the administration
16 of such product), any COVID-19 vaccine that is adminis-
17 tered during any such portion (and the administration of
18 such vaccine), any item or service that is furnished during
19 any such portion for the treatment of COVID-19 or a con-
20 dition that may complicate the treatment of COVID-19,
21 and any services described in section 1916(a)(2)(G).”.

22 (2) EMERGENCY MEDICAID FOR INDIVIDUALS
23 WITH SUSPECTED COVID-19 INFECTIONS.—Section
24 1903(v)(3) of the Social Security Act (42 U.S.C.
25 1396b(v)(3)) is amended by striking “means a” and

1 inserting “means any concern that the individual
2 may have contracted COVID–19 or another.”.

3 (3) TREATMENT OF ASSISTANCE AND SERVICES
4 PROVIDED.—For any period during which a
5 coronavirus public health emergency is in effect—

6 (A) the value of assistance or services pro-
7 vided to any person under a program with re-
8 spect to which a coronavirus response law es-
9 tablishes or expands eligibility or benefits shall
10 not be considered income or resources; and

11 (B)(i) any medical coverage or services
12 shall be considered treatment for an emergency
13 medical condition (as defined in section
14 1903(v)(3) of the Social Security Act (42
15 U.S.C. 1396b(v)(3))) for any purpose under
16 any Federal, State, or local law, including law
17 relating to taxation, welfare, and public assist-
18 ance programs;

19 (ii) a participating State or political sub-
20 division of a State shall not decrease any assist-
21 ance otherwise provided to an individual be-
22 cause of the receipt of benefits under the Social
23 Security Act (42 U.S.C. 301 et seq.); and

24 (iii) assistance and services described in
25 this subparagraph shall be considered noncash

1 disaster assistance, notwithstanding the form in
2 which the assistance and services are provided,
3 except that cash received by an individual or a
4 household may be treated as income by any
5 public benefit program under the rules applica-
6 ble before the date of the enactment of this Act.

7 (4) NONDISCRIMINATION.—No person shall be,
8 on the basis of actual or perceived immigration sta-
9 tus, excluded from participation in, denied the bene-
10 fits of, or subject to discrimination under, any pro-
11 gram or activity funded in whole or in part by
12 amounts made available under a coronavirus re-
13 sponse law.

14 (d) LANGUAGE ACCESS AND PUBLIC OUTREACH FOR
15 PUBLIC HEALTH.—

16 (1) GRANTS AND COOPERATIVE AGREE-
17 MENTS.—

18 (A) IN GENERAL.—The Director of the
19 Centers for Disease Control and Prevention (re-
20 ferred to in this subsection as the “Director”)
21 shall provide grants to, or enter into cooperative
22 agreements with, community-based organiza-
23 tions for the purpose of supporting culturally
24 and linguistically appropriate preparedness, re-
25 sponse, and recovery activities, such as the de-

1 development of educational programs and mate-
2 rials to promote screening, testing, treatment,
3 and public health practices.

4 (B) DEFINITION OF COMMUNITY-BASED
5 ORGANIZATION.—In this paragraph, the term
6 “community-based organization” means an en-
7 tity that has established relationships with
8 hard-to-reach populations, including racial and
9 ethnic minorities, individuals with limited
10 English proficiency, and individuals with dis-
11 abilities.

12 (2) TRANSLATION.—

13 (A) IN GENERAL.—The Director shall pro-
14 vide for the translation of materials on aware-
15 ness, screening, testing, and treatment for
16 COVID–19 into the languages described in the
17 language access plan of the Federal Emergency
18 Management Agency dated October 1, 2016, as
19 the languages most frequently encountered.

20 (B) PUBLIC AVAILABILITY.—Not later
21 than 7 days after the date on which the mate-
22 rials described in subparagraph (A) are made
23 available to the public in English, the Director
24 shall ensure that the translations required by

1 that subparagraph are made available to the
2 public.

3 (3) HOTLINE.—The Director shall establish an
4 informational hotline line that provides, in the lan-
5 guages referred to in paragraph (2)(A), information
6 to the public directly on COVID–19.

7 (4) INTERAGENCY COORDINATION.—With re-
8 spect to individuals with limited English proficiency,
9 the Director shall facilitate interagency coordination
10 among agencies activated through the National Re-
11 sponse Framework based on the language access
12 standards established under the language access
13 plans of the Federal Emergency Management Agen-
14 cy and the Department of Health and Human Serv-
15 ices.

16 (5) AUTHORIZATION OF APPROPRIATIONS.—

17 (A) IN GENERAL.—There is authorized to
18 be appropriated to carry out this subsection
19 \$100,000,000 for fiscal year 2020, to be avail-
20 able until expended.

21 (B) GRANTS AND COOPERATIVE AGREE-
22 MENTS.—Of the amount authorized to be ap-
23 propriated under subparagraph (A), not less
24 than \$50,000,000 shall be made available to
25 carry out paragraph (1).

1 (e) ACCESS TO SUPPORT MEASURES FOR VULNER-
2 ABLE COMMUNITIES.—

3 (1) DISASTER SUPPLEMENTAL NUTRITION AS-
4 SISTANCE PROGRAM BENEFITS.—The Robert T.
5 Stafford Disaster Relief and Emergency Assistance
6 Act (42 U.S.C. 5121 et seq.) is amended—

7 (A) in section 102(1) (42 U.S.C. 5122(1)),
8 by inserting “or pandemic” after “catastrophe”;

9 (B) in section 301 (42 U.S.C. 5141), by
10 inserting “or an emergency due to a pandemic”
11 after “major disaster” each place the term ap-
12 pears;

13 (C) in section 412 (42 U.S.C. 5179)—

14 (i) by inserting “or an emergency due
15 to a pandemic” after “major disaster”
16 each place the term appears;

17 (ii) in subsection (a), by inserting
18 “without regard to regular allotments” be-
19 fore “and to make surplus”; and

20 (iii) by adding at the end the fol-
21 lowing:

22 “(d) ASSISTANCE DURING A PANDEMIC.—In the case
23 of an emergency due to a pandemic, for purposes of pro-
24 viding benefits under this section, the Secretary of Agri-
25 culture shall remove or delay the requirement of an in-

1 person interview, and if an interview occurs, provide an
 2 alternative to the in-person interview requirement for all
 3 applicants. Assistance shall be provided based on need and
 4 not lost provisions.

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 6 are authorized to be appropriated such sums as are nec-
 7 essary to carry out this section, only if such sums are des-
 8 ignated by Congress as being for an emergency require-
 9 ment pursuant to section 251(b)(2)(A)(i) of the Balanced
 10 Budget and Emergency Deficit Control Act of 1985 (2
 11 U.S.C. 901(b)(2)(A)(i)).”; and

12 (D) in section 502(a) (42 U.S.C.
 13 5192(a))—

14 (i) in paragraph (7), by striking
 15 “and” at the end;

16 (ii) in paragraph (8)(B), by striking
 17 the period at the end and inserting a semi-
 18 colon; and

19 (iii) by adding at the end the fol-
 20 lowing:

21 “(9) provide assistance in accordance with sec-
 22 tion 412.”.

23 (2) ACCESS TO BENEFITS USING INDIVIDUAL
 24 TAXPAYER IDENTIFICATION NUMBER.—Subsection
 25 (g)(2)(A) of section 6428 of the Internal Revenue

1 Code of 1986, as added by section 2201 of the
2 Coronavirus Aid, Relief, and Economic Security Act
3 (Public Law 116–136), is amended by inserting be-
4 fore the period at the end “or a taxpayer identifica-
5 tion number”.

6 (3) EXTENSION OF IMMIGRATION STATUS AND
7 EMPLOYMENT AUTHORIZATION.—

8 (A) IN GENERAL.—Notwithstanding any
9 other provision of law, including the Immigra-
10 tion and Nationality Act (8 U.S.C. 1101 et
11 seq.), the Secretary of Homeland Security shall
12 automatically extend the immigration status
13 and employment authorization, as applicable, of
14 an alien described in subparagraph (B) for the
15 same period for which the status and employ-
16 ment authorization was initially granted.

17 (B) ALIEN DESCRIBED.—An alien de-
18 scribed in this subparagraph is an alien (as de-
19 fined in section 101(a) of the Immigration and
20 Nationality Act (8 U.S.C. 1101(a))) whose im-
21 migration status, including permanent, tem-
22 porary, and deferred status, or whose employ-
23 ment authorization—

1 (i) expired during the 30-day period
2 preceding the date of the enactment of this
3 Act; or

4 (ii) will expire not later than—

5 (I) one year after such date of
6 enactment; or

7 (II) 90 days after the date on
8 which the national emergency declared
9 by the President under the National
10 Emergencies Act (50 U.S.C. 1601 et
11 seq.) with respect to the Coronavirus
12 Disease 2019 (COVID–19) is re-
13 scinded.

14 (4) LANGUAGE ACCESS.—Any agency receiving
15 funding under a coronavirus response law shall en-
16 sure that all programs and opportunities made avail-
17 able to the general public provide translated mate-
18 rials describing the programs and opportunities into
19 the languages described in the language access plan
20 of the Federal Emergency Management Agency
21 dated October 1, 2016, as the languages most fre-
22 quently encountered.

23 **SEC. 213. ICE DETENTION.**

24 (a) REVIEWING ICE DETENTION.—During the public
25 health emergency declared by the Secretary of Health and

1 Human Services under section 319 of the Public Health
2 Service Act (42 U.S.C. 247d) with respect to COVID–19,
3 the Secretary of Homeland Security shall review the immi-
4 gration files of all individuals in the custody of U.S. Immi-
5 gration and Customs Enforcement to assess the need for
6 continued detention. The Secretary of Homeland Security
7 shall prioritize for release on recognizance or alternatives
8 to detention individuals who are not subject to mandatory
9 detention laws, unless the individual is a threat to public
10 safety or national security.

11 (b) ACCESS TO ELECTRONIC COMMUNICATIONS AND
12 HYGIENE PRODUCTS.—During the period described in
13 subsection (c), the Secretary of Homeland Security shall
14 ensure that—

15 (1) all individuals in the custody of U.S. Immi-
16 gration and Customs Enforcement—

17 (A) have access to telephonic or video com-
18 munication at no cost to the detained indi-
19 vidual;

20 (B) have access to free, unmonitored tele-
21 phone calls, at any time, to contact attorneys or
22 legal service providers in a sufficiently private
23 space to protect confidentiality;

1 (C) are permitted to receive legal cor-
2 respondence by fax or email rather than postal
3 mail; and

4 (D) are provided sufficient soap, hand san-
5 itizer, and other hygiene products; and

6 (2) nonprofit organizations providing legal ori-
7 entation programming or know-your-rights program-
8 ming to individuals in the custody of U.S. Immigra-
9 tion and Customs Enforcement are permitted broad
10 and flexible access to such individuals—

11 (A) to provide group presentations using
12 remote videoconferencing; and

13 (B) to schedule and provide individual ori-
14 entations using free telephone calls or remote
15 videoconferencing.

16 (c) PERIOD DESCRIBED.—The period described in
17 this subsection—

18 (1) begins on the first day of the public health
19 emergency declared by the Secretary of Health and
20 Human Services under section 319 of the Public
21 Health Service Act (42 U.S.C. 247d) with respect to
22 COVID–19; and

23 (2) ends 90 days after the date on which such
24 public health emergency terminates.

Subtitle C—Contact Tracing

SEC. 221. COVID-19 TESTING, REACHING, AND CONTACTING EVERYONE.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, may award grants to eligible entities to conduct diagnostic testing for COVID-19, to trace and monitor the contacts of infected individuals, and to support the quarantine of such contacts, through—

- (1) mobile health units; and
- (2) as necessary, testing individuals and providing individuals with services related to testing and quarantine at their residences.

(b) PERMISSIBLE USES OF FUNDS.—A grant recipient under this section may use the grant funds, in support of the activities described in subsection (a)—

- (1) to hire, train, compensate, and pay the expenses of individuals; and
- (2) to purchase personal protective equipment and other supplies.

(c) PRIORITY.—In selecting grant recipients under this section, the Secretary shall give priority to—

1 (1) applicants proposing to conduct activities
2 funded under this section in hot spots and medically
3 underserved communities; and

4 (2) applicants that agree, in hiring individuals
5 to carry out activities funded under this section, to
6 hire residents of the area or community where the
7 activities will primarily occur, with higher priority
8 among applicants described in this paragraph given
9 based on the percentage of individuals to be hired
10 from such area or community.

11 (d) DISTRIBUTION.—In selecting grant recipients
12 under this section, the Secretary shall ensure that grants
13 are distributed across urban and rural areas.

14 (e) FEDERAL PRIVACY REQUIREMENTS.—Nothing in
15 this section shall be construed to supersede any Federal
16 privacy or confidentiality requirement, including the regu-
17 lations promulgated under section 264(c) of the Health
18 Insurance Portability and Accountability Act of 1996
19 (Public Law 104–191; 110 Stat. 2033) and section 543
20 of the Public Health Service Act (42 U.S.C. 290dd–2).

21 (f) DEFINITIONS.—In this section:

22 (1) The term “eligible entity” means—

23 (A) a Federally qualified health center (as
24 defined in section 1861(aa) of the Social Secu-
25 rity Act (42 U.S.C. 1395x(aa)));

1 (B) a school-based health clinic;

2 (C) a disproportionate share hospital (as
3 defined under the applicable State plan under
4 title XIX of the Social Security Act (42 U.S.C.
5 1396 et seq.) pursuant to section 1923(a)(1)(A)
6 of such Act (42 U.S.C. 1396r-4));

7 (D) an academic medical center;

8 (E) a nonprofit organization (including any
9 such faith-based organization);

10 (F) an institution of higher education (as
11 defined in section 101 of the Higher Education
12 Act of 1965 (20 U.S.C. 1001));

13 (G) a high school (as defined in section
14 8101 of the Elementary and Secondary Edu-
15 cation Act of 1965 (20 U.S.C. 7801));

16 (H) any Tribal organization including the
17 Indian Health Service and Native American
18 servicing facilities; or

19 (I) any other type of entity that is deter-
20 mined by the Secretary to be an eligible entity
21 for purposes of this section.

22 (2) The term “emergency period” has the
23 meaning given to that term in section 1135(g)(1)(B)
24 of the Social Security Act (42 U.S.C. 1320b-
25 5(g)(1)(B)).

1 (3) The term “hot spot” means a geographic
2 area where the rate of infection with the virus that
3 causes COVID–19 exceeds the national average.

4 (4) The term “medically underserved commu-
5 nity” has the meaning given to that term in section
6 799B of the Public Health Service Act (42 U.S.C.
7 295p).

8 (5) The term “Secretary” means the Secretary
9 of Health and Human Services.

10 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated—

12 (1) \$100,000,000,000 for fiscal year 2020; and

13 (2) such sums as may be necessary for each of
14 fiscal year 2021 and any subsequent fiscal year dur-
15 ing which the emergency period continues.

16 **SEC. 222. NATIONAL SYSTEM FOR COVID–19 TESTING, CON-**
17 **TACT TRACING, SURVEILLANCE, CONTAIN-**
18 **MENT, AND MITIGATION.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services (referred to in this section as the “Sec-
21 retary”), acting through the Director of the Centers for
22 Disease Control and Prevention, and in coordination with
23 State, local, Tribal, and territorial health departments,
24 shall establish and implement a nationwide evidence-based
25 system for—

1 (1) testing, contact tracing, surveillance, con-
2 tainment, and mitigation with respect to COVID–19;

3 (2) offering guidance on voluntary isolation and
4 quarantine of individuals infected with, or exposed to
5 individuals infected with, the virus that causes
6 COVID–19; and

7 (3) public reporting on testing, contact tracing,
8 surveillance, and voluntary isolation and quarantine
9 activities with respect to COVID–19.

10 (b) COORDINATION; TECHNICAL ASSISTANCE.—In
11 carrying out the national system under this section, the
12 Secretary shall—

13 (1) coordinate State, local, Tribal, and terri-
14 torial activities related to testing, contact tracing,
15 surveillance, containment, and mitigation with re-
16 spect to COVID–19, as appropriate; and

17 (2) provide technical assistance for such activi-
18 ties, as appropriate.

19 (c) CONSIDERATION.—In establishing and imple-
20 menting the national system under this section, the Sec-
21 retary shall take into consideration—

22 (1) the State plans referred to in the heading
23 “Public Health and Social Services Emergency
24 Fund” in title I of division B of the Paycheck Pro-

1 tection Program and Health Care Enhancement Act
2 (Public Law 116–139); and

3 (2) the testing strategy submitted under section
4 211.

5 (d) REPORTING.—The Secretary shall—

6 (1) not later than December 31, 2020, submit
7 to the Committee on Energy and Commerce of the
8 House of Representatives and the Committee on
9 Health, Education, Labor, and Pensions a prelimi-
10 nary report on the effectiveness of the activities car-
11 ried out pursuant to this subtitle; and

12 (2) not later than December 21, 2021, submit
13 to such committees a final report on such effective-
14 ness.

15 **SEC. 223. GRANTS.**

16 (a) IN GENERAL.—To implement the national system
17 under section 222, the Secretary of Health and Human
18 Services (referred to in this section as the “Secretary”),
19 acting through the Director of the Centers for Disease
20 Control and Prevention, shall, subject to the availability
21 of appropriations, award grants to State, local, Tribal, and
22 territorial health departments that seek grants under this
23 section to carry out coordinated testing, contact tracing,
24 surveillance, containment, and mitigation with respect to
25 COVID–19, including—

1 (1) diagnostic and surveillance testing and re-
2 porting;

3 (2) community-based contact tracing efforts;
4 and

5 (3) policies related to voluntary isolation and
6 quarantine of individuals infected with, or exposed to
7 individuals infected with, the virus that causes
8 COVID-19.

9 (b) FLEXIBILITY.—The Secretary shall ensure that—

10 (1) the grants under subsection (a) provide
11 flexibility for State, local, Tribal, and territorial
12 health departments to modify, establish, or maintain
13 evidence-based systems; and

14 (2) local health departments receive funding
15 from State health departments or directly from the
16 Centers for Disease Control and Prevention to con-
17 tribute to such systems, as appropriate.

18 (c) ALLOCATIONS.—

19 (1) FORMULA.—The Secretary, acting through
20 the Director of the Centers for Disease Control and
21 Prevention, shall allocate amounts made available
22 pursuant to subsection (a) in accordance with a for-
23 mula to be established by the Secretary that pro-
24 vides a minimum level of funding to each State,
25 local, Tribal, and territorial health department that

1 seeks a grant under this section and allocates addi-
2 tional funding based on the following prioritization:

3 (A) The Secretary shall give highest pri-
4 ority to applicants proposing to serve popu-
5 lations in one or more geographic regions with
6 a high burden of COVID–19 based on data pro-
7 vided by the Centers for Disease Control and
8 Prevention, or other sources as determined by
9 the Secretary.

10 (B) The Secretary shall give second high-
11 est priority to applicants preparing for, or cur-
12 rently working to mitigate, a COVID–19 surge
13 in a geographic region that does not yet have
14 a high number of reported cases of COVID–19
15 based on data provided by the Centers for Dis-
16 ease Control and Prevention, or other sources
17 as determined by the Secretary.

18 (C) The Secretary shall give third highest
19 priority to applicants proposing to serve high
20 numbers of low-income and uninsured popu-
21 lations, including medically underserved popu-
22 lations (as defined in section 330(b)(3) of the
23 Public Health Service Act (42 U.S.C.
24 254b(b)(3))), health professional shortage areas
25 (as defined under section 332(a) of the Public

1 Health Service Act (42 U.S.C. 254e(a))), racial
2 and ethnic minorities, or geographically diverse
3 areas, as determined by the Secretary.

4 (2) NOTIFICATION.—Not later than the date
5 that is one week before first awarding grants under
6 this section, the Secretary shall submit to the Com-
7 mittee on Energy and Commerce of the House of
8 Representatives and the Committee on Health, Edu-
9 cation, Labor, and Pensions of the Senate a notifica-
10 tion detailing the formula established under para-
11 graph (1) for allocating amounts made available pur-
12 suant to subsection (a).

13 (d) USE OF FUNDS.—A State, local, Tribal, and ter-
14 ritorial health department receiving a grant under this
15 section shall, to the extent possible, use the grant funds
16 for the following activities, or other activities deemed ap-
17 propriate by the Director of the Centers for Disease Con-
18 trol and Prevention:

19 (1) TESTING.—To implement a coordinated
20 testing system that—

21 (A) leverages or modernizes existing test-
22 ing infrastructure and capacity;

23 (B) is consistent with the updated testing
24 strategy required under section 211;

1 (C) is coordinated with the State plan for
2 COVID–19 testing prepared as required under
3 the heading “Department of Health and
4 Human Services—Office of the Secretary—
5 Public Health and Social Service Emergency
6 Fund” in title I of division B of the Paycheck
7 Protection Program and Health Care Enhance-
8 ment Act (Public Law 116–139; 134 Stat. 620,
9 624);

10 (D) is informed by contact tracing and
11 surveillance activities under this subtitle;

12 (E) is informed by guidelines established
13 by the Centers for Disease Control and Preven-
14 tion for which populations should be tested;

15 (F) identifies how diagnostic and sero-
16 logical tests in such system shall be validated
17 prior to use;

18 (G) identifies how diagnostic and sero-
19 logical tests and testing supplies will be distrib-
20 uted to implement such system;

21 (H) identifies specific strategies for ensur-
22 ing testing capabilities and accessibility in
23 medically underserved populations (as defined
24 in section 330(b)(3) of the Public Health Serv-
25 ice Act (42 U.S.C. 254b(b)(3))), health profes-

1 sional shortage areas (as defined under section
2 332(a) of the Public Health Service Act (42
3 U.S.C. 254e(a))), racial and ethnic minority
4 populations, and geographically diverse areas,
5 as determined by the Secretary;

6 (I) identifies how testing may be used, and
7 results may be reported, in both health care set-
8 tings (such as hospitals, laboratories for mod-
9 erate or high-complexity testing, pharmacies,
10 mobile testing units, and community health cen-
11 ters) and non-health care settings (such as
12 workplaces, schools, childcare centers, or drive-
13 throughs);

14 (J) allows for testing in sentinel surveil-
15 lance programs, as appropriate; and

16 (K) supports the procurement and dis-
17 tribution of diagnostic and serological tests and
18 testing supplies to meet the goals of the system.

19 (2) CONTACT TRACING.—To implement a co-
20 ordinated contact tracing system that—

21 (A) leverages or modernizes existing con-
22 tact tracing systems and capabilities, including
23 community health workers, health departments,
24 and Federally qualified health centers;

1 (B) is able to investigate cases of COVID–
2 19, and help to identify other potential cases of
3 COVID–19, through tracing contacts of individ-
4 uals with positive diagnoses;

5 (C) establishes culturally competent and
6 multilingual strategies for contact tracing,
7 which may include consultation with and sup-
8 port for cultural or civic organizations with es-
9 tablished ties to the community;

10 (D) provides individuals identified under
11 the contact tracing program with information
12 and support for containment or mitigation;

13 (E) enables State, local, Tribal, and terri-
14 torial health departments to work with a non-
15 governmental, community partner or partners
16 and State and local workforce development sys-
17 tems (as defined in section 3(67) of Workforce
18 Innovation and Opportunity Act (29 U.S.C.
19 3102(67))) receiving grants under section
20 224(b) of this Act to hire and compensate a lo-
21 cally sourced contact tracing workforce, if nec-
22 essary, to supplement the public health work-
23 force, to—

24 (i) identify the number of contact
25 tracers needed for the respective State, lo-

1 cality, territorial, or Tribal health depart-
2 ment to identify all cases of COVID–19
3 currently in the jurisdiction and those an-
4 ticipated to emerge over the next 18
5 months in such jurisdiction;

6 (ii) outline qualifications necessary for
7 contact tracers;

8 (iii) train the existing and newly hired
9 public health workforce on best practices
10 related to tracing close contacts of individ-
11 uals diagnosed with COVID–19, including
12 the protection of individual privacy and
13 cybersecurity protection; and

14 (iv) equip the public health workforce
15 with tools and resources to enable a rapid
16 response to new cases;

17 (F) identifies the level of contact tracing
18 needed within the State, locality, territory, or
19 Tribal area to contain and mitigate the trans-
20 mission of COVID–19;

21 (G) establishes statewide mechanisms to
22 integrate regular evaluation to the Centers for
23 Disease Control and Prevention regarding con-
24 tact tracing efforts, makes such evaluation pub-
25 licly available, and to the extent possible pro-

vides for such evaluation at the county level;
and

(H) identifies specific strategies for ensuring contact tracing activities in medically underserved populations (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), health professional shortage areas (as defined under section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))), racial and ethnic minority populations, and geographically diverse areas, as determined by the Secretary.

(3) SURVEILLANCE.—To strengthen the existing public health surveillance system that—

(A) leverages or modernizes existing surveillance systems within the respective State, local, Tribal, or territorial health department and national surveillance systems;

(B) detects and identifies trends in COVID–19 at the county level;

(C) evaluates State, local, Tribal, and territorial health departments in achieving surveillance capabilities with respect to COVID–19;

(D) integrates and improves disease surveillance and immunization tracking; and

1 (E) identifies specific strategies for ensur-
2 ing disease surveillance in medically under-
3 served populations (as defined in section
4 330(b)(3) of the Public Health Service Act (42
5 U.S.C. 254b(b)(3))), health professional short-
6 age areas (as defined under section 332(a) of
7 the Public Health Service Act (42 U.S.C.
8 254e(a))), racial and ethnic minority popu-
9 lations, and geographically diverse areas, as de-
10 termined by the Secretary.

11 (4) CONTAINMENT AND MITIGATION.—To im-
12 plement a coordinated containment and mitigation
13 system that—

14 (A) leverages or modernizes existing con-
15 tainment and mitigation strategies within the
16 respective State, local, Tribal, or territorial gov-
17 ernments and national containment and mitiga-
18 tion strategies;

19 (B) may provide for, connect to, and lever-
20 age existing social services and support for indi-
21 viduals who have been infected with or exposed
22 to COVID–19 and who are isolated or quar-
23 antined in their homes, such as through—

24 (i) food assistance programs;

1 (ii) guidance for household infection
2 control;

3 (iii) information and assistance with
4 childcare services; and

5 (iv) information and assistance per-
6 taining to support available under the
7 CARES Act (Public Law 116–136) and
8 this Act;

9 (C) provides guidance on the establishment
10 of safe, high-quality, facilities for the voluntary
11 isolation of individuals infected with, or quar-
12 antine of the contacts of individuals exposed to
13 COVID–19, where hospitalization is not re-
14 quired, which facilities should—

15 (i) be prohibited from making inquir-
16 ies relating to the citizenship status of an
17 individual isolated or quarantined; and

18 (ii) be operated by a non-Federal,
19 community partner or partners that—

20 (I) have previously established re-
21 lationships in localities;

22 (II) work with local places of
23 worship, community centers, medical
24 facilities, and schools to recruit local
25 staff for such facilities; and

1 (III) are fully integrated into
2 State, local, Tribal, or territorial con-
3 tainment and mitigation efforts; and

4 (D) identifies specific strategies for ensur-
5 ing containment and mitigation activities in
6 medically underserved populations (as defined
7 in section 330(b)(3) of the Public Health Serv-
8 ice Act (42 U.S.C. 254b(b)(3))), health profes-
9 sional shortage areas (as defined under section
10 332(a) of the Public Health Service Act (42
11 U.S.C. 254e(a))), racial and ethnic minority
12 populations, and geographically diverse areas,
13 as determined by the Secretary.

14 (e) REPORTING.—The Secretary shall facilitate
15 mechanisms for timely, standardized reporting by grantees
16 under this section regarding implementation of the sys-
17 tems established under this section and coordinated proc-
18 esses with the reporting as required and under the heading
19 “Department of Health and Human Services—Office of
20 the Secretary—Public Health and Social Service Emer-
21 gency Fund” in title I of division B of the Paycheck Pro-
22 tection Program and Health Care Enhancement Act (Pub-
23 lic Law 116–139, 134 Stat. 620), including—

24 (1) a summary of county or local health depart-
25 ment level information from the States receiving

1 funding, and information from directly funded local-
2 ities, territories, and Tribal entities, about the activi-
3 ties that will be undertaken using funding awarded
4 under this section, including subgrants;

5 (2) any anticipated shortages of required mate-
6 rials for testing for COVID–19 under subsection (a);
7 and

8 (3) other barriers in the prevention, mitigation,
9 or treatment of COVID–19 under this section.

10 (f) PUBLIC LISTING OF AWARDS.—The Secretary
11 shall—

12 (1) not later than 7 days after first awarding
13 grants under this section, post in a searchable, elec-
14 tronic format a list of all awards made by the Sec-
15 retary under this section, including the recipients
16 and amounts of such awards; and

17 (2) update such list not less than every 7 days
18 until all funds made available to carry out this sec-
19 tion are expended.

20 **SEC. 224. GRANTS TO STATE AND TRIBAL WORKFORCE**
21 **AGENCIES.**

22 (a) DEFINITIONS.—In this section:

23 (1) IN GENERAL.—Except as otherwise pro-
24 vided, the terms in this section have the meanings

1 given the terms in section 3 of the Workforce Inno-
2 vation and Opportunity Act (29 U.S.C. 3102).

3 (2) APPRENTICESHIP; APPRENTICESHIP PRO-
4 GRAM.—The term “apprenticeship” or “apprentice-
5 ship program” means an apprenticeship program
6 registered under the Act of August 16, 1937 (com-
7 monly known as the “National Apprenticeship Act”)
8 (50 Stat. 664, chapter 663; 29 U.S.C. 50 et seq.),
9 including any requirement, standard, or rule promul-
10 gated under such Act, as such requirement, stand-
11 ard, or rule was in effect on December 30, 2019.

12 (3) CONTACT TRACING AND RELATED POSI-
13 TIONS.—The term “contact tracing and related posi-
14 tions” means employment related to contact tracing,
15 surveillance, containment, and mitigation activities
16 as described in paragraphs (2), (3), and (4) of sec-
17 tion 223(d).

18 (4) ELIGIBLE ENTITY.—The term “eligible enti-
19 ty” means—

20 (A) a State or territory, including the Dis-
21 trict of Columbia and Puerto Rico;

22 (B) an Indian Tribe, Tribal organization,
23 Alaska Native entity, Indian-controlled organi-
24 zations serving Indians, or Native Hawaiian or-
25 ganizations;

1 (C) an outlying area; or

2 (D) a local board, if an eligible entity
3 under subparagraphs (A) through (C) has not
4 applied with respect to the area over which the
5 local board has jurisdiction as of the date on
6 which the local board submits an application
7 under subsection (c).

8 (5) ELIGIBLE INDIVIDUAL.—Notwithstanding
9 section 170(b)(2) of the Workforce Innovation and
10 Opportunity Act (29 U.S.C. 3225(b)(2)), the term
11 “eligible individual” means an individual seeking or
12 securing employment in contact tracing and related
13 positions and served by an eligible entity or commu-
14 nity-based organization receiving funding under this
15 section.

16 (6) SECRETARY.—The term “Secretary” means
17 the Secretary of Labor.

18 (b) GRANTS.—

19 (1) IN GENERAL.—Subject to the availability of
20 appropriations under subsection (g), the Secretary
21 shall award national dislocated worker grants under
22 section 170(b)(1)(B) of the Workforce Innovation
23 and Opportunity Act (29 U.S.C. 3225(b)(1)(B)) to
24 each eligible entity that seeks a grant to assist local
25 boards and community-based organizations in car-

1 rying out activities under subsections (f) and (d), re-
2 spectively, for the following purposes:

3 (A) To support the recruitment, place-
4 ment, and training, as applicable, of eligible in-
5 dividuals seeking employment in contact tracing
6 and related positions in accordance with the na-
7 tional system for COVID–19 testing, contact
8 tracing, surveillance, containment, and mitiga-
9 tion established under section 222.

10 (B) To assist with the employment transi-
11 tion to new employment or education and train-
12 ing of individuals employed under this section
13 in preparation for and upon termination of such
14 employment.

15 (2) TIMELINE.—The Secretary of Labor shall—

16 (A) issue application requirements under
17 subsection (c) not later than 10 days after the
18 date of enactment of this section; and

19 (B) award grants to an eligible entity
20 under paragraph (1) not later than 10 days
21 after the date on which the Secretary receives
22 an application from such entity.

23 (c) GRANT APPLICATION.—An eligible entity apply-
24 ing for a grant under this section shall submit an applica-
25 tion to the Secretary, at such time and in such form and

1 manner as the Secretary may reasonably require, which
2 shall include a description of—

3 (1) how the eligible entity will support the re-
4 cruitment, placement, and training, as applicable, of
5 eligible individuals seeking employment in contact
6 tracing and related positions by partnering with—

7 (A) a State, local, Tribal, or territorial
8 health department; or

9 (B) one or more nonprofit or community-
10 based organizations partnering with such health
11 departments;

12 (2) how the activities described in paragraph
13 (1) will support State efforts to address the demand
14 for contact tracing and related positions with respect
15 to—

16 (A) the State plans referred to in the head-
17 ing “Public Health and Social Services Emer-
18 gency Fund” in title I of division B of the Pay-
19 check Protection Program and Health Care En-
20 hancement Act (Public Law 116–139);

21 (B) the testing strategy submitted under
22 section 211; and

23 (C) the number of eligible individuals that
24 the State plans to recruit and train under the

1 plans and strategies described in subparagraphs
2 (A) and (B);

3 (3) the specific strategies for recruiting and
4 placement of eligible individuals from or residing
5 within the communities in which they will work, in-
6 cluding—

7 (A) plans for the recruitment of eligible in-
8 dividuals to serve as contact tracers and related
9 positions, including dislocated workers, individ-
10 uals with barriers to employment, veterans, new
11 entrants in the workforce, or underemployed or
12 furloughed workers, who are from or reside in
13 or near the local area in which they will serve,
14 and who, to the extent practicable—

15 (i) have experience or a background in
16 industry-sectors and occupations such as
17 public health, social services, customer
18 service, case management, or occupations
19 that require related qualifications, skills, or
20 competencies, such as strong interpersonal
21 and communication skills, needed for con-
22 tact tracing and related positions, as de-
23 scribed in section 223(d)(2)(E)(ii); or

24 (ii) seek to transition to public health
25 and public health related occupations upon

1 the conclusion of employment in contact
2 tracing and related positions; and

3 (B) how such strategies will take into ac-
4 count the diversity of such community, includ-
5 ing racial, ethnic, socioeconomic, linguistic, or
6 geographic diversity;

7 (4) the amount, timing, and mechanisms for
8 distribution of funds provided to local boards or
9 through subgrants as described in subsection (d);

10 (5) for eligible entities described in subpara-
11 graphs (A) through (C) of subsection (a)(4), a de-
12 scription of how the eligible entity will ensure the eq-
13 uitable distribution of funds with respect to—

14 (A) geography (such as urban and rural
15 distribution);

16 (B) medically underserved populations (as
17 defined in section 33(b)(3) of the Public Health
18 Service Act (42 U.S.C. 254b(b)));

19 (C) health professional shortage areas (as
20 defined under section 332(a) of the Public
21 Health Service Act (42 U.S.C. 254e(a))); and

22 (D) the racial and ethnic diversity of the
23 area; and

24 (6) for eligible entities who are local boards, a
25 description of how a grant to such eligible entity

1 would serve the equitable distribution of funds as de-
2 scribed in paragraph (5).

3 (d) SUBGRANT AUTHORIZATION AND APPLICATION
4 PROCESS.—

5 (1) IN GENERAL.—An eligible entity may award
6 a subgrant to one or more community-based organi-
7 zations for the purposes of partnering with a State
8 or local board to conduct outreach and education ac-
9 tivities to inform potentially eligible individuals
10 about employment opportunities in contact tracing
11 and related positions.

12 (2) APPLICATION.—A community-based organi-
13 zation shall submit an application at such time and
14 in such manner as the eligible entity may reasonably
15 require, including—

16 (A) a demonstration of the community-
17 based organization's established expertise and
18 effectiveness in community outreach in the local
19 area that such organization plans to serve;

20 (B) a demonstration of the community-
21 based organization's expertise in providing em-
22 ployment or public health information to the
23 local areas in which such organization plans to
24 serve; and

1 (C) a description of the expertise of the
2 community-based organization in utilizing cul-
3 turally competent and multilingual strategies in
4 the provision of services.

5 (e) GRANT DISTRIBUTION.—

6 (1) FEDERAL DISTRIBUTION.—

7 (A) USE OF FUNDS.— The Secretary of
8 Labor shall use the funds appropriated to carry
9 out this section as follows:

10 (i) Subject to clause (ii), the Secretary
11 shall distribute funds among eligible enti-
12 ties in accordance with a formula to be es-
13 tablished by the Secretary that provides a
14 minimum level of funding to each eligible
15 entity that seeks a grant under this section
16 and allocates additional funding as follows:

17 (I) The formula shall give first
18 priority based on the number and pro-
19 portion of contact tracing and related
20 positions that the State plans to re-
21 cruit, place, and train individuals as a
22 part of the State strategy described in
23 subsection (c)(2)(A).

1 (II) Subject to subclause (I), the
2 formula shall give priority in accord-
3 ance with section 223(c).

4 (ii) Not more than 2 percent of the
5 funding for administration of the grants
6 and for providing technical assistance to
7 recipients of funds under this section.

8 (B) EQUITABLE DISTRIBUTION.—If the ge-
9 ographic region served by one or more eligible
10 entities overlaps, the Secretary shall distribute
11 funds among such entities in such a manner
12 that ensures equitable distribution with respect
13 to the factors under subsection (c)(5).

14 (2) ELIGIBLE ENTITY USE OF FUNDS.—An eli-
15 gible entity described in subparagraphs (A) through
16 (C) of subsection (a)(4)—

17 (A) shall, not later than 30 days after the
18 date on which the entity receives grant funds
19 under this section, provide not less than 70 per-
20 cent of grant funds to local boards for the pur-
21 pose of carrying out activities in subsection (f);

22 (B) may use up to 20 percent of such
23 funds to make subgrants to community-based
24 organizations in the service area to conduct out-

1 reach, to potential eligible individuals, as de-
2 scribed in subsection (d);

3 (C) in providing funds to local boards and
4 awarding subgrants under this subsection shall
5 ensure the equitable distribution with respect to
6 the factors described in subsection (c)(5); and

7 (D) may use not more than 10 percent of
8 the funds awarded under this section for the
9 administrative costs of carrying out the grant
10 and for providing technical assistance to local
11 boards and community-based organizations.

12 (3) LOCAL BOARD USE OF FUNDS.—A local
13 board, or an eligible entity that is a local board,
14 shall use—

15 (A) not less than 60 percent of the funds
16 for recruitment and training for COVID–19
17 testing, contact tracing, surveillance, contain-
18 ment, and mitigation established under section
19 222;

20 (B) not less than 30 percent of the funds
21 to support the transition of individuals hired as
22 contact tracers and related positions into an
23 education or training program, or unsubsidized
24 employment upon completion of such positions;
25 and

1 (C) not more than 10 percent of the funds
2 for administrative costs.

3 (f) ELIGIBLE ACTIVITIES.—The State or local boards
4 shall use funds awarded under this section to support the
5 recruitment and placement of eligible individuals, training
6 and employment transition as related to contact tracing
7 and related positions, and for the following activities:

8 (1) Establishing or expanding partnerships
9 with—

10 (A) State, local, Tribal, and territorial
11 public health departments;

12 (B) community-based health providers, in-
13 cluding community health centers and rural
14 health clinics;

15 (C) labor organizations or joint labor man-
16 agement organizations;

17 (D) two-year and four-year institutions of
18 higher education (as defined in section 101 of
19 the Higher Education Act of 1965 (20 U.S.C.
20 1001)), including institutions eligible to receive
21 funds under section 371(a) of the Higher Edu-
22 cation Act of 1965 (20 U.S.C. 1067q(a)); and

23 (E) community action agencies or other
24 community-based organizations serving local

1 areas in which there is a demand for contact
2 tracing and related positions.

3 (2) Providing training for contact tracing and
4 related positions in coordination with State, local,
5 Tribal, or territorial health departments that is con-
6 sistent with the State or territorial testing and con-
7 tact tracing strategy, and ensuring that eligible indi-
8 viduals receive compensation while participating in
9 such training.

10 (3) Providing eligible individuals with—

11 (A) adequate and safe equipment, environ-
12 ments, and facilities for training and super-
13 vision, as applicable;

14 (B) information regarding the wages and
15 benefits related to contact tracing and related
16 positions, as compared to State, local, and na-
17 tional averages;

18 (C) supplies and equipment needed by the
19 eligible individuals to support placement of an
20 individual in contact tracing and related posi-
21 tions, as applicable;

22 (D) an individualized employment plan for
23 each eligible individual, as applicable—

1 (i) in coordination with the entity em-
2 ploying the eligible individual in a contact
3 tracing and related positions; and

4 (ii) which shall include providing a
5 case manager to work with each eligible in-
6 dividual to develop the plan, which may in-
7 clude—

8 (I) identifying employment and
9 career goals, and setting appropriate
10 achievement objectives to attain such
11 goals; and

12 (II) exploring career pathways
13 that lead to in-demand industries and
14 sectors, including in public health and
15 related occupations; and

16 (E) services for the period during which
17 the eligible individual is employed in a contact
18 tracing and related position to ensure job reten-
19 tion, which may include—

20 (i) supportive services throughout the
21 term of employment;

22 (ii) a continuation of skills training as
23 related to employment in contact tracing
24 and related positions, that is conducted in

1 collaboration with the employers of such
2 individuals;

3 (iii) mentorship services and job re-
4 tention support for eligible individuals; or

5 (iv) targeted training for managers
6 and workers working with eligible individ-
7 uals (such as mentors), and human re-
8 source representatives.

9 (4) Supporting the transition and placement in
10 unsubsidized employment for eligible individuals
11 serving in contact tracing and related positions after
12 such positions are no longer necessary in the State
13 or local area, including—

14 (A) any additional training and employ-
15 ment activities as described in section 170(d)(4)
16 of the Workforce Innovation and Opportunity
17 Act (29 U.S.C. 3225(d)(4));

18 (B) developing the appropriate combina-
19 tion of services to enable the eligible individual
20 to achieve the employment and career goals
21 identified under paragraph (3)(D)(ii)(I); and

22 (C) services to assist eligible individuals in
23 maintaining employment for not less than 12
24 months after the completion of employment in

1 contact tracing and related positions, as appro-
2 priate.

3 (5) Any other activities as described in sub-
4 sections (a)(3) and (b) of section 134 of the Work-
5 force Innovation and Opportunity Act (29 U.S.C.
6 3174).

7 (g) LIMITATION.—Notwithstanding section
8 170(d)(3)(A) of the Workforce Innovation and Oppor-
9 tunity Act (29 U.S.C. 3225(d)(3)(A)), a person may be
10 employed in a contact tracing and related positions using
11 funds under this section for a period not greater than 2
12 years.

13 (h) REPORTING BY THE DEPARTMENT OF LABOR.—

14 (1) IN GENERAL.—Not later than 120 days of
15 the enactment of this Act, and once grant funds
16 have been expended under this section, the Secretary
17 shall report to the Committee on Education and
18 Labor of the House of Representatives and the Com-
19 mittee on Health, Education, Labor, and Pensions
20 of the Senate, and make publicly available a report
21 containing a description of—

22 (A) the number of eligible individuals re-
23 cruited, hired, and trained in contact tracing
24 and related positions;

1 (B) the number of individuals successfully
2 transitioned to unsubsidized employment or
3 training at the completion of employment in
4 contact tracing and related positions using
5 funds under this subtitle;

6 (C) the number of such individuals who
7 were unemployed prior to being hired, trained,
8 or deployed as described in paragraph (1);

9 (D) the performance of each program sup-
10 ported by funds under this subtitle with respect
11 to the indicators of performance under section
12 116 of the Workforce Innovation and Oppor-
13 tunity Act (29 U.S.C. 3141), as applicable;

14 (E) the number of individuals in unsub-
15 sidized employment within six months and 1
16 year, respectively, of the conclusion of employ-
17 ment in contact tracing and related positions
18 and, of those, the number of individuals within
19 a State, territorial, or local public health de-
20 partment in an occupation related to public
21 health;

22 (F) any information on how eligible enti-
23 ties, local boards, or community-based organiza-
24 tions that received funding under this sub-
25 section were able to support the goals of the na-

1 tional system for COVID–19 testing, contact
2 tracing, surveillance, containment, and mitiga-
3 tion established under section 222 of this Act;
4 and

5 (G) best practices for improving and in-
6 creasing the transition of individuals employed
7 in contract tracing and related positions to un-
8 subsidized employment.

9 (2) DISAGGREGATION.—All data reported under
10 paragraph (1) shall be disaggregated by race, eth-
11 nicity, sex, age, and, with respect to individuals with
12 barriers to employment, subpopulation of such indi-
13 viduals, except for when the number of participants
14 in a category is insufficient to yield statistically reli-
15 able information or when the results would reveal
16 personally identifiable information about an indi-
17 vidual participant.

18 (i) SPECIAL RULE.—Any funds used for programs
19 under this section that are used to fund an apprenticeship
20 or apprenticeship program shall only be used for, or pro-
21 vided to, an apprenticeship or apprenticeship program
22 that meets the definition of such term subsection (a) of
23 this section, including any funds awarded for the purposes
24 of grants, contracts, or cooperative agreements, or the de-

1 velopment, implementation, or administration, of an ap-
2 prenticeship or an apprenticeship program.

3 (j) INFORMATION SHARING REQUIREMENT FOR
4 HHS.—The Secretary of Health and Human Services,
5 acting through the Director of the Centers for Disease
6 Control and Prevention, shall provide the Secretary of
7 Labor, acting through the Assistant Secretary of the Em-
8 ployment and Training Administration, with information
9 on grants under section 223, including—

10 (1) the formula used to award such grants to
11 State, local, Tribal, and territorial health depart-
12 ments;

13 (2) the dollar amounts of and scope of the work
14 funded under such grants;

15 (3) the geographic areas served by eligible enti-
16 ties that receive such grants; and

17 (4) the number of contact tracers and related
18 positions to be hired using such grants.

19 (k) AUTHORIZATION OF APPROPRIATIONS.—Of the
20 amounts appropriated to carry out this subtitle,
21 \$500,000,000 shall be used by the Secretary of Labor to
22 carry out subsections (a) through (h) of this section.

**TITLE III—FREE TREATMENT
FOR ALL AMERICANS**

**SEC. 301. COVERAGE AT NO COST SHARING OF COVID-19
VACCINE AND TREATMENT.**

(a) MEDICAID.—

(1) IN GENERAL.—Section 1905(a)(4) of the Social Security Act (42 U.S.C. 1396d(a)(4)) is amended—

(A) by striking “and (D)” and inserting “(D)”; and

(B) by striking the semicolon at the end and inserting “; (E) during the portion of the emergency period described in paragraph (1)(B) of section 1135(g) beginning on the date of the enactment of The Heroes Act, a COVID-19 vaccine licensed under section 351 of the Public Health Service Act, or approved or authorized under sections 505 or 564 of the Federal Food, Drug, and Cosmetic Act, and administration of the vaccine; and (F) during such portion of the emergency period described in paragraph (1)(B) of section 1135(g), items or services for the prevention or treatment of COVID-19, including drugs approved or authorized under such section 505 or such section 564 or, without re-

1 gard to the requirements of section
2 1902(a)(10)(B) (relating to comparability), in
3 the case of an individual who is diagnosed with
4 or presumed to have COVID–19, during such
5 portion of such emergency period during which
6 such individual is infected (or presumed in-
7 fected) with COVID–19, the treatment of a
8 condition that may complicate the treatment of
9 COVID–19;”.

10 (2) PROHIBITION OF COST SHARING.—

11 (A) IN GENERAL.—Subsections (a)(2) and
12 (b)(2) of section 1916 of the Social Security
13 Act (42 U.S.C. 1396o) are each amended—

14 (i) in subparagraph (F), by striking
15 “or” at the end;

16 (ii) in subparagraph (G), by striking
17 “; and” and inserting “;”; and

18 (iii) by adding at the end the fol-
19 lowing subparagraphs:

20 “(H) during the portion of the emergency
21 period described in paragraph (1)(B) of section
22 1135(g) beginning on the date of the enactment
23 of this subparagraph, a COVID–19 vaccine li-
24 censed under section 351 of the Public Health
25 Service Act, or approved or authorized under

1 section 505 or 564 of the Federal Food, Drug,
2 and Cosmetic Act, and the administration of
3 such vaccine; or

4 “(I) during such portion of the emergency
5 period described in paragraph (1)(B) of section
6 1135(g), any item or service furnished for the
7 treatment of COVID–19, including drugs ap-
8 proved or authorized under such section 505 or
9 such section 564 or, in the case of an individual
10 who is diagnosed with or presumed to have
11 COVID–19, during the portion of such emer-
12 gency period during which such individual is in-
13 fected (or presumed infected) with COVID–19,
14 the treatment of a condition that may com-
15 plicate the treatment of COVID–19; and”.

16 (B) APPLICATION TO ALTERNATIVE COST
17 SHARING.—Section 1916A(b)(3)(B) of the So-
18 cial Security Act (42 U.S.C. 1396o–1(b)(3)(B))
19 is amended—

20 (i) in clause (xi), by striking “any
21 visit” and inserting “any service”; and

22 (ii) by adding at the end the following
23 clauses:

24 “(xii) During the portion of the emer-
25 gency period described in paragraph (1)(B)

1 of section 1135(g) beginning on the date of
2 the enactment of this clause, a COVID–19
3 vaccine licensed under section 351 of the
4 Public Health Service Act, or approved or
5 authorized under section 505 or 564 of the
6 Federal Food, Drug, and Cosmetic Act,
7 and the administration of such vaccine.

8 “(xiii) During such portion of the
9 emergency period described in paragraph
10 (1)(B) of section 1135(g), an item or serv-
11 ice furnished for the treatment of COVID–
12 19, including drugs approved or authorized
13 under such section 505 or such section 564
14 or, in the case of an individual who is diag-
15 nosed with or presumed to have COVID–
16 19, during such portion of such emergency
17 period during which such individual is in-
18 fected (or presumed infected) with
19 COVID–19, the treatment of a condition
20 that may complicate the treatment of
21 COVID–19.”.

22 (C) CLARIFICATION.—The amendments
23 made by this subsection shall apply with respect
24 to a State plan of a territory in the same man-
25 ner as a State plan of one of the 50 States.

1 (b) STATE PEDIATRIC VACCINE DISTRIBUTION PRO-
2 GRAM.—Section 1928 of the Social Security Act (42
3 U.S.C. 1396s) is amended—

4 (1) in subsection (a)(1)—

5 (A) in subparagraph (A), by striking “;
6 and” and inserting a semicolon;

7 (B) in subparagraph (B), by striking the
8 period and inserting “; and”; and

9 (C) by adding at the end the following sub-
10 paragraph:

11 “(C) during the portion of the emergency
12 period described in paragraph (1)(B) of section
13 1135(g) beginning on the date of the enactment
14 of this subparagraph, each vaccine-eligible child
15 (as defined in subsection (b)) is entitled to re-
16 ceive a COVID–19 vaccine from a program-reg-
17 istered provider (as defined in subsection
18 (h)(7)) without charge for—

19 “(i) the cost of such vaccine; or

20 “(ii) the administration of such vac-
21 cine.”;

22 (2) in subsection (c)(2)—

23 (A) in subparagraph (C)(ii), by inserting “,
24 but, during the portion of the emergency period
25 described in paragraph (1)(B) of section

1 1135(g) beginning on the date of the enactment
2 of The Heroes Act, may not impose a fee for
3 the administration of a COVID–19 vaccine” be-
4 fore the period; and

5 (B) by adding at the end the following sub-
6 paragraph:

7 “(D) The provider will provide and admin-
8 ister an approved COVID–19 vaccine to a vac-
9 cine-eligible child in accordance with the same
10 requirements as apply under the preceding sub-
11 paragraphs to the provision and administration
12 of a qualified pediatric vaccine to such a
13 child.”; and

14 (3) in subsection (d)(1), in the first sentence,
15 by inserting “, including, during the portion of the
16 emergency period described in paragraph (1)(B) of
17 section 1135(g) beginning on the date of the enact-
18 ment of The Heroes Act, with respect to a COVID–
19 19 vaccine licensed under section 351 of the Public
20 Health Service Act, or approved or authorized under
21 section 505 or 564 of the Federal Food, Drug, and
22 Cosmetic Act” before the period.

23 (c) CHIP.—

1 (1) IN GENERAL.—Section 2103(c) of the So-
2 cial Security Act (42 U.S.C. 1397cc(e)) is amended
3 by adding at the end the following paragraph:

4 “(11) COVERAGE OF COVID–19 VACCINES AND
5 TREATMENT.—Regardless of the type of coverage
6 elected by a State under subsection (a), child health
7 assistance provided under such coverage for targeted
8 low-income children and, in the case that the State
9 elects to provide pregnancy-related assistance under
10 such coverage pursuant to section 2112, such preg-
11 nancy-related assistance for targeted low-income
12 pregnant women (as defined in section 2112(d))
13 shall include coverage, during the portion of the
14 emergency period described in paragraph (1)(B) of
15 section 1135(g) beginning on the date of the enact-
16 ment of this paragraph, of—

17 “(A) a COVID–19 vaccine licensed under
18 section 351 of the Public Health Service Act, or
19 approved or authorized under section 505 or
20 564 of the Federal Food, Drug, and Cosmetic
21 Act, and the administration of such vaccine;
22 and

23 “(B) any item or service furnished for the
24 treatment of COVID–19, including drugs ap-
25 proved or authorized under such section 505 or

1 such section 564, or, in the case of an indi-
2 vidual who is diagnosed with or presumed to
3 have COVID–19, during the portion of such
4 emergency period during which such individual
5 is infected (or presumed infected) with COVID–
6 19, the treatment of a condition that may com-
7 plicate the treatment of COVID–19.”.

8 (2) PROHIBITION OF COST SHARING.—Section
9 2103(e)(2) of the Social Security Act (42 U.S.C.
10 1397cc(e)(2)), as amended by section 6004(b)(3) of
11 the Families First Coronavirus Response Act, is
12 amended—

13 (A) in the paragraph header, by inserting
14 “A COVID–19 VACCINE, COVID–19 TREATMENT,”
15 before “OR PREGNANCY-RELATED ASSISTANCE”;
16 and

17 (B) by striking “visits described in section
18 1916(a)(2)(G), or” and inserting “services de-
19 scribed in section 1916(a)(2)(G), vaccines de-
20 scribed in section 1916(a)(2)(H) administered
21 during the portion of the emergency period de-
22 scribed in paragraph (1)(B) of section 1135(g)
23 beginning on the date of the enactment of The
24 Heroes Act, items or services described in sec-

1 tion 1916(a)(2)(I) furnished during such emer-
2 gency period, or”.

3 (d) CONFORMING AMENDMENTS.—Section 1937 of
4 the Social Security Act (42 U.S.C. 1396u–7) is amend-
5 ed—

6 (1) in subsection (a)(1)(B), by inserting “,
7 under subclause (XXIII) of section
8 1902(a)(10)(A)(ii),” after “section
9 1902(a)(10)(A)(i)”;

10 (2) in subsection (b)(5), by adding before the
11 period the following: “, and, effective on the date of
12 the enactment of The Heroes Act, must comply with
13 subparagraphs (F) through (I) of subsections (a)(2)
14 and (b)(2) of section 1916 and subsection (b)(3)(B)
15 of section 1916A”.

16 (e) EFFECTIVE DATE.—The amendments made by
17 this section shall take effect on the date of enactment of
18 this Act and shall apply with respect to a COVID–19 vac-
19 cine beginning on the date that such vaccine is licensed
20 under section 351 of the Public Health Service Act (42
21 U.S.C. 262), or approved or authorized under section 505
22 or 564 of the Federal Food, Drug, and Cosmetic Act.

1 **SEC. 302. OPTIONAL COVERAGE AT NO COST SHARING OF**
2 **COVID-19 TREATMENT AND VACCINES UNDER**
3 **MEDICAID FOR UNINSURED INDIVIDUALS.**

4 (a) IN GENERAL.—Section 1902(a)(10) of the Social
5 Security Act (42 U.S.C. 1396a(a)(10)) is amended, in the
6 matter following subparagraph (G), by striking “and any
7 visit described in section 1916(a)(2)(G)” and inserting the
8 following: “, any COVID-19 vaccine that is administered
9 during any such portion (and the administration of such
10 vaccine), any item or service that is furnished during any
11 such portion for the treatment of COVID-19, including
12 drugs approved or authorized under section 505 or 564
13 of the Federal Food, Drug, and Cosmetic Act, or, in the
14 case of an individual who is diagnosed with or presumed
15 to have COVID-19, during the period such individual is
16 infected (or presumed infected) with COVID-19, the
17 treatment of a condition that may complicate the treat-
18 ment of COVID-19, and any services described in section
19 1916(a)(2)(G)”.

20 (b) DEFINITION OF UNINSURED INDIVIDUAL.—

21 (1) IN GENERAL.—Subsection (ss) of section
22 1902 of the Social Security Act (42 U.S.C. 1396a)
23 is amended to read as follows:

24 “(ss) UNINSURED INDIVIDUAL DEFINED.—For pur-
25 poses of this section, the term ‘uninsured individual’
26 means, notwithstanding any other provision of this title,

1 any individual who is not covered by minimum essential
2 coverage (as defined in section 5000A(f)(1) of the Internal
3 Revenue Code of 1986).”.

4 (2) EFFECTIVE DATE.—The amendment made
5 by paragraph (1) shall take effect and apply as if in-
6 cluded in the enactment of the Families First
7 Coronavirus Response Act (Public Law 116–127).

8 (c) CLARIFICATION REGARDING EMERGENCY SERV-
9 ICES FOR CERTAIN INDIVIDUALS.—Section 1903(v)(2) of
10 the Social Security Act (42 U.S.C. 1396b(v)(2)) is amend-
11 ed by adding at the end the following flush sentence:

12 “For purposes of subparagraph (A), care and serv-
13 ices described in such subparagraph include any in
14 vitro diagnostic product described in section
15 1905(a)(3)(B) (and the administration of such prod-
16 uct), any COVID–19 vaccine (and the administra-
17 tion of such vaccine), any item or service that is fur-
18 nished for the treatment of COVID–19, including
19 drugs approved or authorized under section 505 or
20 564 of the Federal Food, Drug, and Cosmetic Act,
21 or a condition that may complicate the treatment of
22 COVID–19, and any services described in section
23 1916(a)(2)(G).”.

24 (d) INCLUSION OF COVID–19 CONCERN AS AN
25 EMERGENCY CONDITION.—Section 1903(v)(3) of the So-

1 cial Security Act (42 U.S.C. 1396b(v)(3)) is amended by
 2 adding at the end the following flush sentence:

3 “Such term includes any indication that an alien de-
 4 scribed in paragraph (1) may have contracted
 5 COVID–19.”.

6 **SEC. 303. COVERAGE OF TREATMENTS FOR COVID–19 AT NO**
 7 **COST SHARING UNDER THE MEDICARE AD-**
 8 **VANTAGE PROGRAM.**

9 (a) IN GENERAL.—Section 1852(a)(1)(B) of the So-
 10 cial Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is
 11 amended by adding at the end the following new clause:

12 “(vii) SPECIAL COVERAGE RULES FOR
 13 SPECIFIED COVID–19 TREATMENT SERV-
 14 ICES.—Notwithstanding clause (i), in the
 15 case of a specified COVID–19 treatment
 16 service (as defined in section 30201(b) of
 17 The Heroes Act) that is furnished during
 18 a plan year occurring during any portion
 19 of the emergency period defined in section
 20 1135(g)(1)(B) beginning on or after the
 21 date of the enactment of this clause, a
 22 Medicare Advantage plan may not, with re-
 23 spect to such service, impose—

24 “(I) any cost-sharing require-
 25 ment (including a deductible, copay-

ment, or coinsurance requirement);
and

“(II) in the case such service is a
critical specified COVID–19 treat-
ment service (including ventilator
services and intensive care unit serv-
ices), any prior authorization or other
utilization management requirement.

A Medicare Advantage plan may not take
the application of this clause into account
for purposes of a bid amount submitted by
such plan under section 1854(a)(6).”.

(b) IMPLEMENTATION.—Notwithstanding any other
provision of law, the Secretary of Health and Human
Services may implement the amendments made by this
section by program instruction or otherwise.

**SEC. 304. REQUIRING COVERAGE UNDER MEDICARE PDPS
AND MA-PD PLANS, WITHOUT THE IMPOSI-
TION OF COST SHARING OR UTILIZATION
MANAGEMENT REQUIREMENTS, OF DRUGS
INTENDED TO TREAT COVID–19 DURING CER-
TAIN EMERGENCIES.**

(a) COVERAGE REQUIREMENT.—Section 1860D–
4(b)(3) of the Social Security Act (42 U.S.C. 1395w–

1 104(b)(3)) is amended by adding at the end the following
2 new subparagraph:

3 “(I) REQUIRED INCLUSION OF DRUGS IN-
4 TENDED TO TREAT COVID–19.—

5 “(i) IN GENERAL.—Notwithstanding
6 any other provision of law, a PDP sponsor
7 offering a prescription drug plan shall,
8 with respect to a plan year, any portion of
9 which occurs during the period described
10 in clause (ii), be required to—

11 “(I) include in any formulary—

12 “(aa) all covered part D
13 drugs with a medically accepted
14 indication (as defined in section
15 1860D–2(e)(4)) to treat COVID–
16 19 that are marketed in the
17 United States; and

18 “(bb) all drugs authorized
19 under section 564 or 564A of the
20 Federal Food, Drug, and Cos-
21 metic Act to treat COVID–19;
22 and

23 “(II) not impose any prior au-
24 thorization or other utilization man-
25 agement requirement with respect to

1 such drugs described in item (aa) or
2 (bb) of subclause (I) (other than such
3 a requirement that limits the quantity
4 of drugs due to safety).

5 “(ii) PERIOD DESCRIBED.—For pur-
6 poses of clause (i), the period described in
7 this clause is the period during which there
8 exists the public health emergency declared
9 by the Secretary pursuant to section 319
10 of the Public Health Service Act on Janu-
11 ary 31, 2020, entitled ‘Determination that
12 a Public Health Emergency Exists Nation-
13 wide as the Result of the 2019 Novel
14 Coronavirus’ (including any renewal of
15 such declaration pursuant to such sec-
16 tion).”.

17 (b) ELIMINATION OF COST SHARING.—

18 (1) ELIMINATION OF COST SHARING FOR
19 DRUGS INTENDED TO TREAT COVID–19 UNDER
20 STANDARD AND ALTERNATIVE PRESCRIPTION DRUG
21 COVERAGE.—Section 1860D–2 of the Social Security
22 Act (42 U.S.C. 1395w–102) is amended—

23 (A) in subsection (b)—

1 (i) in paragraph (1)(A), by striking
 2 “The coverage” and inserting “Subject to
 3 paragraph (8), the coverage”;

4 (ii) in paragraph (2)—

5 (I) in subparagraph (A), by in-
 6 serting after “Subject to subpara-
 7 graphs (C) and (D)” the following:
 8 “and paragraph (8)”;

9 (II) in subparagraph (C)(i), by
 10 striking “paragraph (4)” and insert-
 11 ing “paragraphs (4) and (8)”;

12 (III) in subparagraph (D)(i), by
 13 striking “paragraph (4)” and insert-
 14 ing “paragraphs (4) and (8)”;

15 (iii) in paragraph (4)(A)(i), by strik-
 16 ing “The coverage” and inserting “Subject
 17 to paragraph (8), the coverage”;

18 (iv) by adding at the end the following
 19 new paragraph:

20 “(8) ELIMINATION OF COST SHARING FOR
 21 DRUGS INTENDED TO TREAT COVID-19.—The cov-
 22 erage does not impose any deductible, copayment,
 23 coinsurance, or other cost-sharing requirement for
 24 drugs described in section 1860D-4(b)(3)(I)(i)(I)
 25 with respect to a plan year, any portion of which oc-

1 curs during the period during which there exists the
2 public health emergency declared by the Secretary
3 pursuant to section 319 of the Public Health Service
4 Act on January 31, 2020, entitled ‘Determination
5 that a Public Health Emergency Exists Nationwide
6 as the Result of the 2019 Novel Coronavirus’ (in-
7 cluding any renewal of such declaration pursuant to
8 such section).’; and

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

11 “(4) SAME ELIMINATION OF COST SHARING FOR
12 DRUGS INTENDED TO TREAT COVID–19.—The cov-
13 erage is in accordance with subsection (b)(8).”.

14 (2) ELIMINATION OF COST SHARING FOR
15 DRUGS INTENDED TO TREAT COVID–19 DISPENSED
16 TO INDIVIDUALS WHO ARE SUBSIDY ELIGIBLE INDIV-
17 VIDUALS.—Section 1860D–14(a) of the Social Secu-
18 rity Act (42 U.S.C. 1395w–114(a)) is amended—

19 (A) in paragraph (1)—

20 (i) in subparagraph (D)—

21 (I) in clause (ii), by striking “In
22 the case of” and inserting “Subject to
23 subparagraph (F), in the case of”;
24 and

1 (II) in clause (iii), by striking
2 “In the case of” and inserting “Sub-
3 ject to subparagraph (F), in the case
4 of”; and

5 (ii) by adding at the end the following
6 new subparagraph:

7 “(F) ELIMINATION OF COST SHARING FOR
8 DRUGS INTENDED TO TREAT COVID-19.—Cov-
9 erage that is in accordance with section
10 1860D-2(b)(8).”; and

11 (B) in paragraph (2)—

12 (i) in subparagraph (B), by striking
13 “A reduction” and inserting “Subject to
14 subparagraph (F), a reduction”;

15 (ii) in subparagraph (D), by striking
16 “The substitution” and inserting “Subject
17 to subparagraph (F), the substitution”;

18 (iii) in subparagraph (E), by inserting
19 after “Subject to” the following: “subpara-
20 graph (F) and”; and

21 (iv) by adding at the end the following
22 new subparagraph:

23 “(F) ELIMINATION OF COST SHARING FOR
24 DRUGS INTENDED TO TREAT COVID-19.—Cov-

1 erage that is in accordance with section
2 1860D–2(b)(8).”.

3 (c) IMPLEMENTATION.—Notwithstanding any other
4 provision of law, the Secretary of Health and Human
5 Services may implement the amendments made by this
6 section by program instruction or otherwise.

7 **SEC. 305. COVERAGE OF COVID-19 RELATED TREATMENT**
8 **AT NO COST SHARING.**

9 (a) IN GENERAL.—A group health plan and a health
10 insurance issuer offering group or individual health insur-
11 ance coverage (including a grandfathered health plan (as
12 defined in section 1251(e) of the Patient Protection and
13 Affordable Care Act)) shall provide coverage, and shall not
14 impose any cost sharing (including deductibles, copay-
15 ments, and coinsurance) requirements, for the following
16 items and services furnished during any portion of the
17 emergency period defined in paragraph (1)(B) of section
18 1135(g) of the Social Security Act (42 U.S.C. 1320b–
19 5(g)) beginning on or after the date of the enactment of
20 this Act:

21 (1) Medically necessary items and services (in-
22 cluding in-person or telehealth visits in which such
23 items and services are furnished) that are furnished
24 to an individual who has been diagnosed with (or
25 after provision of the items and services is diagnosed

1 with) COVID–19 to treat or mitigate the effects of
2 COVID–19.

3 (2) Medically necessary items and services (in-
4 cluding in-person or telehealth visits in which such
5 items and services are furnished) that are furnished
6 to an individual who is presumed to have COVID–
7 19 but is never diagnosed as such, if the following
8 conditions are met:

9 (A) Such items and services are furnished
10 to the individual to treat or mitigate the effects
11 of COVID–19 or to mitigate the impact of
12 COVID–19 on society.

13 (B) Health care providers have taken ap-
14 propriate steps under the circumstances to
15 make a diagnosis, or confirm whether a diag-
16 nosis was made, with respect to such individual,
17 for COVID–19, if possible.

18 (b) ITEMS AND SERVICES RELATED TO COVID–
19 19.—For purposes of this section—

20 (1) not later than one week after the date of
21 the enactment of this section, the Secretary of
22 Health and Human Services, Secretary of Labor,
23 and Secretary of the Treasury shall jointly issue
24 guidance specifying applicable diagnoses and medi-

1 cally necessary items and services related to
2 COVID–19; and

3 (2) such items and services shall include all
4 items or services that are relevant to the treatment
5 or mitigation of COVID–19, regardless of whether
6 such items or services are ordinarily covered under
7 the terms of a group health plan or group or indi-
8 vidual health insurance coverage offered by a health
9 insurance issuer.

10 (c) ENFORCEMENT.—

11 (1) APPLICATION WITH RESPECT TO PHSA,
12 ERISA, AND IRC.—The provisions of this section
13 shall be applied by the Secretary of Health and
14 Human Services, Secretary of Labor, and Secretary
15 of the Treasury to group health plans and health in-
16 surance issuers offering group or individual health
17 insurance coverage as if included in the provisions of
18 part A of title XXVII of the Public Health Service
19 Act, part 7 of the Employee Retirement Income Se-
20 curity Act of 1974, and subchapter B of chapter 100
21 of the Internal Revenue Code of 1986, as applicable.

22 (2) PRIVATE RIGHT OF ACTION.—An individual
23 with respect to whom an action is taken by a group
24 health plan or health insurance issuer offering group
25 or individual health insurance coverage in violation

1 of subsection (a) may commence a civil action
2 against the plan or issuer for appropriate relief. The
3 previous sentence shall not be construed as limiting
4 any enforcement mechanism otherwise applicable
5 pursuant to paragraph (1).

6 (d) IMPLEMENTATION.—The Secretary of Health and
7 Human Services, Secretary of Labor, and Secretary of the
8 Treasury may implement the provisions of this section
9 through sub-regulatory guidance, program instruction or
10 otherwise.

11 (e) TERMS.—The terms “group health plan”, “health
12 insurance issuer”, “group health insurance coverage”, and
13 “individual health insurance coverage” have the meanings
14 given such terms in section 2791 of the Public Health
15 Service Act (42 U.S.C. 300gg–91), section 733 of the Em-
16 ployee Retirement Income Security Act of 1974 (29
17 U.S.C. 1191b), and section 9832 of the Internal Revenue
18 Code of 1986, as applicable.

19 **SEC. 306. REIMBURSEMENT FOR ADDITIONAL HEALTH**
20 **SERVICES RELATING TO CORONAVIRUS.**

21 Title V of division A of the Families First
22 Coronavirus Response Act (Public Law 116–127) is
23 amended under the heading “Department of Health and
24 Human Services—Office of the Secretary—Public Health
25 and Social Services Emergency Fund” by inserting “, or

1 treatment related to SARS-CoV-2 or COVID-19 for un-
2 insured individuals” after “or visits described in para-
3 graph (2) of such section for uninsured individuals”.

4 **TITLE IV—FEDERAL HEALTH** 5 **EQUITY OVERSIGHT**

6 **SEC. 401. COVID-19 RACIAL AND ETHNIC DISPARITIES TASK** 7 **FORCE ACT OF 2020.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services (referred to in this section as the “Sec-
10 retary”) shall establish an interagency task force, to be
11 known as the “COVID-19 Racial and Ethnic Disparities
12 Task Force” (referred to in this section as the “task
13 force”), to gather data about disproportionately affected
14 communities and provide recommendations to combat the
15 racial and ethnic disparities in the COVID-19 response
16 throughout the United States and in response to future
17 public health crises.

18 (b) MEMBERSHIP.—The task force shall be composed
19 of the following:

20 (1) The Secretary of Health and Human Serv-
21 ices.

22 (2) The Assistant Secretary for Planning and
23 Evaluation of the Department of Health and Human
24 Services.

1 (3) The Assistant Secretary for Preparedness
2 and Response of the Department of Health and
3 Human Services.

4 (4) The Director of the Centers for Disease
5 Control and Prevention.

6 (5) The Director of the National Institutes of
7 Health.

8 (6) The Commissioner of Food and Drugs.

9 (7) The Administrator of the Federal Emer-
10 gency Management Agency.

11 (8) The Director of the National Institute on
12 Minority Health and Health Disparities.

13 (9) The Director of the Indian Health Service.

14 (10) The Administrator of the Centers for
15 Medicare & Medicaid Services.

16 (11) The Director of the Agency for Healthcare
17 Research and Quality.

18 (12) The Surgeon General.

19 (13) The Administrator of the Health Re-
20 sources and Services Administration.

21 (14) The Director of the Office of Minority
22 Health.

23 (15) The Secretary of Housing and Urban De-
24 velopment.

25 (16) The Secretary of Education.

1 (17) The Secretary of Labor.

2 (18) The Secretary of Defense.

3 (19) The Secretary of Transportation.

4 (20) The Secretary of the Treasury.

5 (21) The Administrator of the Small Business
6 Administration.

7 (22) The Administrator of the Environmental
8 Protection Agency.

9 (23) Five health care professionals with exper-
10 tise in addressing racial and ethnic disparities, with
11 at least one representative from a rural area, to be
12 appointed by the Secretary.

13 (24) Five policy experts specializing in address-
14 ing racial and ethnic disparities in education or ra-
15 cial and ethnic economic inequality to be appointed
16 by the Secretary.

17 (25) Six representatives from community-based
18 organizations specializing in providing culturally
19 competent care or services and addressing racial and
20 ethnic disparities, to be appointed by the Secretary,
21 with at least one representative from an urban In-
22 dian organization and one representative from a na-
23 tional organization that represents Tribal govern-
24 ments with expertise in Tribal public health.

1 (26) Six State, local, territorial, or Tribal public
2 health officials representing departments of public
3 health, who shall represent jurisdictions from dif-
4 ferent regions of the United States with relatively
5 high concentrations of historically marginalized pop-
6 ulations, to be appointed by the Secretary, with at
7 least one territorial representative and one rep-
8 resentative of a Tribal public health department.

9 (c) ADMINISTRATIVE PROVISIONS.—

10 (1) APPOINTMENT OF NON-GOVERNMENT MEM-
11 BERS.—Notwithstanding any other provision of law,
12 the Secretary shall appoint all non-government mem-
13 bers of the task force within 30 days of the date en-
14 actment of this section.

15 (2) CHAIRPERSON.—The Secretary shall serve
16 as the chairperson of the task force. The Director of
17 the Office of Minority Health shall serve as the vice
18 chairperson.

19 (3) STAFF.—The task force shall have 10 full-
20 time staff members.

21 (4) MEETINGS.—Not later than 45 days after
22 the date of enactment of this section, the full task
23 force shall have its first meeting. The task force
24 shall convene at least once a month thereafter.

1 (5) SUBCOMMITTEES.—The chairperson and
2 vice chairperson of the task force are authorized to
3 establish subcommittees to consider specific issues
4 related to the broader mission of addressing racial
5 and ethnic disparities.

6 (d) FEDERAL EMERGENCY MANAGEMENT AGENCY
7 RESOURCE ALLOCATION REPORTING AND RECOMMENDA-
8 TIONS.—

9 (1) WEEKLY REPORTS.—Not later than 7 days
10 after the task force first meets, and weekly there-
11 after, the task force shall submit to Congress and
12 the Federal Emergency Management Agency a re-
13 port that includes—

14 (A) a description of COVID–19 patient
15 outcomes, including cases, hospitalizations, pa-
16 tients on ventilation, and mortality,
17 disaggregated by race and ethnicity (where such
18 data is missing, the task force shall utilize ap-
19 propriate authorities to improve data collec-
20 tion);

21 (B) the identification of communities that
22 lack resources to combat the COVID–19 pan-
23 demic, including personal protective equipment,
24 ventilators, hospital beds, testing kits, testing
25 supplies, vaccinations (when available), re-

1 sources to conduct surveillance and contact
2 tracing, funding, staffing, and other resources
3 the task force deems essential as needs arise;

4 (C) the identification of communities where
5 racial and ethnic disparities in COVID–19 in-
6 fection, hospitalization, and death rates are out
7 of proportion to the community’s population by
8 a certain threshold, to be determined by the
9 task force based on available public health data;

10 (D) recommendations about how to best al-
11 locate critical COVID–19 resources to—

12 (i) communities with disproportion-
13 ately high COVID–19 infection, hos-
14 pitalization, and death rates; and

15 (ii) communities identified in subpara-
16 graph (C);

17 (E) with respect to communities that are
18 able to reduce racial and ethnic disparities ef-
19 fectively, a description of best practices in-
20 volved; and

21 (F) an update with respect to the response
22 of the Federal Emergency Management Agency
23 to the task force’s previous weeks’ recommenda-
24 tions under this section.

1 (2) GENERAL CONSULTATION.—In submitting
2 weekly reports and recommendations under this sub-
3 section, the task force shall consult with and notify
4 State, local, territorial, and Tribal officials and com-
5 munity-based organizations from communities iden-
6 tified as disproportionately impacted by COVID–19.

7 (3) CONSULTATION WITH INDIAN TRIBES.—In
8 submitting weekly reports and recommendations
9 under this subsection, the Director of Indian Health
10 Service shall, in coordination with the task force,
11 consult with Indian Tribes and Tribal organizations
12 that are disproportionately affected by COVID–19
13 on a government to government basis to identify
14 specific needs and recommendations.

15 (4) DISSEMINATION.—Reports under this sub-
16 section shall be disseminated to all relevant stake-
17 holders, including State, local, territorial, and Tribal
18 officials, and public health departments.

19 (5) TRIBAL DATA.—The task force, in consulta-
20 tion with Indian Tribes and Tribal organizations,
21 shall ensure that an Indian Tribe consents to any
22 public reporting of health data.

23 (e) COVID–19 RELIEF OVERSIGHT AND IMPLEMEN-
24 TATION REPORTS.—Not later than 14 days after the task
25 force first meets, and not later than every 14 days there-

1 after, the task force shall submit to Congress and the rel-
2 evant Federal agencies a report that includes—

3 (1) an examination of funds distributed under
4 COVID–19-related relief and stimulus laws (enacted
5 prior to and after the date of enactment of this Act),
6 including the Coronavirus Preparedness and Re-
7 sponse Emergency Supplemental Appropriations Act,
8 2020 (Public Law 116–123), the Families First
9 Coronavirus Response Act (Public Law 116–127),
10 the Coronavirus Aid, Relief, and Economic Security
11 Act (Public Law 116–136), and the Paycheck Pro-
12 tection Program and Health Care Enhancement Act
13 (Public Law 116–139), and how that distribution
14 impacted racial and ethnic disparities with respect to
15 the COVID–19 pandemic; and

16 (2) recommendations to relevant Federal agen-
17 cies about how to disburse any undisbursed funding
18 from COVID–19-related relief and stimulus laws
19 (enacted prior to and after the date of enactment of
20 this Act), including those laws described in para-
21 graph (1), to address racial and ethnic disparities
22 with respect to the COVID–19 pandemic, including
23 recommendations to—

24 (A) the Department of Health and Human
25 Services about disbursement of funds under the

1 Public Health and Social Service Emergency
2 Fund;

3 (B) the Small Business Administration
4 about disbursement of funds under the Pay-
5 check Protection Program and the Economic
6 Injury Disaster Loan Program; and

7 (C) the Department of Education about
8 disbursement of funds under the Education
9 Stabilization Fund.

10 (f) FINAL COVID–19 REPORTS.—Not later than 90
11 days after the date on which the President declares the
12 end of the COVID–19 public health emergency first de-
13 clared by the Secretary on January 31, 2020, the task
14 force shall submit to Congress a report that—

15 (1) describes inequities within the health care
16 system, implicit bias, structural racism, and social
17 determinants of health (including housing, nutrition,
18 education, economic, and environmental factors) that
19 contributed to racial and ethnic health disparities
20 with respect to the COVID–19 pandemic and how
21 these factors contributed to such disparities;

22 (2) examines the initial Federal response to the
23 COVID–19 pandemic and its impact on the racial
24 and ethnic disparities in COVID–19 infection, hos-
25 pitalization, and death rates; and

1 (3) contains recommendations to combat racial
2 and ethnic disparities in future infectious disease re-
3 sponses, including future COVID–19 outbreaks.

4 (g) SUNSET AND SUCCESSOR TASK FORCE.—

5 (1) SUNSET.—The task force shall terminate on
6 the date that is 90 days after the date on which the
7 President declares the end of the COVID–19 public
8 health emergency first declared by the Secretary on
9 January 31, 2020.

10 (2) SUCCESSOR.—Upon the termination of the
11 task force under paragraph (1), the Secretary shall
12 establish a permanent Infectious Disease Racial and
13 Ethnic Disparities Task Force based on the mem-
14 bership, convening, and reporting requirements rec-
15 ommended by the task force in reports submitted
16 under this section.

17 (h) AUTHORIZATION OF APPROPRIATIONS.—There is
18 authorized to be appropriated, such sums as may be nec-
19 essary to carry out this section.

20 **SEC. 402. PROTECTION OF THE HHS OFFICES OF MINORITY**
21 **HEALTH.**

22 (a) IN GENERAL.—Pursuant to section 1707A of the
23 Public Health Service Act (42 U.S.C. 300u–6a), the Of-
24 fices of Minority Health established within the Centers for
25 Disease Control and Prevention, the Health Resources

1 and Services Administration, the Substance Abuse and
2 Mental Health Services Administration, the Agency for
3 Healthcare Research and Quality, the Food and Drug Ad-
4 ministration, and the Centers for Medicare & Medicaid
5 Services, are offices that, regardless of change in the
6 structure of the Department of Health and Human Serv-
7 ices, shall report to the Secretary of Health and Human
8 Services.

9 (b) SENSE OF CONGRESS.—It is the sense of the
10 Congress that any effort to eliminate or consolidate such
11 Offices of Minority Health undermines the progress
12 achieved so far.

13 **SEC. 403. ESTABLISH AN INTERAGENCY COUNSEL AND**
14 **GRANT PROGRAMS ON SOCIAL DETER-**
15 **MINANTS OF HEALTH.**

16 (a) SHORT TITLE.—This section may be cited as the
17 “Social Determinants Accelerator Act of 2020”.

18 (b) FINDINGS; PURPOSES.—

19 (1) FINDINGS.—Congress finds the following:

20 (A) There is a significant body of evidence
21 showing that economic and social conditions
22 have a powerful impact on individual and popu-
23 lation health outcomes, including health dispari-
24 ties associated with public health emergencies,
25 and well-being, as well as medical costs.

1 (B) State, local, and Tribal governments
2 and the service delivery partners of such gov-
3 ernments face significant challenges in coordi-
4 nating benefits and services delivered through
5 the Medicaid program and other social services
6 programs because of the fragmented and com-
7 plex nature of Federal and State funding and
8 administrative requirements.

9 (C) The Federal Government should
10 prioritize and proactively assist State and local
11 governments to strengthen the capacity of State
12 and local governments to improve health and
13 social outcomes for individuals, thereby improv-
14 ing cost-effectiveness and return on investment.

15 (2) PURPOSES.—The purposes of this Act are
16 as follows:

17 (A) To establish effective, coordinated Fed-
18 eral technical assistance to help State and local
19 governments to improve outcomes and cost-ef-
20 fectiveness of, and return on investment from,
21 health and social services programs.

22 (B) To build a pipeline of State and locally
23 designed, cross-sector interventions and strate-
24 gies that generate rigorous evidence about how
25 to improve health and social outcomes, and in-

crease the cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal health and social services programs.

(C) To enlist State and local governments and the service providers of such governments as partners in identifying Federal statutory, regulatory, and administrative challenges in improving the health and social outcomes of, cost-effectiveness of, and return on investment from, Federal spending on individuals enrolled in Medicaid.

(D) To develop strategies to improve health and social outcomes without denying services to, or restricting the eligibility of, vulnerable populations.

(c) SOCIAL DETERMINANTS ACCELERATOR COUNCIL.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this Act as the “Secretary”), in coordination with the Administrator of the Centers for Medicare & Medicaid Services (referred to in this Act as the “Administrator”), shall establish an interagency council, to be known as the Social Determinants Accelerator Interagency Council

(referred to in this Act as the “Council”) to achieve the purposes listed in subsection (b)(1).

(2) MEMBERSHIP.—

(A) FEDERAL COMPOSITION.—The Council shall be composed of at least one designee from each of the following Federal agencies:

(i) The Office of Management and Budget.

(ii) The Department of Agriculture.

(iii) The Department of Education.

(iv) The Indian Health Service.

(v) The Department of Housing and Urban Development.

(vi) The Department of Labor.

(vii) The Department of Transportation.

(viii) Any other Federal agency the Chair of the Council determines necessary.

(B) DESIGNATION.—

(i) IN GENERAL.—The head of each agency specified in subparagraph (A) shall designate at least one employee to serve as a member of the Council.

1 (ii) RESPONSIBILITIES.—An employee
2 described in this clause shall be a senior
3 employee of the agency—

4 (I) whose responsibilities relate
5 to authorities, policies, and procedures
6 with respect to the health and well-
7 being of individuals receiving medical
8 assistance under a State plan (or a
9 waiver of such plan) under title XIX
10 of the Social Security Act (42 U.S.C.
11 1396 et seq.); or

12 (II) who has authority to imple-
13 ment and evaluate transformative ini-
14 tiatives that harness data or conducts
15 rigorous evaluation to improve the im-
16 pact and cost-effectiveness of federally
17 funded services and benefits.

18 (C) HHS REPRESENTATION.—In addition
19 to the designees under subparagraph (A), the
20 Council shall include designees from at least
21 three agencies within the Department of Health
22 and Human Services, including the Centers for
23 Medicare & Medicaid Services, at least one of
24 whom shall meet the criteria under this section.

1 (D) OMB ROLE.—The Director of the Of-
2 fice of Management and Budget shall facilitate
3 the timely resolution of Governmentwide and
4 multiagency issues to help the Council achieve
5 consensus recommendations described under
6 this section.

7 (E) NON-FEDERAL COMPOSITION.—The
8 Comptroller General of the United States may
9 designate up to 6 Council designees—

10 (i) who have relevant subject matter
11 expertise, including expertise implementing
12 and evaluating transformative initiatives
13 that harness data and conduct evaluations
14 to improve the impact and cost-effective-
15 ness of Federal Government services; and

16 (ii) that each represent—

17 (I) State, local, and Tribal health
18 and human services agencies;

19 (II) public housing authorities or
20 State housing finance agencies;

21 (III) State and local government
22 budget offices;

23 (IV) State Medicaid agencies; or

24 (V) national consumer advocacy
25 organizations.

1 (F) CHAIR.—

2 (i) IN GENERAL.—The Secretary shall
3 select the Chair of the Council from among
4 the members of the Council.

5 (ii) INITIATING GUIDANCE.—The
6 Chair, on behalf of the Council, shall iden-
7 tify and invite individuals from diverse en-
8 tities to provide the Council with advice
9 and information pertaining to addressing
10 social determinants of health, including—

11 (I) individuals from State and
12 local government health and human
13 services agencies;

14 (II) individuals from State Med-
15 icaid agencies;

16 (III) individuals from State and
17 local government budget offices;

18 (IV) individuals from public
19 housing authorities or State housing
20 finance agencies;

21 (V) individuals from nonprofit or-
22 ganizations, small businesses, and
23 philanthropic organizations;

24 (VI) advocates;

25 (VII) researchers; and

1 (VIII) any other individuals the
2 Chair determines to be appropriate.

3 (3) DUTIES.—The duties of the Council are—

4 (A) to make recommendations to the Sec-
5 retary and the Administrator regarding the cri-
6 teria for making awards under this section;

7 (B) to identify Federal authorities and op-
8 portunities for use by States or local govern-
9 ments to improve coordination of funding and
10 administration of Federal programs, the bene-
11 ficiaries of whom include individuals, and which
12 may be unknown or underutilized and to make
13 information on such authorities and opportuni-
14 ties publicly available;

15 (C) to provide targeted technical assistance
16 to States developing a social determinants ac-
17 celerator plan under this section, including
18 identifying potential statutory or regulatory
19 pathways for implementation of the plan and
20 assisting in identifying potential sources of
21 funding to implement the plan;

22 (D) to report to Congress annually on the
23 subjects set forth in this section;

24 (E) to develop and disseminate evaluation
25 guidelines and standards that can be used to

1 reliably assess the impact of an intervention or
2 approach that may be implemented pursuant to
3 this Act on outcomes, cost-effectiveness of, and
4 return on investment from Federal, State, local,
5 and Tribal governments, and to facilitate tech-
6 nical assistance, where needed, to help to im-
7 prove State and local evaluation designs and
8 implementation;

9 (F) to seek feedback from State, local, and
10 Tribal governments, including through an an-
11 nual survey by an independent third party, on
12 how to improve the technical assistance the
13 Council provides to better equip State, local,
14 and Tribal governments to coordinate health
15 and social service programs;

16 (G) to solicit applications for grants under
17 this section; and

18 (H) to coordinate with other cross-agency
19 initiatives focused on improving the health and
20 well-being of low-income and at-risk populations
21 in order to prevent unnecessary duplication be-
22 tween agency initiatives.

23 (4) SCHEDULE.—Not later than 60 days after
24 the date of the enactment of this Act, the Council
25 shall convene to develop a schedule and plan for car-

1 rying out the duties described in this section, includ-
2 ing solicitation of applications for the grants under
3 this section.

4 (5) REPORT TO CONGRESS.—The Council shall
5 submit an annual report to Congress, which shall in-
6 clude—

7 (A) a list of the Council members;

8 (B) activities and expenditures of the
9 Council;

10 (C) summaries of the interventions and ap-
11 proaches that will be supported by State, local,
12 and Tribal governments that received a grant
13 under this section, including—

14 (i) the best practices and evidence-
15 based approaches such governments plan
16 to employ to achieve the purposes listed in
17 this section; and

18 (ii) a description of how the practices
19 and approaches will impact the outcomes,
20 cost-effectiveness of, and return on invest-
21 ment from, Federal, State, local, and Trib-
22 al governments with respect to such pur-
23 poses;

24 (D) the feedback received from State and
25 local governments on ways to improve the tech-

1 nical assistance of the Council, including find-
2 ings from a third-party survey and actions the
3 Council plans to take in response to such feed-
4 back; and

5 (E) the major statutory, regulatory, and
6 administrative challenges identified by State,
7 local, and Tribal governments that received a
8 grant under subsection (d), and the actions that
9 Federal agencies are taking to address such
10 challenges.

11 (6) FACA APPLICABILITY.—The Federal Advi-
12 sory Committee Act (5 U.S.C. App.) shall not apply
13 to the Council.

14 (7) COUNCIL PROCEDURES.—The Secretary, in
15 consultation with the Comptroller General of the
16 United States and the Director of the Office of Man-
17 agement and Budget, shall establish procedures for
18 the Council to—

19 (A) ensure that adequate resources are
20 available to effectively execute the responsibil-
21 ities of the Council;

22 (B) effectively coordinate with other rel-
23 evant advisory bodies and working groups to
24 avoid unnecessary duplication;

1 (C) create transparency to the public and
2 Congress with regard to Council membership,
3 costs, and activities, including through use of
4 modern technology and social media to dissemi-
5 nate information; and

6 (D) avoid conflicts of interest that would
7 jeopardize the ability of the Council to make de-
8 cisions and provide recommendations.

9 (d) SOCIAL DETERMINANTS ACCELERATOR GRANTS
10 TO STATES OR LOCAL GOVERNMENTS.—

11 (1) GRANTS TO STATES, LOCAL GOVERNMENTS,
12 AND TRIBES.—Not later than 180 days after the
13 date of the enactment of this Act, the Administrator,
14 in consultation with the Secretary and the Council,
15 shall award on a competitive basis not more than 25
16 grants to eligible applicants described in this section,
17 for the development of social determinants accel-
18 erator plans, as described in this section.

19 (2) ELIGIBLE APPLICANT.—An eligible appli-
20 cant described in this section is a State, local, or
21 Tribal health or human services agency that—

22 (A) demonstrates the support of relevant
23 parties across relevant State, local, or Tribal ju-
24 risdictions; and

1 (B) in the case of an applicant that is a
2 local government agency, provides to the Sec-
3 retary a letter of support from the lead State
4 health or human services agency for the State
5 in which the local government is located.

6 (3) AMOUNT OF GRANT.—The Administrator,
7 in coordination with the Council, shall determine the
8 total amount that the Administrator will make avail-
9 able to each grantee under this section.

10 (4) APPLICATION.—An eligible applicant seek-
11 ing a grant under this section shall include in the
12 application the following information:

13 (A) The target population (or populations)
14 that would benefit from implementation of the
15 social determinants accelerator plan proposed to
16 be developed by the applicant.

17 (B) A description of the objective or objec-
18 tives and outcome goals of such proposed plan,
19 which shall include at least one health outcome
20 and at least one other important social out-
21 come.

22 (C) The sources and scope of inefficiencies
23 that, if addressed by the plan, could result in
24 improved cost-effectiveness of or return on in-

1 vestment from Federal, State, local, and Tribal
2 governments.

3 (D) A description of potential interventions
4 that could be designed or enabled using such
5 proposed plan.

6 (E) The State, local, Tribal, academic,
7 nonprofit, community-based organizations, and
8 other private sector partners that would partici-
9 pate in the development of the proposed plan
10 and subsequent implementation of programs or
11 initiatives included in such proposed plan.

12 (F) Such other information as the Admin-
13 istrator, in consultation with the Secretary and
14 the Council, determines necessary to achieve the
15 purposes of this Act.

16 (5) USE OF FUNDS.—A recipient of a grant
17 under this section may use funds received through
18 the grant for the following purposes:

19 (A) To convene and coordinate with rel-
20 evant government entities and other stake-
21 holders across sectors to assist in the develop-
22 ment of a social determinant accelerator plan.

23 (B) To identify populations of individuals
24 receiving medical assistance under a State plan
25 (or a waiver of such plan) under title XIX of

1 the Social Security Act (42 U.S.C. 1396 et
2 seq.) who may benefit from the proposed ap-
3 proaches to improving the health and well-being
4 of such individuals through the implementation
5 of the proposed social determinants accelerator
6 plan.

7 (C) To engage qualified research experts to
8 advise on relevant research and to design a pro-
9 posed evaluation plan, in accordance with the
10 standards and guidelines issued by the Admin-
11 istrator.

12 (D) To collaborate with the Council to sup-
13 port the development of social determinants ac-
14 celerator plans.

15 (E) To prepare and submit a final social
16 determinants accelerator plan to the Council.

17 (6) CONTENTS OF PLANS.—A social deter-
18 minant accelerator plan developed under this section
19 shall include the following:

20 (A) A description of the target population
21 (or populations) that would benefit from imple-
22 mentation of the social determinants accelerator
23 plan, including an analysis describing the pro-
24 jected impact on the well-being of individuals
25 described in paragraph (5)(B).

1 (B) A description of the interventions or
2 approaches designed under the social deter-
3 minants accelerator plan and the evidence for
4 selecting such interventions or approaches.

5 (C) The objectives and outcome goals of
6 such interventions or approaches, including at
7 least one health outcome and at least one other
8 important social outcome.

9 (D) A plan for accessing and linking rel-
10 evant data to enable coordinated benefits and
11 services for the jurisdictions described in this
12 section and an evaluation of the proposed inter-
13 ventions and approaches.

14 (E) A description of the State, local, Trib-
15 al, academic, nonprofit, or community-based or-
16 ganizations, or any other private sector organi-
17 zations that would participate in implementing
18 the proposed interventions or approaches, and
19 the role each would play to contribute to the
20 success of the proposed interventions or ap-
21 proaches.

22 (F) The identification of the funding
23 sources that would be used to finance the pro-
24 posed interventions or approaches.

1 (G) A description of any financial incen-
2 tives that may be provided, including outcome-
3 focused contracting approaches to encourage
4 service providers and other partners to improve
5 outcomes of, cost-effectiveness of, and return on
6 investment from, Federal, State, local, or Tribal
7 government spending.

8 (H) The identification of the applicable
9 Federal, State, local, or Tribal statutory and
10 regulatory authorities, including waiver authori-
11 ties, to be leveraged to implement the proposed
12 interventions or approaches.

13 (I) A description of potential consider-
14 ations that would enhance the impact,
15 scalability, or sustainability of the proposed
16 interventions or approaches and the actions the
17 grant awardee would take to address such con-
18 siderations.

19 (J) A proposed evaluation plan, to be car-
20 ried out by an independent evaluator, to meas-
21 ure the impact of the proposed interventions or
22 approaches on the outcomes of, cost-effective-
23 ness of, and return on investment from, Fed-
24 eral, State, local, and Tribal governments.

1 (K) Precautions for ensuring that vulner-
2 able populations will not be denied access to
3 Medicaid or other essential services as a result
4 of implementing the proposed plan.

5 (e) FUNDING.—

6 (1) IN GENERAL.—Out of any money in the
7 Treasury not otherwise appropriated, there is appro-
8 priated to carry out this Act \$25,000,000, of which
9 up to \$5,000,000 may be used to carry out this Act,
10 to remain available for obligation until the date that
11 is 5 years after the date of enactment of this Act.

12 (2) RESERVATION OF FUNDS.—

13 (A) IN GENERAL.—Of the funds made
14 available under paragraph (1), the Secretary
15 shall reserve not less than 20 percent to award
16 grants to eligible applicants for the development
17 of social determinants accelerator plans under
18 this section intended to serve rural populations.

19 (B) EXCEPTION.—In the case of a fiscal
20 year for which the Secretary determines that
21 there are not sufficient eligible applicants to
22 award up to 25 grants under section 4 that are
23 intended to serve rural populations and the Sec-
24 retary cannot satisfy the 20-percent require-
25 ment, the Secretary may reserve an amount

1 that is less than 20 percent of amounts made
2 available under paragraph (1) to award grants
3 for such purpose.

4 (3) RULE OF CONSTRUCTION.—Nothing in this
5 Act shall prevent Federal agencies represented on
6 the Council from contributing additional funding
7 from other sources to support activities to improve
8 the effectiveness of the Council.

9 **SEC. 404. ACCOUNTABILITY AND TRANSPARENCY WITHIN**
10 **THE DEPARTMENT OF HEALTH AND HUMAN**
11 **SERVICES.**

12 Title XXXIV of the Public Health Service Act is
13 amended by inserting after subtitle C the following:

14 **“Subtitle D—Strengthening**
15 **Accountability**

16 **“SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.**

17 “(a) IN GENERAL.—The Secretary shall establish
18 within the Office for Civil Rights an Office of Health Dis-
19 parities, which shall be headed by a director to be ap-
20 pointed by the Secretary.

21 “(b) PURPOSE.—The Office of Health Disparities
22 shall ensure that the health programs, activities, and oper-
23 ations of health entities that receive Federal financial as-
24 sistance are in compliance with title VI of the Civil Rights
25 Act, including through the following activities:

1 “(1) The development and implementation of
2 an action plan to address racial and ethnic health
3 care disparities, which shall address concerns relat-
4 ing to the Office for Civil Rights as released by the
5 United States Commission on Civil Rights in the re-
6 port entitled ‘Health Care Challenge: Acknowledging
7 Disparity, Confronting Discrimination, and Ensur-
8 ing Equity’ (September 1999) in conjunction with
9 the reports by the National Academy of Sciences
10 (formerly known as the Institute of Medicine) enti-
11 tled ‘Unequal Treatment: Confronting Racial and
12 Ethnic Disparities in Health Care’, ‘Crossing the
13 Quality Chasm: A New Health System for the 21st
14 Century’, ‘In the Nation’s Compelling Interest: En-
15 suring Diversity in the Health Care Workforce’,
16 ‘The National Partnership for Action to End Health
17 Disparities’, and ‘The Health of Lesbian, Gay, Bi-
18 sexual, and Transgender People’, and other related
19 reports by the National Academy of Sciences. This
20 plan shall be publicly disclosed for review and com-
21 ment and the final plan shall address any comments
22 or concerns that are received by the Office.

23 “(2) Investigative and enforcement actions
24 against intentional discrimination and policies and
25 practices that have a disparate impact on minorities.

1 “(3) The review of racial, ethnic, gender iden-
2 tity, sexual orientation, sex, disability status, socio-
3 economic status, and primary language health data
4 collected by Federal health agencies to assess health
5 care disparities related to intentional discrimination
6 and policies and practices that have a disparate im-
7 pact on minorities. Such review shall include an as-
8 sessment of health disparities in communities with a
9 combination of these classes.

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

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

15 “(6) Coordination and oversight of activities of
16 the civil rights compliance offices established under
17 section 3442.

18 “(7) Ensuring—

19 “(A) at a minimum, compliance with the
20 most recent version of the Office of Manage-
21 ment and Budget statistical policy directive en-
22 titled ‘Standards for Maintaining, Collecting,
23 and Presenting Federal Data on Race and Eth-
24 nicity’; and

1 “(B) consideration of available data and
2 language standards such as—

3 “(i) the standards for collecting and
4 reporting data under section 3101; and

5 “(ii) the National Standards on Cul-
6 turally and Linguistically Appropriate
7 Services of the Office of Minority Health.

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

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

13 “(2) staff with expertise in—

14 “(A) epidemiology;

15 “(B) statistics;

16 “(C) health quality assurance;

17 “(D) minority health and health dispari-
18 ties;

19 “(E) cultural and linguistic competency;

20 “(F) civil rights; and

21 “(G) social, behavioral, and economic de-
22 terminants of health.

23 “(d) REPORT.—Not later than December 31, 2021,
24 and annually thereafter, the Secretary, in collaboration
25 with the Director of the Office for Civil Rights and the

1 Deputy Assistant Secretary for Minority Health, shall
2 submit a report to the Committee on Health, Education,
3 Labor, and Pensions of the Senate and the Committee on
4 Energy and Commerce of the House of Representatives
5 that includes—

6 “(1) the number of cases filed, broken down by
7 category;

8 “(2) the number of cases investigated and
9 closed by the office;

10 “(3) the outcomes of cases investigated;

11 “(4) the staffing levels of the office including
12 staff credentials;

13 “(5) the number of other lingering and emerg-
14 ing cases in which civil rights inequities can be dem-
15 onstrated; and

16 “(6) the number of cases remaining open and
17 an explanation for their open status.

18 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section
20 such sums as may be necessary for each of fiscal years
21 2021 through 2026.

1 **“SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OF-**
2 **FICES FOR CIVIL RIGHTS WITHIN FEDERAL**
3 **HEALTH AND HUMAN SERVICES AGENCIES.**

4 “(a) IN GENERAL.—The Secretary shall establish
5 civil rights compliance offices in each agency within the
6 Department of Health and Human Services that admin-
7 isters health programs.

8 “(b) PURPOSE OF OFFICES.—Each office established
9 under subsection (a) shall ensure that recipients of Fed-
10 eral financial assistance under Federal health programs
11 administer programs, services, and activities in a manner
12 that—

13 “(1) does not discriminate, either intentionally
14 or in effect, on the basis of race, national origin, lan-
15 guage, ethnicity, sex, age, disability, sexual orienta-
16 tion, and gender identity; and

17 “(2) promotes the reduction and elimination of
18 disparities in health and health care based on race,
19 national origin, language, ethnicity, sex, age, dis-
20 ability, sexual orientation, and gender identity.

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

24 “(1) The establishment of compliance and pro-
25 gram participation standards for recipients of Fed-
26 eral financial assistance under each program admin-

1 istered by the applicable agency, including the estab-
2 lishment of disparity reduction standards to encom-
3 pass disparities in health and health care related to
4 race, national origin, language, ethnicity, sex, age,
5 disability, sexual orientation, and gender identity.

6 “(2) The development and implementation of
7 program-specific guidelines that interpret and apply
8 Department of Health and Human Services guid-
9 ance under title VI of the Civil Rights Act of 1964
10 and section 1557 of the Patient Protection and Af-
11 fordable Care Act to each Federal health program
12 administered by the agency.

13 “(3) The development of a disparity-reduction
14 impact analysis methodology that shall be applied to
15 every rule issued by the agency and published as
16 part of the formal rulemaking process under sections
17 555, 556, and 557 of title 5, United States Code.

18 “(4) Oversight of data collection, analysis, and
19 publication requirements for all recipients of Federal
20 financial assistance under each Federal health pro-
21 gram administered by the agency; compliance with,
22 at a minimum, the most recent version of the Office
23 of Management and Budget statistical policy direc-
24 tive entitled ‘Standards for Maintaining, Collecting,
25 and Presenting Federal Data on Race and Eth-

1 nicity'; and consideration of available data and lan-
2 guage standards such as—

3 “(A) the standards for collecting and re-
4 porting data under section 3101; and

5 “(B) the National Standards on Culturally
6 and Linguistically Appropriate Services of the
7 Office of Minority Health.

8 “(5) The conduct of publicly available studies
9 regarding discrimination within Federal health pro-
10 grams administered by the agency as well as dis-
11 parity reduction initiatives by recipients of Federal
12 financial assistance under Federal health programs.

13 “(6) Annual reports to the Committee on
14 Health, Education, Labor, and Pensions and the
15 Committee on Finance of the Senate and the Com-
16 mittee on Energy and Commerce and the Committee
17 on Ways and Means of the House of Representatives
18 on the progress in reducing disparities in health and
19 health care through the Federal programs adminis-
20 tered by the agency.

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

23 “(1) DEPARTMENT OF HEALTH AND HUMAN
24 SERVICES.—The Office for Civil Rights of the De-
25 partment of Health and Human Services shall pro-

1 vide standard-setting and compliance review inves-
2 tigation support services to the Civil Rights Compli-
3 ance Office for each agency described in subsection
4 (a), subject to paragraph (2).

5 “(2) DEPARTMENT OF JUSTICE.—The Office
6 for Civil Rights of the Department of Justice may,
7 as appropriate, institute formal proceedings when a
8 civil rights compliance office established under sub-
9 section (a) determines that a recipient of Federal fi-
10 nancial assistance is not in compliance with the dis-
11 parity reduction standards of the applicable agency.

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

14 “(1) under the Social Security Act (42 U.S.C.
15 301 et seq.) that pay for health care and services;
16 and

17 “(2) under this Act that provide Federal finan-
18 cial assistance for health care, biomedical research,
19 health services research, and programs designed to
20 improve the public’s health, including health service
21 programs.”.

**TITLE V—EXPANDED
INSURANCE ACCESS**

**SEC. 501. MEDICARE SPECIAL ENROLLMENT PERIOD FOR
INDIVIDUALS RESIDING IN COVID-19 EMER-
GENCY AREAS.**

(a) IN GENERAL.—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)) is amended by adding at the end the following new paragraph:

“(5)(A) In the case of an individual who—

“(i) is eligible under section 1836 to enroll in the medical insurance program established by this part,

“(ii) did not enroll (or elected not to be deemed enrolled) under this section during an enrollment period, and

“(iii) during the emergency period (as described in section 1135(g)(1)(B)), resided in an emergency area (as described in such section), there shall be a special enrollment period described in subparagraph (B).

“(B) The special enrollment period referred to in subparagraph (A) is the period that begins not later than July 1, 2020, and ends on the last day of the month in which the emer-

1 agency period (as described in section
2 1135(g)(1)(B)) ends.”.

3 (b) COVERAGE PERIOD FOR INDIVIDUALS
4 TRANSITIONING FROM OTHER COVERAGE.—Section
5 1838(e) of the Social Security Act (42 U.S.C. 1395q(e))
6 is amended—

7 (1) by striking “pursuant to section 1837(i)(3)
8 or 1837(i)(4)(B)—” and inserting the following:
9 “pursuant to—

10 “(1) section 1837(i)(3) or 1837(i)(4)(B)—”;

11 (2) by redesignating paragraphs (1) and (2) as
12 subparagraphs (A) and (B), respectively, and mov-
13 ing the indentation of each such subparagraph 2
14 ems to the right;

15 (3) by striking the period at the end of the sub-
16 paragraph (B), as so redesignated, and inserting “;
17 or”; and

18 (4) by adding at the end the following new
19 paragraph:

20 “(2) section 1837(i)(5), the coverage period
21 shall begin on the first day of the month following
22 the month in which the individual so enrolls.”.

23 (c) FUNDING.—The Secretary of Health and Human
24 Services shall provide for the transfer from the Federal
25 Hospital Insurance Trust Fund (as described in section

1 1817 of the Social Security Act (42 U.S.C. 1395i)) and
 2 the Federal Supplementary Medical Insurance Trust
 3 Fund (as described in section 1841 of such Act (42 U.S.C.
 4 1395t)), in such proportions as determined appropriate by
 5 the Secretary, to the Social Security Administration, of
 6 \$30,000,000, to remain available until expended, for pur-
 7 poses of carrying out the amendments made by this sec-
 8 tion.

9 (d) IMPLEMENTATION.—Notwithstanding any other
 10 provision of law, the Secretary of Health and Human
 11 Services may implement the amendments made by this
 12 section by program instruction or otherwise.

13 **SEC. 502. SPECIAL ENROLLMENT PERIOD THROUGH EX-**
 14 **CHANGES; FEDERAL EXCHANGE OUTREACH**
 15 **AND EDUCATIONAL ACTIVITIES.**

16 (a) SPECIAL ENROLLMENT PERIOD THROUGH EX-
 17 CHANGES.—Section 1311(c) of the Patient Protection and
 18 Affordable Care Act (42 U.S.C. 18031(c)) is amended—

19 (1) in paragraph (6)—

20 (A) in subparagraph (C), by striking at the
 21 end “and”;

22 (B) in subparagraph (D), by striking at
 23 the end the period and inserting “; and”; and

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

1 “(E) subject to subparagraph (B) of para-
2 graph (8), the special enrollment period de-
3 scribed in subparagraph (A) of such para-
4 graph.”; and

5 (2) by adding at the end the following new
6 paragraph:

7 “(8) SPECIAL ENROLLMENT PERIOD FOR CER-
8 TAIN PUBLIC HEALTH EMERGENCY.—

9 “(A) IN GENERAL.—The Secretary shall,
10 subject to subparagraph (B), require an Ex-
11 change to provide—

12 “(i) for a special enrollment period
13 during the emergency period described in
14 section 1135(g)(1)(B) of the Social Secu-
15 rity Act—

16 “(I) which shall begin on the
17 date that is one week after the date of
18 the enactment of this paragraph and
19 which, in the case of an Exchange es-
20 tablished or operated by the Secretary
21 within a State pursuant to section
22 1321(c), shall be an 8-week period;
23 and

24 “(II) during which any individual
25 who is otherwise eligible to enroll in a

1 qualified health plan through the Ex-
2 change may enroll in such a qualified
3 health plan; and

4 “(ii) that, in the case of an individual
5 who enrolls in a qualified health plan
6 through the Exchange during such enroll-
7 ment period, the coverage period under
8 such plan shall begin, at the option of the
9 individual, on April 1, 2020, or on the first
10 day of the month following the day the in-
11 dividual selects a plan through such special
12 enrollment period.

13 “(B) EXCEPTION.—The requirement of
14 subparagraph (A) shall not apply to a State-op-
15 erated or State-established Exchange if such
16 Exchange, prior to the date of the enactment of
17 this paragraph, established or otherwise pro-
18 vided for a special enrollment period to address
19 access to coverage under qualified health plans
20 offered through such Exchange during the
21 emergency period described in section
22 1135(g)(1)(B) of the Social Security Act.”.

23 (b) FEDERAL EXCHANGE OUTREACH AND EDU-
24 CATIONAL ACTIVITIES.—Section 1321(c) of the Patient
25 Protection and Affordable Care Act (42 U.S.C. 18041(c))

1 is amended by adding at the end the following new para-
2 graph:

3 “(3) OUTREACH AND EDUCATIONAL ACTIVI-
4 TIES.—

5 “(A) IN GENERAL.—In the case of an Ex-
6 change established or operated by the Secretary
7 within a State pursuant to this subsection, the
8 Secretary shall carry out outreach and edu-
9 cational activities for purposes of informing po-
10 tential enrollees in qualified health plans offered
11 through the Exchange of the availability of cov-
12 erage under such plans and financial assistance
13 for coverage under such plans. Such outreach
14 and educational activities shall be provided in a
15 manner that is culturally and linguistically ap-
16 propriate to the needs of the populations being
17 served by the Exchange (including hard-to-
18 reach populations, such as racial and sexual mi-
19 norities, limited English proficient populations,
20 and young adults).

21 “(B) LIMITATION ON USE OF FUNDS.—No
22 funds appropriated under this paragraph shall
23 be used for expenditures for promoting non-
24 ACA compliant health insurance coverage.

1 “(C) NON-ACA COMPLIANT HEALTH IN-
2 SURANCE COVERAGE.—For purposes of sub-
3 paragraph (B):

4 “(i) The term ‘non-ACA compliant
5 health insurance coverage’ means health
6 insurance coverage, or a group health plan,
7 that is not a qualified health plan.

8 “(ii) Such term includes the following:

9 “(I) An association health plan.

10 “(II) Short-term limited duration
11 insurance.

12 “(D) FUNDING.—There are appropriated,
13 out of any funds in the Treasury not otherwise
14 appropriated, \$25,000,000, to remain available
15 until expended—

16 “(i) to carry out this paragraph; and

17 “(ii) at the discretion of the Sec-
18 retary, to carry out section 1311(i), with
19 respect to an Exchange established or op-
20 erated by the Secretary within a State pur-
21 suant to this subsection.”.

22 (c) IMPLEMENTATION.—The Secretary of Health and
23 Human Services may implement the provisions of (includ-
24 ing amendments made by) this section through subregu-
25 latory guidance, program instruction, or otherwise.

1 **SEC. 503. MOMMA’S ACT.**

2 (a) **SHORT TITLE.**—This section may be cited as the
3 “Mothers and Offspring Mortality and Morbidity Aware-
4 ness Act” or the “MOMMA’s Act”.

5 (b) **FINDINGS.**—Congress finds the following:

6 (1) Every year, across the United States,
7 4,000,000 women give birth, about 700 women suf-
8 fer fatal complications during pregnancy, while giv-
9 ing birth or during the postpartum period, and
10 70,000 women suffer near-fatal, partum-related
11 complications.

12 (2) The maternal mortality rate is often used as
13 a proxy to measure the overall health of a popu-
14 lation. While the infant mortality rate in the United
15 States has reached its lowest point, the risk of death
16 for women in the United States during pregnancy,
17 childbirth, or the postpartum period is higher than
18 such risk in many other developed nations. The esti-
19 mated maternal mortality rate (per 100,000 live
20 births) for the 48 contiguous States and Wash-
21 ington, DC increased from 18.8 percent in 2000 to
22 23.8 percent in 2014 to 26.6 percent in 2018. This
23 estimated rate is on par with such rate for under-
24 developed nations such as Iraq and Afghanistan.

25 (3) International studies estimate the 2015 ma-
26 ternal mortality rate in the United States as 26.4

1 per 100,000 live births, which is almost twice the
2 2015 World Health Organization estimation of 14
3 per 100,000 live births.

4 (4) It is estimated that more than 60 percent
5 of maternal deaths in the United States are prevent-
6 able.

7 (5) According to the Centers for Disease Con-
8 trol and Prevention, the maternal mortality rate var-
9 ies drastically for women by race and ethnicity.
10 There are 12.7 deaths per 100,000 live births for
11 White women, 43.5 deaths per 100,000 live births
12 for African-American women, and 14.4 deaths per
13 100,000 live births for women of other ethnicities.
14 While maternal mortality disparately impacts Afri-
15 can-American women, this urgent public health crisis
16 traverses race, ethnicity, socioeconomic status, edu-
17 cational background, and geography.

18 (6) African-American women are 3 to 4 times
19 more likely to die from causes related to pregnancy
20 and childbirth compared to non-Hispanic White
21 women.

22 (7) The findings described in paragraphs (1)
23 through (6) are of major concern to researchers,
24 academics, members of the business community, and
25 providers across the obstetrical continuum rep-

1 resented by organizations such as March of Dimes;
2 the Preeclampsia Foundation; the American College
3 of Obstetricians and Gynecologists; the Society for
4 Maternal-Fetal Medicine; the Association of Women's
5 Health, Obstetric, and Neonatal Nurses; the
6 California Maternal Quality Care Collaborative;
7 Black Women's Health Imperative; the National
8 Birth Equity Collaborative; Black Mamas Matter Alliance;
9 EverThrive Illinois; the National Association
10 of Certified Professional Midwives; PCOS Challenge:
11 The National Polycystic Ovary Syndrome Association;
12 and the American College of Nurse Midwives.

13 (8) Hemorrhage, cardiovascular and coronary
14 conditions, cardiomyopathy, infection, embolism,
15 mental health conditions, preeclampsia and eclampsia,
16 polycystic ovary syndrome, infection and sepsis,
17 and anesthesia complications are the predominant
18 medical causes of maternal-related deaths and complications.
19 Most of these conditions are largely preventable or manageable.
20

21 (9) Oral health is an important part of
22 perinatal health. Reducing bacteria in a woman's
23 mouth during pregnancy can significantly reduce her
24 risk of developing oral diseases and spreading decay-causing
25 bacteria to her baby. Moreover, some evi-

1 dence suggests that women with periodontal disease
2 during pregnancy could be at greater risk for poor
3 birth outcomes, such as preeclampsia, pre-term
4 birth, and low-birth weight. Furthermore, a woman's
5 oral health during pregnancy is a good predictor of
6 her newborn's oral health, and since mothers can
7 unintentionally spread oral bacteria to their babies,
8 putting their children at higher risk for tooth decay,
9 prevention efforts should happen even before chil-
10 dren are born, as a matter of pre-pregnancy health
11 and prenatal care during pregnancy.

12 (10) The United States has not been able to
13 submit a formal maternal mortality rate to inter-
14 national data repositories since 2007. Thus, no offi-
15 cial maternal mortality rate exists for the United
16 States. There can be no maternal mortality rate
17 without streamlining maternal mortality-related data
18 from the State level and extrapolating such data to
19 the Federal level.

20 (11) In the United States, death reporting and
21 analysis is a State function rather than a Federal
22 process. States report all deaths—including mater-
23 nal deaths—on a semi-voluntary basis, without
24 standardization across States. While the Centers for
25 Disease Control and Prevention has the capacity and

1 system for collecting death-related data based on
2 death certificates, these data are not sufficiently re-
3 ported by States in an organized and standard for-
4 mat across States such that the Centers for Disease
5 Control and Prevention is able to identify causes of
6 maternal death and best practices for the prevention
7 of such death.

8 (12) Vital statistics systems often underesti-
9 mate maternal mortality and are insufficient data
10 sources from which to derive a full scope of medical
11 and social determinant factors contributing to ma-
12 ternal deaths. While the addition of pregnancy
13 checkboxes on death certificates since 2003 have
14 likely improved States' abilities to identify preg-
15 nancy-related deaths, they are not generally com-
16 pleted by obstetrical providers or persons trained to
17 recognize pregnancy-related mortality. Thus, these
18 vital forms may be missing information or may cap-
19 ture inconsistent data. Due to varying maternal
20 mortality-related analyses, lack of reliability, and
21 granularity in data, current maternal mortality
22 informatics do not fully encapsulate the myriad med-
23 ical and socially determinant factors that contribute
24 to such high maternal mortality rates within the
25 United States compared to other developed nations.

1 Lack of standardization of data and data sharing
2 across States and between Federal entities, health
3 networks, and research institutions keep the Nation
4 in the dark about ways to prevent maternal deaths.

5 (13) Having reliable and valid State data ag-
6 gregated at the Federal level are critical to the Na-
7 tion's ability to quell surges in maternal death and
8 imperative for researchers to identify long-lasting
9 interventions.

10 (14) Leaders in maternal wellness highly rec-
11 ommend that maternal deaths be investigated at the
12 State level first, and that standardized, streamlined,
13 de-identified data regarding maternal deaths be sent
14 annually to the Centers for Disease Control and Pre-
15 vention. Such data standardization and collection
16 would be similar in operation and effect to the Na-
17 tional Program of Cancer Registries of the Centers
18 for Disease Control and Prevention and akin to the
19 Confidential Enquiry in Maternal Deaths Pro-
20 gramme in the United Kingdom. Such a maternal
21 mortalities and morbidities registry and surveillance
22 system would help providers, academicians, law-
23 makers, and the public to address questions con-
24 cerning the types of, causes of, and best practices to

1 thwart, pregnancy-related or pregnancy-associated
2 mortality and morbidity.

3 (15) The United Nations' Millennium Develop-
4 ment Goal 5a aimed to reduce by 75 percent, be-
5 tween 1990 and 2015, the maternal mortality rate,
6 yet this metric has not been achieved. In fact, the
7 maternal mortality rate in the United States has
8 been estimated to have more than doubled between
9 2000 and 2014. Yet, because national data are not
10 fully available, the United States does not have an
11 official maternal mortality rate.

12 (16) Many States have struggled to establish or
13 maintain Maternal Mortality Review Committees
14 (referred to in this section as "MMRC"). On the
15 State level, MMRCs have lagged because States have
16 not had the resources to mount local reviews. State-
17 level reviews are necessary as only the State depart-
18 ments of health have the authority to request med-
19 ical records, autopsy reports, and police reports crit-
20 ical to the function of the MMRC.

21 (17) The United Kingdom regards maternal
22 deaths as a health systems failure and a national
23 committee of obstetrics experts review each maternal
24 death or near-fatal childbirth complication. Such
25 committee also establishes the predominant course of

1 maternal-related deaths from conditions such as
2 preeclampsia. Consequently, the United Kingdom
3 has been able to reduce its incidence of preeclampsia
4 to less than one in 10,000 women—its lowest rate
5 since 1952.

6 (18) The United States has no comparable, co-
7 ordinated Federal process by which to review cases
8 of maternal mortality, systems failures, or best prac-
9 tices. Many States have active MMRCs and leverage
10 their work to impact maternal wellness. For exam-
11 ple, the State of California has worked extensively
12 with their State health departments, health and hos-
13 pital systems, and research collaborative organiza-
14 tions, including the California Maternal Quality Care
15 Collaborative and the Alliance for Innovation on Ma-
16 ternal Health, to establish MMRCs, wherein such
17 State has determined the most prevalent causes of
18 maternal mortality and recorded and shared data
19 with providers and researchers, who have developed
20 and implemented safety bundles and care protocols
21 related to preeclampsia, maternal hemorrhage, and
22 the like. In this way, the State of California has
23 been able to leverage its maternal mortality review
24 board system, generate data, and apply those data
25 to effect changes in maternal care-related protocol.

1 To date, the State of California has reduced its ma-
2 ternal mortality rate, which is now comparable to
3 the low rates of the United Kingdom.

4 (19) Hospitals and health systems across the
5 United States lack standardization of emergency ob-
6 stetrical protocols before, during, and after delivery.
7 Consequently, many providers are delayed in recog-
8 nizing critical signs indicating maternal distress that
9 quickly escalate into fatal or near-fatal incidences.
10 Moreover, any attempt to address an obstetrical
11 emergency that does not consider both clinical and
12 public health approaches falls woefully under the
13 mark of excellent care delivery. State-based maternal
14 quality collaborative organizations, such as the Cali-
15 fornia Maternal Quality Care Collaborative or enti-
16 ties participating in the Alliance for Innovation on
17 Maternal Health (AIM), have formed obstetrical pro-
18 tocols, tool kits, and other resources to improve sys-
19 tem care and response as they relate to maternal
20 complications and warning signs for such conditions
21 as maternal hemorrhage, hypertension, and
22 preeclampsia.

23 (20) The Centers for Disease Control and Pre-
24 vention reports that nearly half of all maternal
25 deaths occur in the immediate postpartum period—

1 the 42 days following a pregnancy—whereas more
2 than one-third of pregnancy-related or pregnancy-as-
3 sociated deaths occur while a person is still preg-
4 nant. Yet, for women eligible for the Medicaid pro-
5 gram on the basis of pregnancy, such Medicaid cov-
6 erage lapses at the end of the month on which the
7 60th postpartum day lands.

8 (21) The experience of serious traumatic
9 events, such as being exposed to domestic violence,
10 substance use disorder, or pervasive racism, can
11 over-activate the body's stress-response system.
12 Known as toxic stress, the repetition of high-doses
13 of cortisol to the brain, can harm healthy neuro-
14 logical development, which can have cascading phys-
15 ical and mental health consequences, as documented
16 in the Adverse Childhood Experiences study of the
17 Centers for Disease Control and Prevention.

18 (22) A growing body of evidence-based research
19 has shown the correlation between the stress associ-
20 ated with one's race—the stress of racism—and
21 one's birthing outcomes. The stress of sex and race
22 discrimination and institutional racism has been
23 demonstrated to contribute to a higher risk of ma-
24 ternal mortality, irrespective of one's gestational
25 age, maternal age, socioeconomic status, or indi-

1 vidual-level health risk factors, including poverty,
2 limited access to prenatal care, and poor physical
3 and mental health (although these are not nominal
4 factors). African-American women remain the most
5 at risk for pregnancy-associated or pregnancy-re-
6 lated causes of death. When it comes to
7 preeclampsia, for example, which is related to obe-
8 sity, African-American women of normal weight re-
9 main the most at risk of dying during the perinatal
10 period compared to non-African-American obese
11 women.

12 (23) The rising maternal mortality rate in the
13 United States is driven predominantly by the dis-
14 proportionately high rates of African-American ma-
15 ternal mortality.

16 (24) African-American women are 3 to 4 times
17 more likely to die from pregnancy or maternal-re-
18 lated distress than are White women, yielding one of
19 the greatest and most disconcerting racial disparities
20 in public health.

21 (25) Compared to women from other racial and
22 ethnic demographics, African-American women
23 across the socioeconomic spectrum experience pro-
24 longed, unrelenting stress related to racial and gen-
25 der discrimination, contributing to higher rates of

1 maternal mortality, giving birth to low-weight ba-
2 bies, and experiencing pre-term birth. Racism is a
3 risk-factor for these aforementioned experiences.
4 This cumulative stress often extends across the life
5 course and is situated in everyday spaces where Afri-
6 can-American women establish livelihood. Structural
7 barriers, lack of access to care, and genetic pre-
8 dispositions to health vulnerabilities exacerbate Afri-
9 can-American women's likelihood to experience poor
10 or fatal birthing outcomes, but do not fully account
11 for the great disparity.

12 (26) African-American women are twice as like-
13 ly to experience postpartum depression, and dis-
14 proportionately higher rates of preeclampsia com-
15 pared to White women.

16 (27) Racism is deeply ingrained in United
17 States systems, including in health care delivery sys-
18 tems between patients and providers, often resulting
19 in disparate treatment for pain, irreverence for cul-
20 tural norms with respect to health, and
21 dismissiveness. Research has demonstrated that pa-
22 tients respond more warmly and adhere to medical
23 treatment plans at a higher degree with providers of
24 the same race or ethnicity or with providers with
25 great ability to exercise empathy. However, the pro-

1 vider pool is not primed with many people of color,
2 nor are providers (whether student-doctors in train-
3 ing or licensed practitioners) consistently required to
4 undergo implicit bias, cultural competency, or empa-
5 thy training on a consistent, on-going basis.

6 (c) IMPROVING FEDERAL EFFORTS WITH RESPECT
7 TO PREVENTION OF MATERNAL MORTALITY.—

8 (1) TECHNICAL ASSISTANCE FOR STATES WITH
9 RESPECT TO REPORTING MATERNAL MORTALITY.—

10 Not later than one year after the date of enactment
11 of this Act, the Director of the Centers for Disease
12 Control and Prevention (referred to in this section
13 as the “Director”), in consultation with the Admin-
14 istrator of the Health Resources and Services Ad-
15 ministration, shall provide technical assistance to
16 States that elect to report comprehensive data on
17 maternal mortality, including oral, mental, and
18 breastfeeding health information, for the purpose of
19 encouraging uniformity in the reporting of such data
20 and to encourage the sharing of such data among
21 the respective States.

22 (2) BEST PRACTICES RELATING TO PREVEN-
23 TION OF MATERNAL MORTALITY.—

24 (A) IN GENERAL.—Not later than one year
25 after the date of enactment of this Act—

1 (i) the Director, in consultation with
2 relevant patient and provider groups, shall
3 issue best practices to State maternal mor-
4 tality review committees on how best to
5 identify and review maternal mortality
6 cases, taking into account any data made
7 available by States relating to maternal
8 mortality, including data on oral, mental,
9 and breastfeeding health, and utilization of
10 any emergency services; and

11 (ii) the Director, working in collabora-
12 tion with the Health Resources and Serv-
13 ices Administration, shall issue best prac-
14 tices to hospitals, State professional society
15 groups, and perinatal quality collaboratives
16 on how best to prevent maternal mortality.

17 (B) AUTHORIZATION OF APPROPRIA-
18 TIONS.—For purposes of carrying out this sub-
19 section, there is authorized to be appropriated
20 \$5,000,000 for each of fiscal years 2021
21 through 2025.

22 (3) ALLIANCE FOR INNOVATION ON MATERNAL
23 HEALTH GRANT PROGRAM.—

24 (A) IN GENERAL.—Not later than one year
25 after the date of enactment of this Act, the Sec-

1 retary of Health and Human Services (referred
2 to in this subsection as the “Secretary”), acting
3 through the Associate Administrator of the Ma-
4 ternal and Child Health Bureau of the Health
5 Resources and Services Administration, shall
6 establish a grant program to be known as the
7 Alliance for Innovation on Maternal Health
8 Grant Program (referred to in this subsection
9 as “AIM”) under which the Secretary shall
10 award grants to eligible entities for the purpose
11 of—

12 (i) directing widespread adoption and
13 implementation of maternal safety bundles
14 through collaborative State-based teams;
15 and

16 (ii) collecting and analyzing process,
17 structure, and outcome data to drive con-
18 tinuous improvement in the implementa-
19 tion of such safety bundles by such State-
20 based teams with the ultimate goal of
21 eliminating preventable maternal mortality
22 and severe maternal morbidity in the
23 United States.

1 (B) ELIGIBLE ENTITIES.—In order to be
2 eligible for a grant under paragraph (1), an en-
3 tity shall—

4 (i) submit to the Secretary an applica-
5 tion at such time, in such manner, and
6 containing such information as the Sec-
7 retary may require; and

8 (ii) demonstrate in such application
9 that the entity is an interdisciplinary,
10 multi-stakeholder, national organization
11 with a national data-driven maternal safety
12 and quality improvement initiative based
13 on implementation approaches that have
14 been proven to improve maternal safety
15 and outcomes in the United States.

16 (C) USE OF FUNDS.—An eligible entity
17 that receives a grant under paragraph (1) shall
18 use such grant funds—

19 (i) to develop and implement, through
20 a robust, multi-stakeholder process, mater-
21 nal safety bundles to assist States and
22 health care systems in aligning national,
23 State, and hospital-level quality improve-
24 ment efforts to improve maternal health
25 outcomes, specifically the reduction of ma-

1 ternal mortality and severe maternal mor-
2 bidity;

3 (ii) to ensure, in developing and im-
4 plementing maternal safety bundles under
5 subparagraph (A), that such maternal
6 safety bundles—

7 (I) satisfy the quality improve-
8 ment needs of a State or health care
9 system by factoring in the results and
10 findings of relevant data reviews, such
11 as reviews conducted by a State ma-
12 ternal mortality review committee;
13 and

14 (II) address topics such as—

15 (aa) obstetric hemorrhage;

16 (bb) maternal mental health;

17 (cc) the maternal venous
18 system;

19 (dd) obstetric care for
20 women with substance use dis-
21 orders, including opioid use dis-
22 order;

23 (ee) postpartum care basics
24 for maternal safety;

- 1 (ff) reduction of peripartum
2 racial and ethnic disparities;
3 (gg) reduction of primary
4 caesarean birth;
5 (hh) severe hypertension in
6 pregnancy;
7 (ii) severe maternal mor-
8 bidity reviews;
9 (jj) support after a severe
10 maternal morbidity event;
11 (kk) thromboembolism;
12 (ll) optimization of support
13 for breastfeeding; and
14 (mm) maternal oral health;
15 and
16 (iii) to provide ongoing technical as-
17 sistance at the national and State levels to
18 support implementation of maternal safety
19 bundles under subparagraph (A).
- 20 (D) MATERNAL SAFETY BUNDLE DE-
21 FINED.—For purposes of this subsection, the
22 term “maternal safety bundle” means standard-
23 ized, evidence-informed processes for maternal
24 health care.

1 (E) AUTHORIZATION OF APPROPRIA-
2 TIONS.—For purposes of carrying out this sub-
3 section, there is authorized to be appropriated
4 \$10,000,000 for each of fiscal years 2021
5 through 2025.

6 (4) FUNDING FOR STATE-BASED PERINATAL
7 QUALITY COLLABORATIVES DEVELOPMENT AND SUS-
8 TAINABILITY.—

9 (A) IN GENERAL.—Not later than one year
10 after the date of enactment of this Act, the Sec-
11 retary of Health and Human Services (referred
12 to in this subsection as the “Secretary”), acting
13 through the Division of Reproductive Health of
14 the Centers for Disease Control and Prevention,
15 shall establish a grant program to be known as
16 the State-Based Perinatal Quality Collaborative
17 grant program under which the Secretary
18 awards grants to eligible entities for the pur-
19 pose of development and sustainability of
20 perinatal quality collaboratives in every State,
21 the District of Columbia, and eligible terri-
22 tories, in order to measurably improve perinatal
23 care and perinatal health outcomes for preg-
24 nant and postpartum women and their infants.

1 (B) GRANT AMOUNTS.—Grants awarded
2 under this subsection shall be in amounts not to
3 exceed \$250,000 per year, for the duration of
4 the grant period.

5 (C) STATE-BASED PERINATAL QUALITY
6 COLLABORATIVE DEFINED.—For purposes of
7 this subsection, the term “State-based perinatal
8 quality collaborative” means a network of mul-
9 tidisciplinary teams that—

10 (i) work to improve measurable out-
11 comes for maternal and infant health by
12 advancing evidence-informed clinical prac-
13 tices using quality improvement principles;

14 (ii) work with hospital-based or out-
15 patient facility-based clinical teams, ex-
16 perts, and stakeholders, including patients
17 and families, to spread best practices and
18 optimize resources to improve perinatal
19 care and outcomes;

20 (iii) employ strategies that include the
21 use of the collaborative learning model to
22 provide opportunities for hospitals and
23 clinical teams to collaborate on improve-
24 ment strategies, rapid-response data to
25 provide timely feedback to hospital and

1 other clinical teams to track progress, and
2 quality improvement science to provide
3 support and coaching to hospital and clin-
4 ical teams; and

5 (iv) have the goal of improving popu-
6 lation-level outcomes in maternal and in-
7 fant health.

8 (D) AUTHORIZATION OF APPROPRIA-
9 TIONS.—For purposes of carrying out this sub-
10 section, there is authorized to be appropriated
11 \$14,000,000 per year for each of fiscal years
12 2021 through 2025.

13 (5) EXPANSION OF MEDICAID AND CHIP COV-
14 ERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

15 (A) REQUIRING COVERAGE OF ORAL
16 HEALTH SERVICES FOR PREGNANT AND
17 POSTPARTUM WOMEN.—

18 (i) MEDICAID.—Section 1905 of the
19 Social Security Act (42 U.S.C. 1396d) is
20 amended—

21 (I) in subsection (a)(4)—

22 (aa) by striking “; and (D)”
23 and inserting “; (D)”; and

24 (bb) by inserting “; and (E)”
25 oral health services for pregnant

1 and postpartum women (as de-
2 fined in subsection (ee))” after
3 “subsection (bb))”; and
4 (II) by adding at the end the fol-
5 lowing new subsection:

6 “(ee) ORAL HEALTH SERVICES FOR PREGNANT AND
7 POSTPARTUM WOMEN.—

8 “(1) IN GENERAL.—For purposes of this title,
9 the term ‘oral health services for pregnant and
10 postpartum women’ means dental services necessary
11 to prevent disease and promote oral health, restore
12 oral structures to health and function, and treat
13 emergency conditions that are furnished to a woman
14 during pregnancy (or during the 1-year period be-
15 ginning on the last day of the pregnancy).

16 “(2) COVERAGE REQUIREMENTS.—To satisfy
17 the requirement to provide oral health services for
18 pregnant and postpartum women, a State shall, at
19 a minimum, provide coverage for preventive, diag-
20 nostic, periodontal, and restorative care consistent
21 with recommendations for perinatal oral health care
22 and dental care during pregnancy from the Amer-
23 ican Academy of Pediatric Dentistry and the Amer-
24 ican College of Obstetricians and Gynecologists.”.

1 (ii) CHIP.—Section 2103(c)(5)(A) of
2 the Social Security Act (42 U.S.C.
3 1397cc(c)(5)(A)) is amended by inserting
4 “or a targeted low-income pregnant
5 woman” after “targeted low-income child”.

6 (B) EXTENDING MEDICAID COVERAGE FOR
7 PREGNANT AND POSTPARTUM WOMEN.—Section
8 1902 of the Social Security Act (42 U.S.C.
9 1396a) is amended—

10 (i) in subsection (e)—

11 (I) in paragraph (5)—

12 (aa) by inserting “(including
13 oral health services for pregnant
14 and postpartum women (as de-
15 fined in section 1905(ee))” after
16 “postpartum medical assistance
17 under the plan”; and

18 (bb) by striking “60-day”
19 and inserting “1-year”; and

20 (II) in paragraph (6), by striking
21 “60-day” and inserting “1-year”; and

22 (ii) in subsection (l)(1)(A), by striking
23 “60-day” and inserting “1-year”.

24 (C) EXTENDING MEDICAID COVERAGE FOR
25 LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of

1 the Social Security Act (42 U.S.C.
2 1396b(v)(4)(A)) is amended by striking “60-
3 day” and inserting “1-year”.

4 (D) EXTENDING CHIP COVERAGE FOR
5 PREGNANT AND POSTPARTUM WOMEN.—Section
6 2112(d)(2)(A) of the Social Security Act (42
7 U.S.C. 1397ll(d)(2)(A)) is amended by striking
8 “60-day” and inserting “1-year”.

9 (E) MAINTENANCE OF EFFORT.—

10 (i) MEDICAID.—Section 1902(l) of the
11 Social Security Act (42 U.S.C. 1396a(l)) is
12 amended by adding at the end the fol-
13 lowing new paragraph:

14 “(5) During the period that begins on the date of
15 enactment of this paragraph and ends on the date that
16 is five years after such date of enactment, as a condition
17 for receiving any Federal payments under section 1903(a)
18 for calendar quarters occurring during such period, a
19 State shall not have in effect, with respect to women who
20 are eligible for medical assistance under the State plan
21 or under a waiver of such plan on the basis of being preg-
22 nant or having been pregnant, eligibility standards, meth-
23 odologies, or procedures under the State plan or waiver
24 that are more restrictive than the eligibility standards,
25 methodologies, or procedures, respectively, under such

1 plan or waiver that are in effect on the date of enactment
2 of this paragraph.”.

3 (ii) CHIP.—Section 2105(d) of the
4 Social Security Act (42 U.S.C. 1397ee(d))
5 is amended by adding at the end the fol-
6 lowing new paragraph:

7 “(4) IN ELIGIBILITY STANDARDS FOR TAR-
8 GETED LOW-INCOME PREGNANT WOMEN.—During
9 the period that begins on the date of enactment of
10 this paragraph and ends on the date that is five
11 years after such date of enactment, as a condition
12 of receiving payments under subsection (a) and sec-
13 tion 1903(a), a State that elects to provide assist-
14 ance to women on the basis of being pregnant (in-
15 cluding pregnancy-related assistance provided to tar-
16 geted low-income pregnant women (as defined in
17 section 2112(d)), pregnancy-related assistance pro-
18 vided to women who are eligible for such assistance
19 through application of section 1902(v)(4)(A)(i)
20 under section 2107(e)(1), or any other assistance
21 under the State child health plan (or a waiver of
22 such plan) which is provided to women on the basis
23 of being pregnant) shall not have in effect, with re-
24 spect to such women, eligibility standards, meth-
25 odologies, or procedures under such plan (or waiver)

1 that are more restrictive than the eligibility stand-
2 ards, methodologies, or procedures, respectively,
3 under such plan (or waiver) that are in effect on the
4 date of enactment of this paragraph.”.

5 (F) INFORMATION ON BENEFITS.—The
6 Secretary of Health and Human Services shall
7 make publicly available on the internet website
8 of the Department of Health and Human Serv-
9 ices, information regarding benefits available to
10 pregnant and postpartum women and under the
11 Medicaid program and the Children’s Health
12 Insurance Program, including information on—

13 (i) benefits that States are required to
14 provide to pregnant and postpartum
15 women under such programs;

16 (ii) optional benefits that States may
17 provide to pregnant and postpartum
18 women under such programs; and

19 (iii) the availability of different kinds
20 of benefits for pregnant and postpartum
21 women, including oral health and mental
22 health benefits, under such programs.

23 (G) FEDERAL FUNDING FOR COST OF EX-
24 TENDED MEDICAID AND CHIP COVERAGE FOR
25 POSTPARTUM WOMEN.—

1 (i) MEDICAID.—Section 1905 of the
2 Social Security Act (42 U.S.C. 1396d), as
3 amended by paragraph (1), is further
4 amended—

5 (I) in subsection (b), by striking
6 “and (aa)” and inserting “(aa), and
7 (ff)”; and

8 (II) by adding at the end the fol-
9 lowing:

10 “(ff) INCREASED FMAP FOR EXTENDED MEDICAL
11 ASSISTANCE FOR POSTPARTUM WOMEN.—Notwith-
12 standing subsection (b), the Federal medical assistance
13 percentage for a State, with respect to amounts expended
14 by such State for medical assistance for a woman who is
15 eligible for such assistance on the basis of being pregnant
16 or having been pregnant that is provided during the 305-
17 day period that begins on the 60th day after the last day
18 of her pregnancy (including any such assistance provided
19 during the month in which such period ends), shall be
20 equal to—

21 “(1) 100 percent for the first 20 calendar quar-
22 ters during which this subsection is in effect; and

23 “(2) 90 percent for calendar quarters there-
24 after.”.

1 (ii) CHIP.—Section 2105(c) of the
2 Social Security Act (42 U.S.C. 1397ee(c))
3 is amended by adding at the end the fol-
4 lowing new paragraph:

5 “(12) ENHANCED PAYMENT FOR EXTENDED
6 ASSISTANCE PROVIDED TO PREGNANT WOMEN.—
7 Notwithstanding subsection (b), the enhanced
8 FMAP, with respect to payments under subsection
9 (a) for expenditures under the State child health
10 plan (or a waiver of such plan) for assistance pro-
11 vided under the plan (or waiver) to a woman who is
12 eligible for such assistance on the basis of being
13 pregnant (including pregnancy-related assistance
14 provided to a targeted low-income pregnant woman
15 (as defined in section 2112(d)), pregnancy-related
16 assistance provided to a woman who is eligible for
17 such assistance through application of section
18 1902(v)(4)(A)(i) under section 2107(e)(1), or any
19 other assistance under the plan (or waiver) provided
20 to a woman who is eligible for such assistance on the
21 basis of being pregnant) during the 305-day period
22 that begins on the 60th day after the last day of her
23 pregnancy (including any such assistance provided
24 during the month in which such period ends), shall
25 be equal to—

1 “(A) 100 percent for the first 20 calendar
2 quarters during which this paragraph is in ef-
3 fect; and

4 “(B) 90 percent for calendar quarters
5 thereafter.”.

6 (H) EFFECTIVE DATE.—

7 (i) IN GENERAL.—Subject to subpara-
8 graph (B), the amendments made by this
9 subsection shall take effect on the first day
10 of the first calendar quarter that begins on
11 or after the date that is one year after the
12 date of enactment of this Act.

13 (ii) EXCEPTION FOR STATE LEGISLA-
14 TION.—In the case of a State plan under
15 title XIX of the Social Security Act or a
16 State child health plan under title XXI of
17 such Act that the Secretary of Health and
18 Human Services determines requires State
19 legislation in order for the respective plan
20 to meet any requirement imposed by
21 amendments made by this subsection, the
22 respective plan shall not be regarded as
23 failing to comply with the requirements of
24 such title solely on the basis of its failure
25 to meet such an additional requirement be-

1 fore the first day of the first calendar
2 quarter beginning after the close of the
3 first regular session of the State legislature
4 that begins after the date of enactment of
5 this Act. For purposes of the previous sen-
6 tence, in the case of a State that has a 2-
7 year legislative session, each year of the
8 session shall be considered to be a separate
9 regular session of the State legislature.

10 (6) REGIONAL CENTERS OF EXCELLENCE.—

11 Part P of title III of the Public Health Service Act
12 is amended by adding at the end the following new
13 section:

14 **“SEC. 399V-7. REGIONAL CENTERS OF EXCELLENCE AD-**
15 **DRESSING IMPLICIT BIAS AND CULTURAL**
16 **COMPETENCY IN PATIENT-PROVIDER INTER-**
17 **ACTIONS EDUCATION.**

18 “(a) IN GENERAL.—Not later than one year after the
19 date of enactment of this section, the Secretary, in con-
20 sultation with such other agency heads as the Secretary
21 determines appropriate, shall award cooperative agree-
22 ments for the establishment or support of regional centers
23 of excellence addressing implicit bias and cultural com-
24 petency in patient-provider interactions education for the
25 purpose of enhancing and improving how health care pro-

1 professionals are educated in implicit bias and delivering cul-
2 turally competent health care.

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

5 “(1) be a public or other nonprofit entity speci-
6 fied by the Secretary that provides educational and
7 training opportunities for students and health care
8 professionals, which may be a health system, teach-
9 ing hospital, community health center, medical
10 school, school of public health, dental school, social
11 work school, school of professional psychology, or
12 any other health professional school or program at
13 an institution of higher education (as defined in sec-
14 tion 101 of the Higher Education Act of 1965) fo-
15 cused on the prevention, treatment, or recovery of
16 health conditions that contribute to maternal mor-
17 tality and the prevention of maternal mortality and
18 severe maternal morbidity;

19 “(2) demonstrate community engagement and
20 participation, such as through partnerships with
21 home visiting and case management programs; and

22 “(3) provide to the Secretary such information,
23 at such time and in such manner, as the Secretary
24 may require.

1 “(c) DIVERSITY.—In awarding a cooperative agree-
2 ment under subsection (a), the Secretary shall take into
3 account any regional differences among eligible entities
4 and make an effort to ensure geographic diversity among
5 award recipients.

6 “(d) DISSEMINATION OF INFORMATION.—

7 “(1) PUBLIC AVAILABILITY.—The Secretary
8 shall make publicly available on the internet website
9 of the Department of Health and Human Services
10 information submitted to the Secretary under sub-
11 section (b)(3).

12 “(2) EVALUATION.—The Secretary shall evalu-
13 ate each regional center of excellence established or
14 supported pursuant to subsection (a) and dissemi-
15 nate the findings resulting from each such evalua-
16 tion to the appropriate public and private entities.

17 “(3) DISTRIBUTION.—The Secretary shall share
18 evaluations and overall findings with State depart-
19 ments of health and other relevant State level offices
20 to inform State and local best practices.

21 “(e) MATERNAL MORTALITY DEFINED.—In this sec-
22 tion, the term ‘maternal mortality’ means death of a
23 woman that occurs during pregnancy or within the one-
24 year period following the end of such pregnancy.

1 “(f) AUTHORIZATION OF APPROPRIATIONS.—For
 2 purposes of carrying out this section, there is authorized
 3 to be appropriated \$5,000,000 for each of fiscal years
 4 2021 through 2025.”.

5 (7) SPECIAL SUPPLEMENTAL NUTRITION PRO-
 6 GRAM FOR WOMEN, INFANTS, AND CHILDREN.—Sec-
 7 tion 17(d)(3)(A)(ii) of the Child Nutrition Act of
 8 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

9 (A) by striking the clause designation and
 10 heading and all that follows through “A State”
 11 and inserting the following:

12 “(ii) WOMEN.—

13 “(I) BREASTFEEDING WOMEN.—

14 A State”;

15 (B) in subclause (I) (as so designated), by
 16 striking “1 year” and all that follows through
 17 “earlier” and inserting “2 years postpartum”;
 18 and

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

20 “(II) POSTPARTUM WOMEN.—A

21 State may elect to certify a
 22 postpartum woman for a period of 2
 23 years.”.

24 (8) DEFINITIONS.—In this section:

1 (A) MATERNAL MORTALITY.—The term
2 “maternal mortality” means death of a woman
3 that occurs during pregnancy or within the one-
4 year period following the end of such preg-
5 nancy.

6 (B) SEVERE MATERNAL MORBIDITY.—The
7 term “severe maternal morbidity” includes un-
8 expected outcomes of labor and delivery that re-
9 sult in significant short-term or long-term con-
10 sequences to a woman’s health.

11 (d) INCREASING EXCISE TAXES ON CIGARETTES AND
12 ESTABLISHING EXCISE TAX EQUITY AMONG ALL TO-
13 BACCO PRODUCT TAX RATES.—

14 (1) TAX PARITY FOR ROLL-YOUR-OWN TO-
15 BACCO.—Section 5701(g) of the Internal Revenue
16 Code of 1986 is amended by striking “\$24.78” and
17 inserting “\$49.56”.

18 (2) TAX PARITY FOR PIPE TOBACCO.—Section
19 5701(f) of the Internal Revenue Code of 1986 is
20 amended by striking “\$2.8311 cents” and inserting
21 “\$49.56”.

22 (3) TAX PARITY FOR SMOKELESS TOBACCO.—

23 (A) Section 5701(e) of the Internal Rev-
24 enue Code of 1986 is amended—

1 (i) in paragraph (1), by striking
2 “\$1.51” and inserting “\$26.84”;

3 (ii) in paragraph (2), by striking
4 “50.33 cents” and inserting “\$10.74”; and

5 (iii) by adding at the end the fol-
6 lowing:

7 “(3) SMOKELESS TOBACCO SOLD IN DISCRETE
8 SINGLE-USE UNITS.—On discrete single-use units,
9 \$100.66 per thousand.”.

10 (B) Section 5702(m) of such Code is
11 amended—

12 (i) in paragraph (1), by striking “or
13 chewing tobacco” and inserting “, chewing
14 tobacco, or discrete single-use unit”;

15 (ii) in paragraphs (2) and (3), by in-
16 serting “that is not a discrete single-use
17 unit” before the period in each such para-
18 graph; and

19 (iii) by adding at the end the fol-
20 lowing:

21 “(4) DISCRETE SINGLE-USE UNIT.—The term
22 ‘discrete single-use unit’ means any product con-
23 taining tobacco that—

24 “(A) is not intended to be smoked; and

1 “(B) is in the form of a lozenge, tablet,
2 pill, pouch, dissolvable strip, or other discrete
3 single-use or single-dose unit.”.

4 (4) TAX PARITY FOR SMALL CIGARS.—Para-
5 graph (1) of section 5701(a) of the Internal Revenue
6 Code of 1986 is amended by striking “\$50.33” and
7 inserting “\$100.66”.

8 (5) TAX PARITY FOR LARGE CIGARS.—

9 (A) IN GENERAL.—Paragraph (2) of sec-
10 tion 5701(a) of the Internal Revenue Code of
11 1986 is amended by striking “52.75 percent”
12 and all that follows through the period and in-
13 serting the following: “\$49.56 per pound and a
14 proportionate tax at the like rate on all frac-
15 tional parts of a pound but not less than
16 10.066 cents per cigar.”.

17 (B) GUIDANCE.—The Secretary of the
18 Treasury, or the Secretary’s delegate, may issue
19 guidance regarding the appropriate method for
20 determining the weight of large cigars for pur-
21 poses of calculating the applicable tax under
22 section 5701(a)(2) of the Internal Revenue
23 Code of 1986.

24 (6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO
25 AND CERTAIN PROCESSED TOBACCO.—Subsection (o)

1 of section 5702 of the Internal Revenue Code of
2 1986 is amended by inserting “, and includes proc-
3 essed tobacco that is removed for delivery or deliv-
4 ered to a person other than a person with a permit
5 provided under section 5713, but does not include
6 removals of processed tobacco for exportation” after
7 “wrappers thereof”.

8 (7) CLARIFYING TAX RATE FOR OTHER TO-
9 BACCO PRODUCTS.—

10 (A) IN GENERAL.—Section 5701 of the In-
11 ternal Revenue Code of 1986 is amended by
12 adding at the end the following new subsection:

13 “(i) OTHER TOBACCO PRODUCTS.—Any product not
14 otherwise described under this section that has been deter-
15 mined to be a tobacco product by the Food and Drug Ad-
16 ministration through its authorities under the Family
17 Smoking Prevention and Tobacco Control Act shall be
18 taxed at a level of tax equivalent to the tax rate for ciga-
19 rettes on an estimated per use basis as determined by the
20 Secretary.”.

21 (B) ESTABLISHING PER USE BASIS.—For
22 purposes of section 5701(i) of the Internal Rev-
23 enue Code of 1986, not later than 12 months
24 after the later of the date of the enactment of
25 this Act or the date that a product has been de-

1 terminated to be a tobacco product by the Food
 2 and Drug Administration, the Secretary of the
 3 Treasury (or the Secretary of the Treasury's
 4 delegate) shall issue final regulations estab-
 5 lishing the level of tax for such product that is
 6 equivalent to the tax rate for cigarettes on an
 7 estimated per use basis.

8 (8) CLARIFYING DEFINITION OF TOBACCO
 9 PRODUCTS.—

10 (A) IN GENERAL.—Subsection (c) of sec-
 11 tion 5702 of the Internal Revenue Code of 1986
 12 is amended to read as follows:

13 “(c) TOBACCO PRODUCTS.—The term ‘tobacco prod-
 14 ucts’ means—

15 “(1) cigars, cigarettes, smokeless tobacco, pipe
 16 tobacco, and roll-your-own tobacco, and

17 “(2) any other product subject to tax pursuant
 18 to section 5701(i).”.

19 (B) CONFORMING AMENDMENTS.—Sub-
 20 section (d) of section 5702 of such Code is
 21 amended by striking “cigars, cigarettes, smoke-
 22 less tobacco, pipe tobacco, or roll-your-own to-
 23 bacco” each place it appears and inserting “to-
 24 bacco products”.

25 (9) INCREASING TAX ON CIGARETTES.—

1 (A) SMALL CIGARETTES.—Section
 2 5701(b)(1) of such Code is amended by striking
 3 “\$50.33” and inserting “\$100.66”.

4 (B) LARGE CIGARETTES.—Section
 5 5701(b)(2) of such Code is amended by striking
 6 “\$105.69” and inserting “\$211.38”.

7 (10) TAX RATES ADJUSTED FOR INFLATION.—
 8 Section 5701 of such Code, as amended by sub-
 9 section (g), is amended by adding at the end the fol-
 10 lowing new subsection:

11 “(j) INFLATION ADJUSTMENT.—

12 “(1) IN GENERAL.—In the case of any calendar
 13 year beginning after 2021, the dollar amounts pro-
 14 vided under this chapter shall each be increased by
 15 an amount equal to—

16 “(A) such dollar amount, multiplied by

17 “(B) the cost-of-living adjustment deter-
 18 mined under section 1(f)(3) for the calendar
 19 year, determined by substituting ‘calendar year
 20 2017’ for ‘calendar year 2016’ in subparagraph
 21 (A)(ii) thereof.

22 “(2) ROUNDING.—If any amount as adjusted
 23 under paragraph (1) is not a multiple of \$0.01, such
 24 amount shall be rounded to the next highest multiple
 25 of \$0.01.”.

1 (11) FLOOR STOCKS TAXES.—

2 (A) IMPOSITION OF TAX.—On tobacco
3 products manufactured in or imported into the
4 United States which are removed before any tax
5 increase date and held on such date for sale by
6 any person, there is hereby imposed a tax in an
7 amount equal to the excess of—

8 (i) the tax which would be imposed
9 under section 5701 of the Internal Rev-
10 enue Code of 1986 on the article if the ar-
11 ticle had been removed on such date, over

12 (ii) the prior tax (if any) imposed
13 under section 5701 of such Code on such
14 article.

15 (B) CREDIT AGAINST TAX.—Each person
16 shall be allowed as a credit against the taxes
17 imposed by paragraph (1) an amount equal to
18 \$500. Such credit shall not exceed the amount
19 of taxes imposed by paragraph (1) on such date
20 for which such person is liable.

21 (C) LIABILITY FOR TAX AND METHOD OF
22 PAYMENT.—

23 (i) LIABILITY FOR TAX.—A person
24 holding tobacco products on any tax in-
25 crease date to which any tax imposed by

1 paragraph (1) applies shall be liable for
2 such tax.

3 (ii) METHOD OF PAYMENT.—The tax
4 imposed by paragraph (1) shall be paid in
5 such manner as the Secretary shall pre-
6 scribe by regulations.

7 (iii) TIME FOR PAYMENT.—The tax
8 imposed by paragraph (1) shall be paid on
9 or before the date that is 120 days after
10 the effective date of the tax rate increase.

11 (D) ARTICLES IN FOREIGN TRADE
12 ZONES.—Notwithstanding the Act of June 18,
13 1934 (commonly known as the Foreign Trade
14 Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.),
15 or any other provision of law, any article which
16 is located in a foreign trade zone on any tax in-
17 crease date shall be subject to the tax imposed
18 by paragraph (1) if—

19 (i) internal revenue taxes have been
20 determined, or customs duties liquidated,
21 with respect to such article before such
22 date pursuant to a request made under the
23 1st proviso of section 3(a) of such Act; or

24 (ii) such article is held on such date
25 under the supervision of an officer of the

1 United States Customs and Border Protec-
2 tion of the Department of Homeland Secu-
3 rity pursuant to the 2d proviso of such sec-
4 tion 3(a).

5 (E) DEFINITIONS.—For purposes of this
6 subsection—

7 (i) IN GENERAL.—Any term used in
8 this subsection which is also used in sec-
9 tion 5702 of such Code shall have the
10 same meaning as such term has in such
11 section.

12 (ii) TAX INCREASE DATE.—The term
13 “tax increase date” means the effective
14 date of any increase in any tobacco prod-
15 uct excise tax rate pursuant to the amend-
16 ments made by this section (other than
17 subsection (j) thereof).

18 (iii) SECRETARY.—The term “Sec-
19 retary” means the Secretary of the Treas-
20 ury or the Secretary’s delegate.

21 (F) CONTROLLED GROUPS.—Rules similar
22 to the rules of section 5061(e)(3) of such Code
23 shall apply for purposes of this subsection.

24 (G) OTHER LAWS APPLICABLE.—All provi-
25 sions of law, including penalties, applicable with

1 respect to the taxes imposed by section 5701 of
2 such Code shall, insofar as applicable and not
3 inconsistent with the provisions of this sub-
4 section, apply to the floor stocks taxes imposed
5 by paragraph (1), to the same extent as if such
6 taxes were imposed by such section 5701. The
7 Secretary may treat any person who bore the
8 ultimate burden of the tax imposed by para-
9 graph (1) as the person to whom a credit or re-
10 fund under such provisions may be allowed or
11 made.

12 (12) EFFECTIVE DATES.—

13 (A) IN GENERAL.—Except as provided in
14 paragraphs (2) through (4), the amendments
15 made by this section shall apply to articles re-
16 moved (as defined in section 5702(j) of the In-
17 ternal Revenue Code of 1986) after the last day
18 of the month which includes the date of the en-
19 actment of this Act.

20 (B) DISCRETE SINGLE-USE UNITS AND
21 PROCESSED TOBACCO.—The amendments made
22 by subsections (c)(1)(C), (c)(2), and (f) shall
23 apply to articles removed (as defined in section
24 5702(j) of the Internal Revenue Code of 1986)

1 after the date that is 6 months after the date
2 of the enactment of this Act.

3 (C) LARGE CIGARS.—The amendments
4 made by subsection (e) shall apply to articles
5 removed after December 31, 2021.

6 (D) OTHER TOBACCO PRODUCTS.—The
7 amendments made by subsection (g)(1) shall
8 apply to products removed after the last day of
9 the month which includes the date that the Sec-
10 retary of the Treasury (or the Secretary of the
11 Treasury’s delegate) issues final regulations es-
12 tablishing the level of tax for such product.

13 **SEC. 504. ALLOWING FOR MEDICAL ASSISTANCE UNDER**
14 **MEDICAID FOR INMATES DURING 30-DAY PE-**
15 **RIOD PRECEDING RELEASE.**

16 (a) IN GENERAL.—The subdivision (A) following
17 paragraph (30) of section 1905(a) of the Social Security
18 Act (42 U.S.C. 1396d(a)) is amended by inserting “and
19 except during the 30-day period preceding the date of re-
20 lease of such individual from such public institution” after
21 “medical institution”.

22 (b) REPORT.—Not later than June 30, 2022, the
23 Medicaid and CHIP Payment and Access Commission
24 shall submit a report to Congress on the Medicaid inmate
25 exclusion under the subdivision (A) following paragraph

1 (30) of section 1905(a) of the Social Security Act (42
2 U.S.C. 1396d(a)). Such report may, to the extent prac-
3 ticable, include the following information:

4 (1) The number of incarcerated individuals who
5 would otherwise be eligible to enroll for medical as-
6 sistance under a State plan approved under title
7 XIX of the Social Security Act (42 U.S.C. 1396 et
8 seq.) (or a waiver of such a plan).

9 (2) Access to health care for incarcerated indi-
10 viduals, including a description of medical services
11 generally available to incarcerated individuals.

12 (3) A description of current practices related to
13 the discharge of incarcerated individuals, including
14 how prisons interact with State Medicaid agencies to
15 ensure that such individuals who are eligible to en-
16 roll for medical assistance under a State plan or
17 waiver described in paragraph (1) are so enrolled.

18 (4) If determined appropriate by the Commis-
19 sion, recommendations for Congress, the Depart-
20 ment of Health and Human Services, or States re-
21 garding the Medicaid inmate exclusion.

22 (5) Any other information that the Commission
23 determines would be useful to Congress.

1 **SEC. 505. PROVIDING FOR IMMEDIATE MEDICAID ELIGI-**
2 **BILITY FOR FORMER FOSTER YOUTH.**

3 Section 1002(a)(2) of the SUPPORT for Patients
4 and Communities Act (Public Law 115–271) is amended
5 by striking “January 1, 2023” and inserting “the date
6 of enactment of the Ending Health Disparities During
7 COVID–19 Act of 2020”.

8 **SEC. 506. EXPANDED COVERAGE FOR FORMER FOSTER**
9 **YOUTH.**

10 (a) COVERAGE CONTINUITY FOR FORMER FOSTER
11 CARE CHILDREN UP TO AGE 26.—

12 (1) IN GENERAL.—Section 1002(a)(1)(B) of the
13 SUPPORT for Patients and Communities Act (Pub-
14 lic Law 115–271) is amended by striking all that
15 follows after “item (cc),” and inserting the following:
16 “by striking ‘responsibility of the State’ and all that
17 follows through ‘475(8)(B)(iii); and’ and inserting
18 ‘responsibility of a State on the date of attaining 18
19 years of age (or such higher age as such State has
20 elected under section 475(8)(B)(iii)), or who were in
21 such care at any age but subsequently left such care
22 to enter into a legal guardianship with a kinship
23 caregiver (without regard to whether kinship guard-
24 ianship payments are being made on behalf of the
25 child under this part) or were emancipated from
26 such care prior to attaining age 18;’”.

1 (2) AMENDMENTS TO SOCIAL SECURITY ACT.—

2 (A) IN GENERAL.—Section
3 1902(a)(10)(A)(i)(IX) of the Social Security
4 Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as
5 amended by section 1002(a) of the SUPPORT
6 for Patients and Communities Act (Public Law
7 115–271), is amended—

8 (i) in item (bb), by striking the semi-
9 colon at the end and inserting “; and”; and

10 (ii) by striking item (dd).

11 (B) EFFECTIVE DATE.—The amendments
12 made by this paragraph shall take effect on
13 January 1, 2023.

14 (b) OUTREACH EFFORTS FOR ENROLLMENT OF
15 FORMER FOSTER CHILDREN.—Section 1902(a) of the So-
16 cial Security Act (42 U.S.C. 1396a(a)) is amended—

17 (1) in paragraph (85), by striking “; and” and
18 inserting a semicolon;

19 (2) in paragraph (86), by striking the period at
20 the end and inserting “; and”; and

21 (3) by inserting after paragraph (86) the fol-
22 lowing new paragraph:

23 “(87) not later than January 1, 2020, establish
24 an outreach and enrollment program, in coordination
25 with the State agency responsible for administering

1 the State plan under part E of title IV and any
 2 other appropriate or interested agencies, designed to
 3 increase the enrollment of individuals who are eligi-
 4 ble for medical assistance under the State plan
 5 under paragraph (10)(A)(i)(IX) in accordance with
 6 best practices established by the Secretary.”.

7 **SEC. 507. REMOVING CITIZENSHIP AND IMMIGRATION BAR-**
 8 **RIERS TO ACCESS TO AFFORDABLE HEALTH**
 9 **CARE UNDER ACA.**

10 (a) IN GENERAL.—

11 (1) PREMIUM TAX CREDITS.—Section 36B of
 12 the Internal Revenue Code of 1986 is amended—

13 (A) in subsection (c)(1)(B)—

14 (i) by amending the heading to read
 15 as follows: “SPECIAL RULE FOR CERTAIN
 16 INDIVIDUALS INELIGIBLE FOR MEDICAID
 17 DUE TO STATUS”, and

18 (ii) in clause (ii), by striking “lawfully
 19 present in the United States, but” and in-
 20 serting “who”, and

21 (B) by striking subsection (e).

22 (2) COST-SHARING REDUCTIONS.—Section 1402
 23 of the Patient Protection and Affordable Care Act
 24 (42 U.S.C. 18071) is amended by striking sub-
 25 section (e).

1 (3) BASIC HEALTH PROGRAM ELIGIBILITY.—
2 Section 1331(e)(1)(B) of the Patient Protection and
3 Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is
4 amended by striking “lawfully present in the United
5 States”.

6 (4) RESTRICTIONS ON FEDERAL PAYMENTS.—
7 Section 1412 of the Patient Protection and Afford-
8 able Care Act (42 U.S.C. 18082) is amended by
9 striking subsection (d).

10 (5) REQUIREMENT TO MAINTAIN MINIMUM ES-
11 SENTIAL COVERAGE.—Section 5000A(d) of the In-
12 ternal Revenue Code of 1986 is amended by striking
13 paragraph (3) and by redesignating paragraph (4)
14 as paragraph (3).

15 (b) CONFORMING AMENDMENTS.—

16 (1) Section 1411(a) of the Patient Protection
17 and Affordable Care Act (42 U.S.C. 18081(a)) is
18 amended by striking paragraph (1) and redesign-
19 ating paragraphs (2), (3), and (4) as paragraphs
20 (1), (2), and (3), respectively.

21 (2) Section 1312(f) of the Patient Protection
22 and Affordable Care Act (42 U.S.C. 18032(f)) is
23 amended—

1 (A) in the heading, by striking “; ACCESS
2 LIMITED TO CITIZENS AND LAWFUL RESI-
3 DENTS”; and

4 (B) by striking paragraph (3).

5 **SEC. 508. MEDICAID IN THE TERRITORIES.**

6 (a) ELIMINATION OF GENERAL MEDICAID FUNDING
7 LIMITATIONS (“CAP”) FOR TERRITORIES.—

8 (1) IN GENERAL.—Section 1108 of the Social
9 Security Act (42 U.S.C. 1308) is amended—

10 (A) in subsection (f), in the matter pre-
11 ceding paragraph (1), by striking “subsection
12 (g)” and inserting “subsections (g) and (h)”;

13 (B) in subsection (g)(2), in the matter pre-
14 ceding subparagraph (A), by inserting “and
15 subsection (h)” after “paragraphs (3) and (5)”;
16 and

17 (C) by adding at the end the following new
18 subsection:

19 “(h) SUNSET OF MEDICAID FUNDING LIMITATIONS
20 FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE
21 UNITED STATES, GUAM, THE NORTHERN MARIANA IS-
22 LANDS, AND AMERICAN SAMOA.—Subsections (f) and (g)
23 shall not apply to Puerto Rico, the Virgin Islands of the
24 United States, Guam, the Northern Mariana Islands, and
25 American Samoa beginning with fiscal year 2020.”.

1 (2) CONFORMING AMENDMENTS.—

2 (A) Section 1902(j) of the Social Security
3 Act (42 U.S.C. 1396a(j)) is amended by strik-
4 ing “, the limitation in section 1108(f),”.

5 (B) Section 1903(u) of the Social Security
6 Act (42 U.S.C. 1396b(u)) is amended by strik-
7 ing paragraph (4).

8 (C) Section 1323(c)(1) of the Patient Pro-
9 tection and Affordable Care Act (42 U.S.C.
10 18043(c)(1)) is amended by striking “2019”
11 and inserting “2018”.

12 (3) EFFECTIVE DATE.—The amendments made
13 by this section shall apply beginning with fiscal year
14 2021.

15 (b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL
16 ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR
17 TERRITORIES.—Section 1905(b) of the Social Security
18 Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by
19 inserting “for fiscal years before fiscal year 2020” after
20 “American Samoa”.

21 (c) APPLICATION OF MEDICAID WAIVER AUTHORITY
22 TO ALL OF THE TERRITORIES.—

23 (1) IN GENERAL.—Section 1902(j) of the Social
24 Security Act (42 U.S.C. 1396a(j)) is amended—

1 (A) by striking “American Samoa and the
2 Northern Mariana Islands” and inserting
3 “Puerto Rico, the Virgin Islands of the United
4 States, Guam, the Northern Mariana Islands,
5 and American Samoa”;

6 (B) by striking “American Samoa or the
7 Northern Mariana Islands” and inserting
8 “Puerto Rico, the Virgin Islands of the United
9 States, Guam, the Northern Mariana Islands,
10 or American Samoa”;

11 (C) by inserting “(1)” after “(j)”;

12 (D) by inserting “except as otherwise pro-
13 vided in this subsection,” after “Notwith-
14 standing any other requirement of this title”;
15 and

16 (E) by adding at the end the following:

17 “(2) The Secretary may not waive under this
18 subsection the requirement of subsection
19 (a)(10)(A)(i)(IX) (relating to coverage of adults for-
20 merly under foster care) with respect to any terri-
21 tory.”.

22 (2) EFFECTIVE DATE.—The amendments made
23 by this section shall apply beginning October 1,
24 2021.

1 (d) PERMITTING MEDICAID DSH ALLOTMENTS FOR
2 TERRITORIES.—Section 1923(f) of the Social Security Act
3 (42 U.S.C. 1396r–4) is amended—

4 (1) in paragraph (6), by adding at the end the
5 following new subparagraph:

6 “(C) TERRITORIES.—

7 “(i) FISCAL YEAR 2020.—For fiscal
8 year 2020, the DSH allotment for Puerto
9 Rico, the Virgin Islands of the United
10 States, Guam, the Northern Mariana Is-
11 lands, and American Samoa shall bear the
12 same ratio to \$300,000,000 as the ratio of
13 the number of individuals who are low-in-
14 come or uninsured and residing in such re-
15 spective territory (as estimated from time
16 to time by the Secretary) bears to the
17 sums of the number of such individuals re-
18 siding in all of the territories.

19 “(ii) SUBSEQUENT FISCAL YEAR.—
20 For each subsequent fiscal year, the DSH
21 allotment for each such territory is subject
22 to an increase in accordance with para-
23 graph (2).”; and

24 (2) in paragraph (9), by inserting before the pe-
25 riod at the end the following: “, and includes, begin-

1 ning with fiscal year 2021, Puerto Rico, the Virgin
 2 Islands of the United States, Guam, the Northern
 3 Mariana Islands, and American Samoa”.

4 **SEC. 509. REMOVING MEDICARE BARRIER TO HEALTH**
 5 **CARE.**

6 (a) PART A.—Section 1818(a)(3) of the Social Secu-
 7 rity Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking
 8 “an alien” and all that follows through “under this sec-
 9 tion” and inserting “an individual who is lawfully present
 10 in the United States”.

11 (b) PART B.—Section 1836(2) of the Social Security
 12 Act (42 U.S.C. 1395o(2)) is amended by striking “an
 13 alien” and all that follows through “under this part” and
 14 inserting “an individual who is lawfully present in the
 15 United States”.

16 **SEC. 510. REMOVING BARRIERS TO HEALTH CARE AND NU-**
 17 **TRITION ASSISTANCE FOR CHILDREN, PREG-**
 18 **NANT PERSONS, AND LAWFULLY PRESENT IN-**
 19 **DIVIDUALS.**

20 (a) MEDICAID.—Section 1903(v) of the Social Secu-
 21 rity Act (42 U.S.C. 1396b(v)) is amended by striking
 22 paragraph (4) and inserting the following new paragraph:
 23 “(4)(A) Notwithstanding sections 401(a), 402(b),
 24 403, and 421 of the Personal Responsibility and Work Op-
 25 portunity Reconciliation Act of 1996 and paragraph (1),

1 payment shall be made to a State under this section for
2 medical assistance furnished to an alien under this title
3 (including an alien described in such paragraph) who
4 meets any of the following conditions:

5 “(i) The alien is otherwise eligible for such as-
6 sistance under the State plan approved under this
7 title (other than the requirement of the receipt of
8 aid or assistance under title IV, supplemental secu-
9 rity income benefits under title XVI, or a State sup-
10 plementary payment) within either or both of the
11 following eligibility categories:

12 “(I) Children under 21 years of age, in-
13 cluding any optional targeted low-income child
14 (as such term is defined in section
15 1905(u)(2)(B)).

16 “(II) Pregnant persons during pregnancy
17 and during the 12-month period beginning on
18 the last day of the pregnancy.

19 “(ii) The alien is lawfully present in the United
20 States.

21 “(B) No debt shall accrue under an affidavit of sup-
22 port against any sponsor of an alien who meets the condi-
23 tions specified in subparagraph (A) on the basis of the
24 provision of medical assistance to such alien under this

1 paragraph and the cost of such assistance shall not be con-
2 sidered as an unreimbursed cost.”.

3 (b) SCHIP.—Subparagraph (N) of section
4 2107(e)(1) of the Social Security Act (42 U.S.C.
5 1397gg(e)(1)) is amended to read as follows:

6 “(N) Paragraph (4) of section 1903(v) (re-
7 lating to coverage of categories of children,
8 pregnant persons, and other lawfully present in-
9 dividuals).”.

10 (c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Not-
11 withstanding sections 401(a), 402(a), and 403(a) of the
12 Personal Responsibility and Work Opportunity Reconcili-
13 ation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a))
14 and section 6(f) of the Food and Nutrition Act of 2008
15 (7 U.S.C. 2015(f)), persons who are lawfully present in
16 the United States shall be not be ineligible for benefits
17 under the supplemental nutrition assistance program on
18 the basis of their immigration status or date of entry into
19 the United States.

20 (d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—
21 Section 421(d)(3) of the Personal Responsibility and
22 Work Opportunity Reconciliation Act of 1996 (8 U.S.C.
23 1631(d)(3)) is amended by striking “to the extent that
24 a qualified alien is eligible under section 402(a)(2)(J)”
25 and inserting, “to the extent that a child is a member of

1 a household under the supplemental nutrition assistance
2 program”.

3 (e) ENSURING PROPER SCREENING.—Section
4 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7
5 U.S.C. 2020(e)(2)(B)) is amended—

6 (1) by redesignating clauses (vi) and (vii) as
7 clauses (vii) and (viii); and

8 (2) by inserting after clause (v) the following:

9 “(vi) shall provide a method for imple-
10 menting section 421 of the Personal Re-
11 sponsibility and Work Opportunity Rec-
12 onciliation Act of 1996 (8 U.S.C. 1631)
13 that does not require any unnecessary in-
14 formation from persons who may be ex-
15 empt from that provision;”.

16 **SEC. 511. REPEAL OF REQUIREMENT FOR DOCUMENTA-**
17 **TION EVIDENCING CITIZENSHIP OR NATION-**
18 **ALITY UNDER THE MEDICAID PROGRAM.**

19 (a) REPEAL.—Subsections (i)(22) and (x) of section
20 1903 of the Social Security Act (42 U.S.C. 1396b) are
21 each repealed.

22 (b) CONFORMING AMENDMENTS.—

23 (1) STATE PAYMENTS FOR MEDICAL ASSIST-
24 ANCE.—Section 1902 of the Social Security Act (42
25 U.S.C. 1396a) is amended—

1 (A) by amending paragraph (46) of sub-
2 section (a) to read as follows:

3 “(46) provide that information is requested and
4 exchanged for purposes of income and eligibility
5 verification in accordance with a State system which
6 meets the requirements of section 1137 of this
7 Act;”;

8 (B) in subsection (e)(13)(A)(i)—

9 (i) in the matter preceding subclause
10 (I), by striking “sections 1902(a)(46)(B)
11 and 1137(d)” and inserting “section
12 1137(d)”; and

13 (ii) in subclause (IV), by striking
14 “1902(a)(46)(B) or”; and

15 (C) by striking subsection (ee).

16 (2) PAYMENT TO STATES.—Section 1903 of the
17 Social Security Act (42 U.S.C. 1396b) is amended—

18 (A) in subsection (i), by redesignating
19 paragraphs (23) through (26) as paragraphs
20 (22) through (25), respectively; and

21 (B) by redesignating subsections (y) and
22 (z) as subsections (x) and (y), respectively.

23 (3) REPEAL.—Subsection (c) of section 6036 of
24 the Deficit Reduction Act of 2005 (42 U.S.C. 1396b
25 note) is repealed.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect as if included in the enact-
3 ment of the Deficit Reduction Act of 2005.

4 **TITLE VI—COMMUNITY BASED**
5 **GRANTS**

6 **SEC. 601. GRANTS FOR RACIAL AND ETHNIC APPROACHES**
7 **TO COMMUNITY HEALTH.**

8 (a) PURPOSE.—It is the purpose of this section to
9 award grants to assist communities in mobilizing and or-
10 ganizing resources in support of effective and sustainable
11 programs that will reduce or eliminate disparities in health
12 and health care experienced by racial and ethnic minority
13 individuals.

14 (b) AUTHORITY TO AWARD GRANTS.—The Secretary
15 of Health and Human Services, acting through the Ad-
16 ministrator of the Health Resources and Services Admin-
17 istration (referred to in this section as the “Secretary”),
18 shall award grants to eligible entities to assist in design-
19 ing, implementing, and evaluating culturally and linguis-
20 tically appropriate, science-based, and community-driven
21 sustainable strategies to eliminate racial and ethnic health
22 and health care disparities.

23 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
24 grant under this section, an entity shall—

25 (1) represent a coalition—

1 (A) whose principal purpose is to develop
2 and implement interventions to reduce or elimi-
3 nate a health or health care disparity in a tar-
4 geted racial or ethnic minority group in the
5 community served by the coalition; and

6 (B) that includes—

7 (i) members selected from among—

8 (I) public health departments;

9 (II) community-based organiza-
10 tions;

11 (III) university and research or-
12 ganizations;

13 (IV) Indian tribes or tribal orga-
14 nizations (as such terms are defined
15 in section 4 of the Indian Self-Deter-
16 mination and Education Assistance
17 Act (25 U.S.C. 5304)), the Indian
18 Health Service, or any other organiza-
19 tion that serves Alaska Natives; and

20 (V) interested public or private
21 health care providers or organizations
22 as determined appropriate by the Sec-
23 retary; and

24 (ii) at least 1 member from a commu-
25 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 health issues such
13 as infant mortality, breast and cervical cancer
14 screening and management, musculoskeletal
15 diseases and obesity, prostate cancer screening
16 and management, cardiovascular disease, diabe-
17 tes, child and adult immunization levels, oral
18 disease, or other health priority areas as des-
19 ignated by the Secretary; and

20 (C) a demonstration of a proven record of
21 accomplishment of the coalition members in
22 serving and working with the targeted commu-
23 nity.

24 (d) SUSTAINABILITY.—The Secretary shall give pri-
25 ority to an eligible entity under this section if the entity

1 agrees that, with respect to the costs to be incurred by
2 the entity in carrying out the activities for which the grant
3 was awarded, the entity (and each of the participating
4 partners in the coalition represented by the entity) will
5 maintain its expenditures of non-Federal funds for such
6 activities at a level that is not less than the level of such
7 expenditures during the fiscal year immediately preceding
8 the first fiscal year for which the grant is awarded.

9 (e) NONDUPLICATION.—Any funds provided to an eli-
10 gible entity through a grant under this section shall—

11 (1) supplement, not supplant, any other Federal
12 funds made available to the entity for the purposes
13 of this section; and

14 (2) not be used to duplicate the activities of any
15 other health disparity grant program under this Act,
16 including an amendment made by this Act.

17 (f) TECHNICAL ASSISTANCE.—The Secretary may,
18 either directly or by grant or contract, provide any entity
19 that receives a grant under this section with technical and
20 other nonfinancial assistance necessary to meet the re-
21 quirements of this section.

22 (g) DISSEMINATION.—The Secretary shall encourage
23 and enable eligible entities receiving grants under this sec-
24 tion to share best practices, evaluation results, and reports
25 with communities not affiliated with such entities, by

1 using the Internet, conferences, and other pertinent infor-
2 mation regarding the projects funded by this section, in-
3 cluding through using outreach efforts of the Office of Mi-
4 nority Health and the Centers for Disease Control and
5 Prevention.

6 (h) ADMINISTRATIVE BURDENS.—The Secretary
7 shall make every effort to minimize duplicative or unneces-
8 sary administrative burdens on eligible entities receiving
9 grants under this section.

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

13 **SEC. 602. GRANTS TO PROMOTE HEALTH FOR UNDER-**
14 **SERVED COMMUNITIES.**

15 Part Q of title III of the Public Health Service Act
16 (42 U.S.C. 280g et seq.) is amended by adding at the end
17 the following:

18 **“SEC. 399Z-3. GRANTS TO PROMOTE HEALTH FOR UNDER-**
19 **SERVED COMMUNITIES.**

20 “(a) GRANTS AUTHORIZED.—The Secretary, in col-
21 laboration with the Administrator of the Health Resources
22 and Services Administration and other Federal officials
23 determined appropriate by the Secretary, is authorized to
24 award grants to eligible entities—

1 “(1) to promote health for underserved commu-
2 nities, with preference given to projects that benefit
3 racial and ethnic minority women, racial and ethnic
4 minority children, adolescents, and lesbian, gay, bi-
5 sexual, transgender, queer, or questioning commu-
6 nities; and

7 “(2) to strengthen health outreach initiatives in
8 medically underserved communities, including lin-
9 guistically isolated populations.

10 “(b) USE OF FUNDS.—Grants awarded pursuant to
11 subsection (a) may be used to support the activities of
12 community health workers, including such activities—

13 “(1) to educate and provide outreach regarding
14 enrollment in health insurance including the State
15 Children’s Health Insurance Program under title
16 XXI of the Social Security Act, Medicare under title
17 XVIII of such Act, and Medicaid under title XIX of
18 such Act;

19 “(2) to educate and provide outreach in a com-
20 munity setting regarding health problems prevalent
21 among underserved communities, and especially
22 among racial and ethnic minority women, racial and
23 ethnic minority children, adolescents, and lesbian,
24 gay, bisexual, transgender, queer, or questioning
25 communities;

1 “(3) to educate and provide experiential learn-
2 ing opportunities and target risk factors and healthy
3 behaviors that impede or contribute to achieving
4 positive health outcomes, including—

5 “(A) healthy nutrition;

6 “(B) physical activity;

7 “(C) overweight or obesity;

8 “(D) tobacco use, including the use of e-
9 cigarettes and vaping;

10 “(E) alcohol and substance use;

11 “(F) injury and violence;

12 “(G) sexual health;

13 “(H) mental health;

14 “(I) musculoskeletal health and arthritis;

15 “(J) prenatal and postnatal care;

16 “(K) dental and oral health;

17 “(L) understanding informed consent;

18 “(M) stigma; and

19 “(N) environmental hazards;

20 “(4) to promote community wellness and aware-
21 ness; and

22 “(5) to educate and refer target populations to
23 appropriate health care agencies and community-
24 based programs and organizations in order to in-

1 crease access to quality health care services, includ-
2 ing preventive health services.

3 “(c) APPLICATION.—

4 “(1) IN GENERAL.—Each eligible entity that
5 desires to receive a grant under subsection (a) shall
6 submit an application to the Secretary, at such time,
7 in such manner, and accompanied by such additional
8 information as the Secretary may require.

9 “(2) CONTENTS.—Each application submitted
10 pursuant to paragraph (1) shall—

11 “(A) describe the activities for which as-
12 sistance under this section is sought;

13 “(B) contain an assurance that, with re-
14 spect to each community health worker pro-
15 gram receiving funds under the grant awarded,
16 such program provides in-language training and
17 supervision to community health workers to en-
18 able such workers to provide authorized pro-
19 gram activities in (at least) the most commonly
20 used languages within a particular geographic
21 region;

22 “(C) contain an assurance that the appli-
23 cant will evaluate the effectiveness of commu-
24 nity health worker programs receiving funds
25 under the grant;

1 “(D) contain an assurance that each com-
2 munity health worker program receiving funds
3 under the grant will provide culturally com-
4 petent services in the linguistic context most
5 appropriate for the individuals served by the
6 program;

7 “(E) contain a plan to document and dis-
8 seminate project descriptions and results to
9 other States and organizations as identified by
10 the Secretary; and

11 “(F) describe plans to enhance the capac-
12 ity of individuals to utilize health services and
13 health-related social services under Federal,
14 State, and local programs by—

15 “(i) assisting individuals in estab-
16 lishing eligibility under the programs and
17 in receiving the services or other benefits
18 of the programs; and

19 “(ii) providing other services, as the
20 Secretary determines to be appropriate,
21 which may include transportation and
22 translation services.

23 “(d) PRIORITY.—In awarding grants under sub-
24 section (a), the Secretary shall give priority to those appli-
25 cants—

1 “(1) who propose to target geographic areas
2 that—

3 “(A)(i) have a high percentage of residents
4 who are uninsured or underinsured (if the tar-
5 geted geographic area is located in a State that
6 has elected to make medical assistance available
7 under section 1902(a)(10)(A)(i)(VIII) of the
8 Social Security Act to individuals described in
9 such section);

10 “(ii) have a high percentage of under-
11 insured residents in a particular geographic
12 area (if the targeted geographic area is located
13 in a State that has not so elected); or

14 “(iii) have a high number of households ex-
15 periencing extreme poverty; and

16 “(B) have a high percentage of families for
17 whom English is not their primary language or
18 including smaller limited English-proficient
19 communities within the region that are not oth-
20 erwise reached by linguistically appropriate
21 health services;

22 “(2) with experience in providing health or
23 health-related social services to individuals who are
24 underserved with respect to such services; and

1 “(3) with documented community activity and
2 experience with community health workers.

3 “(e) COLLABORATION WITH ACADEMIC INSTITU-
4 TIONS.—The Secretary shall encourage community health
5 worker programs receiving funds under this section to col-
6 laborate with academic institutions, including minority-
7 serving institutions. Nothing in this section shall be con-
8 strued to require such collaboration.

9 “(f) QUALITY ASSURANCE AND COST EFFECTIVE-
10 NESS.—The Secretary shall establish guidelines for ensur-
11 ing the quality of the training and supervision of commu-
12 nity health workers under the programs funded under this
13 section and for ensuring the cost effectiveness of such pro-
14 grams.

15 “(g) MONITORING.—The Secretary shall monitor
16 community health worker programs identified in approved
17 applications and shall determine whether such programs
18 are in compliance with the guidelines established under
19 subsection (f).

20 “(h) TECHNICAL ASSISTANCE.—The Secretary may
21 provide technical assistance to community health worker
22 programs identified in approved applications with respect
23 to planning, developing, and operating programs under the
24 grant.

25 “(i) REPORT TO CONGRESS.—

1 “(1) IN GENERAL.—Not later than 4 years
2 after the date on which the Secretary first awards
3 grants under subsection (a), the Secretary shall sub-
4 mit to Congress a report regarding the grant
5 project.

6 “(2) CONTENTS.—The report required under
7 paragraph (1) shall include the following:

8 “(A) A description of the programs for
9 which grant funds were used.

10 “(B) The number of individuals served.

11 “(C) An evaluation of—

12 “(i) the effectiveness of these pro-
13 grams;

14 “(ii) the cost of these programs; and

15 “(iii) the impact of these programs on
16 the health outcomes of the community resi-
17 dents.

18 “(D) Recommendations for sustaining the
19 community health worker programs developed
20 or assisted under this section.

21 “(E) Recommendations regarding training
22 to enhance career opportunities for community
23 health workers.

24 “(j) DEFINITIONS.—In this section:

1 “(1) COMMUNITY HEALTH WORKER.—The term
2 ‘community health worker’ means an individual who
3 promotes health or nutrition within the community
4 in which the individual resides—

5 “(A) by serving as a liaison between com-
6 munities and health care agencies;

7 “(B) by providing guidance and social as-
8 sistance to community residents;

9 “(C) by enhancing community residents’
10 ability to effectively communicate with health
11 care providers;

12 “(D) by providing culturally and linguis-
13 tically appropriate health or nutrition edu-
14 cation;

15 “(E) by advocating for individual and com-
16 munity health, including dental, oral, mental,
17 and environmental health, or nutrition needs;

18 “(F) by taking into consideration the
19 needs of the communities served, including the
20 prevalence rates of risk factors that impede
21 achieving positive healthy outcomes among
22 women and children, especially among racial
23 and ethnic minority women and children; and

24 “(G) by providing referral and followup
25 services.

1 “(2) COMMUNITY SETTING.—The term ‘commu-
2 nity setting’ means a home or a community organi-
3 zation that serves a population.

4 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
5 tity’ means—

6 “(A) a unit of State, territorial, local, or
7 Tribal government (including a federally recog-
8 nized Tribe or Alaska Native village); or

9 “(B) a community-based organization.

10 “(4) MEDICALLY UNDERSERVED COMMUNITY.—
11 The term ‘medically underserved community’ means
12 a community—

13 “(A) that has a substantial number of in-
14 dividuals who are members of a medically un-
15 derserved population, as defined by section
16 330(b)(3);

17 “(B) a significant portion of which is a
18 health professional shortage area as designated
19 under section 332; and

20 “(C) that includes populations that are lin-
21 guistically isolated, such as geographic areas
22 with a shortage of health professionals able to
23 provide linguistically appropriate services.

24 “(5) SUPPORT.—The term ‘support’ means the
25 provision of training, supervision, and materials

1 needed to effectively deliver the services described in
2 subsection (b), reimbursement for services, and
3 other benefits.

4 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 \$15,000,000 for each of fiscal years 2021 through 2025.”.

7 **SEC. 603. ADDRESSING COVID-19 HEALTH INEQUITIES AND**
8 **IMPROVING HEALTH EQUITY.**

9 (a) IN GENERAL.—Not later than 60 days after the
10 date of enactment of this Act, the Secretary of Health and
11 Human Services (referred to in this section as the “Sec-
12 retary”), acting through the Director of the Centers for
13 Disease Control and Prevention, shall award grants to eli-
14 gible entities to establish or expand programs to improve
15 health equity regarding COVID-19 and reduce or elimi-
16 nate inequities, including racial and ethnic inequities, in
17 the incidence, prevalence, and health outcomes of COVID-
18 19.

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

21 (1) be a nongovernmental entity or consortium
22 of entities that works to improve health and health
23 equity in populations or communities disproportion-
24 ately affected by adverse health outcomes, includ-
25 ing—

1 (A) racial and ethnic minority commu-
2 nities;

3 (B) Indian Tribes, Tribal organizations,
4 and urban Indian organizations;

5 (C) people with disabilities;

6 (D) English language learners;

7 (E) older adults;

8 (F) low-income communities;

9 (G) justice-involved communities;

10 (H) immigrant communities; and

11 (I) communities on the basis of their sex-
12 ual orientation or gender identity;

13 (2) have demonstrated experience in success-
14 fully working in and partnering with such commu-
15 nities, and have an established record of accomplish-
16 ment in improving health outcomes or preventing,
17 reducing or eliminating health inequities, including
18 racial and ethnic inequities, in those communities;

19 (3) communicate with State, local, and Tribal
20 health departments to coordinate grant activities, as
21 appropriate; and

22 (4) submit to the Secretary an application at
23 such time, in such manner, and containing such in-
24 formation as the Secretary may require.

1 (c) USE OF FUNDS.—An entity shall use amounts re-
2 ceived under grant under this section to establish, improve
3 upon, or expand programs to improve health equity re-
4 garding COVID–19 and reduce or eliminate inequities, in-
5 cluding racial and ethnic inequities, in the incidence, prev-
6 alence, and health outcomes of COVID–19. Such uses may
7 include—

8 (1) acquiring and distributing medical supplies,
9 such as personal protective equipment, to commu-
10 nities that are at an increased risk of COVID–19;

11 (2) helping people enroll in a health insurance
12 plan that meets minimum essential coverage;

13 (3) increasing the availability of COVID–19
14 testing and any future COVID–19 treatments or
15 vaccines in communities that are at an increased
16 risk of COVID–19;

17 (4) aiding communities and individuals in fol-
18 lowing guidelines and best practices in regards to
19 COVID–19, including physical distancing guidelines;

20 (5) helping communities and COVID–19 sur-
21 vivors recover and cope with the long-term health
22 impacts of COVID–19;

23 (6) addressing social determinants of health,
24 such as transportation, nutrition, housing, discrimi-
25 nation, health care access, including mental health

1 care and substance use disorder prevention, treat-
2 ment, and recovery, health literacy, employment sta-
3 tus, and working conditions, education, income, and
4 stress, that impact COVID–19 incidence, prevalence,
5 and health outcomes, and facilitating or providing
6 access to needed services;

7 (7) the provision of anti-racism and implicit
8 and explicit bias training for health care providers
9 and other relevant professionals;

10 (8) creating and disseminating culturally in-
11 formed, linguistically appropriate, accessible, and
12 medically accurate outreach and education regarding
13 COVID–19;

14 (9) acquiring, retaining, and training a diverse
15 workforce; and

16 (10) improving the accessibility to health care,
17 including accessibility to health care providers, men-
18 tal health care, and COVID–19 testing for people
19 with disabilities.

20 (d) ADMINISTRATION.—

21 (1) PRIORITY.—In awarding grants under this
22 section, the Secretary shall give priority to eligible
23 entities that are a community-based organization or
24 have an established history of successfully working
25 in and partnering with the community or with popu-

1 lations which the entity intends to provide services
2 under the grant. The Secretary shall also utilize
3 available demographic data to give priority to eligible
4 entities working with populations or communities
5 disproportionately affected by COVID–19.

6 (2) GEOGRAPHICAL DIVERSITY.—The Secretary
7 shall seek to ensure geographical diversity among
8 grant recipients.

9 (3) REDUCTION OF BURDENS.—In admin-
10 istering the grant program under this section, the
11 Secretary shall make every effort to minimize unnec-
12 essary administrative burdens on eligible entities re-
13 ceiving such grants.

14 (4) TECHNICAL ASSISTANCE.—The Secretary
15 shall provide technical assistance to eligible entities
16 on best practices for applying grants under this sec-
17 tion.

18 (e) DURATION.—A grant awarded under this section
19 shall be for a period of 3 years.

20 (f) REPORTING.—

21 (1) BY GRANTEE.—Not later than 180 days
22 after the end of a grant period under this section,
23 the grantee shall submit to the Secretary a report on
24 the activities conducted under the grant, including—

1 (A) a description of the impact of grant
2 activities, including on—

3 (i) outreach and education related to
4 COVID–19; and

5 (ii) improving public health activities
6 related to COVID–19, including physical
7 distancing;

8 (B) the number of individuals reached by
9 the activities under the grant and, to the extent
10 known, the disaggregated demographic data of
11 such individuals, such as by race, ethnicity, sex
12 (including sexual orientation and gender iden-
13 tity), income, disability status, or primary lan-
14 guage; and

15 (C) any other information the Secretary
16 determines is necessary.

17 (2) BY SECRETARY.—Not later than 1 year
18 after the end of the grant program under this sec-
19 tion, the Secretary shall submit to Congress a report
20 on the grant program, including a summary of the
21 information gathered under paragraph (1).

22 (g) SUPPLEMENT, NOT SUPPLANT.—Grants awarded
23 under this Act shall be used to supplement and not sup-
24 plant any other Federal funds made available to carry out
25 the activities described in this Act.

1 (h) FUNDING.—Out of funds in the Treasury not oth-
2 erwise appropriated, there are appropriated to carry out
3 this section, \$500,000,000 for each of fiscal years 2020
4 through 2022.

5 **SEC. 604. IMPROVING SOCIAL DETERMINANTS OF HEALTH.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) Healthy People 2020 defines social deter-
8 minants of health as conditions in the environments
9 in which people live, learn, work, play, worship, and
10 age that affect a wide range of health, functioning,
11 and quality-of-life outcomes and risks.

12 (2) One of the overarching goals of Healthy
13 People 2020 is to “create social and physical envi-
14 ronments that promote good health for all”.

15 (3) Healthy People 2020 developed a “place-
16 based” organizing framework, reflecting five key
17 areas of social determinants of health namely—

18 (A) economic stability;

19 (B) education;

20 (C) social and community context;

21 (D) health and health care; and

22 (E) neighborhood and built environment.

23 (4) It is estimated that medical care accounts
24 for only 10 to 20 percent of the modifiable contribu-
25 tors to healthy outcomes for a population.

1 (5) The Centers for Medicare & Medicaid Serv-
2 ices has indicated the importance of the social deter-
3 minants in its work stating that, “As we seek to fos-
4 ter innovation, rethink rural health, find solutions to
5 the opioid epidemic, and continue to put patients
6 first, we need to take into account social deter-
7 minants of health and recognize their importance.”.

8 (6) The Department of Health and Human
9 Services’ Public Health 3.0 initiative recognizes the
10 role of public health in working across sectors on so-
11 cial determinants of health, as well as the role of
12 public health as chief health strategist in commu-
13 nities.

14 (7) Through its Health Impact in 5 Years ini-
15 tiative, the Centers for Disease Control and Preven-
16 tion has highlighted nonclinical, community-wide ap-
17 proaches that show positive health impacts, results
18 within five years, and cost effectiveness or cost sav-
19 ings over the lifetime of the population or earlier.

20 (8) Health departments and the Centers for
21 Disease Control and Prevention are not funded for
22 such cross-cutting work.

23 (9) Providing grants to public health depart-
24 ments and other eligible entities to coordinate cross-
25 sector collaboration will allow a community-wide, evi-

1 dence-based approach to address underlying social
2 determinants of health.

3 (b) SOCIAL DETERMINANTS OF HEALTH PRO-
4 GRAM.—

5 (1) PROGRAM.—To the extent and in the
6 amounts made available in advance in appropriations
7 Acts, the Director of the Centers for Disease Control
8 and Prevention (in this section referred to as the
9 “Director”) shall carry out a program, to be known
10 as the Social Determinants of Health Program (in
11 this section referred to as the “Program”), to
12 achieve the following goals:

13 (A) Improve health outcomes and reduce
14 health inequities by coordinating social deter-
15 minants of health activities across the Centers
16 for Disease Control and Prevention.

17 (B) Improve the capacity of public health
18 agencies and community organizations to ad-
19 dress social determinants of health in commu-
20 nities.

21 (2) ACTIVITIES.—To achieve the goals listed in
22 paragraph (1), the Director shall carry out activities
23 including the following:

24 (A) Coordinating across the Centers for
25 Disease Control and Prevention to ensure that

1 relevant programs consider and incorporate so-
2 cial determinants of health in grant awards and
3 other activities.

4 (B) Awarding grants under subsection (c)
5 to State, local, territorial, and Tribal health
6 agencies and organizations, and to other eligible
7 entities, to address social determinants of
8 health in target communities.

9 (C) Awarding grants under subsection (d)
10 to nonprofit organizations and public or other
11 nonprofit institutions of higher education—

12 (i) to conduct research on best prac-
13 tices to improve social determinants of
14 health;

15 (ii) to provide technical assistance,
16 training, and evaluation assistance to
17 grantees under subsection (c); and

18 (iii) to disseminate best practices to
19 grantees under subsection (c).

20 (D) Coordinating, supporting, and aligning
21 activities of the Centers for Disease Control and
22 Prevention related to social determinants of
23 health with activities of other Federal agencies
24 related to social determinants of health, includ-
25 ing such activities of agencies in the Depart-

1 ment of Health and Human Services such as
2 the Centers for Medicare & Medicaid Services.

3 (E) Collecting and analyzing data related
4 to the social determinants of health.

5 (c) GRANTS TO ADDRESS SOCIAL DETERMINANTS OF
6 HEALTH.—

7 (1) IN GENERAL.—The Director, as part of the
8 Program, shall award grants to eligible entities to
9 address social determinants of health in their com-
10 munities.

11 (2) ELIGIBILITY.—To be eligible to apply for a
12 grant under this subsection, an entity shall be—

13 (A) a State, local, territorial, or Tribal
14 health agency or organization;

15 (B) a qualified nongovernmental entity, as
16 defined by the Director; or

17 (C) a consortium of entities that includes
18 a State, local, territorial, or Tribal health agen-
19 cy or organization.

20 (3) USE OF FUNDS.—

21 (A) IN GENERAL.—A grant under this sub-
22 section shall be used to address social deter-
23 minants of health in a target community by de-
24 signing and implementing innovative, evidence-
25 based, cross-sector strategies.

1 (B) TARGET COMMUNITY.—For purposes
2 of this subsection, a target community shall be
3 a State, county, city, or other municipality.

4 (4) PRIORITY.—In awarding grants under this
5 subsection, the Director shall prioritize applicants
6 proposing to serve target communities with signifi-
7 cant unmet health and social needs, as defined by
8 the Director.

9 (5) APPLICATION.—To seek a grant under this
10 subsection, an eligible entity shall—

11 (A) submit an application at such time, in
12 such manner, and containing such information
13 as the Director may require;

14 (B) propose a set of activities to address
15 social determinants of health through evidence-
16 based, cross-sector strategies, which activities
17 may include—

18 (i) collecting quantifiable data from
19 health care, social services, and other enti-
20 ties regarding the most significant gaps in
21 health-promoting social, economic, and en-
22 vironmental needs;

23 (ii) identifying evidence-based ap-
24 proaches to meeting the nonmedical, social
25 needs of populations identified by data col-

lection described in clause (i), such as unstable housing or inadequate food;

(iii) developing scalable methods to meet patients' social needs identified in clinical settings or other sites;

(iv) convening entities such as local and State governmental and nongovernmental organizations, health systems, payors, and community-based organizations to review, plan, and implement community-wide interventions and strategies to advance health-promoting social conditions;

(v) monitoring and evaluating the impact of activities funded through the grant on the health and well-being of the residents of the target community and on the cost of health care; and

(vi) such other activities as may be specified by the Director;

(C) demonstrate how the eligible entity will collaborate with—

(i) health systems;

(ii) payors, including, as appropriate, medicaid managed care organizations (as defined in section 1903(m)(1)(A) of the

1 Social Security Act (42 U.S.C.
2 1396b(m)(1)(A))), Medicare Advantage
3 plans under part C of title XVIII of such
4 Act (42 U.S.C. 1395w–21 et seq.), and
5 health insurance issuers and group health
6 plans (as such terms are defined in section
7 2791 of the Public Health Service Act);

8 (iii) other relevant stakeholders and
9 initiatives in areas of need, such as the Ac-
10 countable Health Communities Model of
11 the Centers for Medicare & Medicaid Serv-
12 ices, health homes under the Medicaid pro-
13 gram under title XIX of the Social Secu-
14 rity Act (42 U.S.C. 1396 et seq.), commu-
15 nity-based organizations, and human serv-
16 ices organizations;

17 (iv) other non-health care sector orga-
18 nizations, including organizations focusing
19 on transportation, housing, or food access;
20 and

21 (v) local employers; and

22 (D) identify key health inequities in the
23 target community and demonstrate how the
24 proposed efforts of the eligible entity would ad-
25 dress such inequities.

1 (6) MONITORING AND EVALUATION.—As a con-
2 dition of receipt of a grant under this subsection, a
3 grantee shall agree to submit an annual report to
4 the Director describing the activities carried out
5 through the grant and the outcomes of such activi-
6 ties.

7 (7) INDEPENDENT NATIONAL EVALUATION.—

8 (A) IN GENERAL.—Not later than 5 years
9 after the first grants are awarded under this
10 subsection, the Director shall provide for the
11 commencement of an independent national eval-
12 uation of the Program under this subsection.

13 (B) REPORT TO CONGRESS.—Not later
14 than 60 days after receiving the results of such
15 independent national evaluation, the Director
16 shall report such results to the Congress.

17 (d) RESEARCH AND TRAINING.—The Director, as
18 part of the Program—

19 (1) shall award grants to nonprofit organiza-
20 tions and public or other nonprofit institutions of
21 higher education—

22 (A) to conduct research on best practices
23 to improve social determinants of health;

1 (B) to provide technical assistance, train-
 2 ing, and evaluation assistance to grantees under
 3 subsection (c); and

4 (C) to disseminate best practices to grant-
 5 ees under subsection (c); and

6 (2) may require a grantee under paragraph (1)
 7 to provide technical assistance and capacity building
 8 to entities that are eligible entities under subsection
 9 (c) but not receiving funds through such subsection.
 10 (e) FUNDING.—

11 (1) IN GENERAL.—There is authorized to be
 12 appropriated to carry out this section, \$50,000,000
 13 for each of fiscal years 2021 through 2026.

14 (2) ALLOCATION.—Of the amount made avail-
 15 able to carry out this section for a fiscal year, not
 16 less than 75 percent shall be used for grants under
 17 subsections (c) and (d).

18 **SEC. 605. FUNDING TO STATES, LOCALITIES, AND COMMU-**
 19 **NITY-BASED ORGANIZATIONS FOR EMER-**
 20 **GENCY AID AND SERVICES.**

21 (a) FUNDING FOR STATES.—

22 (1) INCREASE IN FUNDING FOR SOCIAL SERV-
 23 ICES BLOCK GRANT PROGRAM.—

24 (A) APPROPRIATION.—Out of any money
 25 in the Treasury of the United States not other-

1 wise appropriated, there are appropriated
2 \$9,600,000,000, which shall be available for
3 payments under section 2002 of the Social Se-
4 curity Act.

5 (B) DEADLINE FOR DISTRIBUTION OF
6 FUNDS.—Within 45 days after the date of the
7 enactment of this Act, the Secretary of Health
8 and Human Services shall distribute the funds
9 made available by this paragraph, which shall
10 be made available to States on an emergency
11 basis for immediate obligation and expenditure.

12 (C) SUBMISSION OF REVISED PRE-EX-
13 PENDITURE REPORT.—Within 90 days after a
14 State receives funds made available by this
15 paragraph, the State shall submit to the Sec-
16 retary a revised pre-expenditure report pursu-
17 ant to title XX of the Social Security Act that
18 describes how the State plans to administer the
19 funds.

20 (D) OBLIGATION OF FUNDS BY STATES.—
21 A State to which funds made available by this
22 paragraph are distributed shall obligate the
23 funds not later than December 31, 2020.

24 (E) EXPENDITURE OF FUNDS BY
25 STATES.—A grantee to which a State (or a sub-

1 grantee to which a grantee) provides funds
2 made available by this paragraph shall expend
3 the funds not later than December 31, 2021.

4 (2) RULES GOVERNING USE OF ADDITIONAL
5 FUNDS.—A State to which funds made available by
6 paragraph (1)(B) are distributed shall use the funds
7 in accordance with the following:

8 (A) PURPOSE.—

9 (i) IN GENERAL.—The State shall use
10 the funds only to support the provision of
11 emergency services to disadvantaged chil-
12 dren, families, and households.

13 (ii) DISADVANTAGED DEFINED.—In
14 this paragraph, the term “disadvantaged”
15 means, with respect to an entity, that the
16 entity—

17 (I) is an individual, or is located
18 in a community, that is experiencing
19 material hardship;

20 (II) is a household in which there
21 is a child (as defined in section 12(d)
22 of the Richard B. Russell National
23 School Lunch Act) or a child served
24 under section 11(a)(1) of such Act,
25 who, if not for the closure of the

1 school attended by the child during a
2 public health emergency designation
3 and due to concerns about a COVID–
4 19 outbreak, would receive free or re-
5 duced price school meals pursuant to
6 such Act;

7 (III) is an individual, or is lo-
8 cated in a community, with barriers to
9 employment; or

10 (IV) is located in a community
11 that, as of the date of the enactment
12 of this Act, is not experiencing a 56-
13 day downward trajectory of—

14 (aa) influenza-like illnesses;

15 (bb) COVID-like syndromic
16 cases;

17 (cc) documented COVID–19
18 cases; or

19 (dd) positive test results as
20 a percentage of total COVID–19
21 tests.

22 (B) PASS-THROUGH TO LOCAL ENTI-
23 TIES.—

24 (i) In the case of a State in which a
25 county administers or contributes finan-

1 cially to the non-Federal share of the
2 amounts expended in carrying out a State
3 program funded under title IV of the So-
4 cial Security Act, the State may pass funds
5 so made available through to—

6 (I) the chief elected official of the
7 city or urban county that administers
8 the program; or

9 (II) local government and com-
10 munity-based organizations.

11 (ii) In the case of any other State, the
12 State shall—

13 (I) pass the funds through to—

14 (aa)(AA) local governments
15 that will expend or distribute the
16 funds in consultation with com-
17 munity-based organizations with
18 experience serving disadvantaged
19 families or individuals; or

20 (BB) community-based or-
21 ganizations with experience serv-
22 ing disadvantaged families and
23 individuals; and

24 (bb) sub-State areas in pro-
25 portions based on the population

1 of disadvantaged individuals liv-
2 ing in the areas; and

3 (II) report to the Secretary on
4 how the State determined the
5 amounts passed through pursuant to
6 this clause.

7 (C) METHODS.—

8 (i) IN GENERAL.—The State shall use
9 the funds only for—

10 (I) administering emergency serv-
11 ices;

12 (II) providing short-term cash,
13 non-cash, or in-kind emergency dis-
14 aster relief;

15 (III) providing services with dem-
16 onstrated need in accordance with ob-
17 jective criteria that are made available
18 to the public;

19 (IV) operational costs directly re-
20 lated to providing services described
21 in subclauses (I), (II), and (III);

22 (V) local government emergency
23 social service operations; and

24 (VI) providing emergency social
25 services to rural and frontier commu-

1 nities that may not have access to
2 other emergency funding streams.

3 (ii) ADMINISTERING EMERGENCY
4 SERVICES DEFINED.—In clause (i), the
5 term “administering emergency services”
6 means—

7 (I) providing basic disaster relief,
8 economic, and well-being necessities to
9 ensure communities are able to safely
10 observe shelter-in-place and social
11 distancing orders;

12 (II) providing necessary supplies
13 such as masks, gloves, and soap, to
14 protect the public against infectious
15 disease; and

16 (III) connecting individuals, chil-
17 dren, and families to services or pay-
18 ments for which they may already be
19 eligible.

20 (D) PROHIBITIONS.—

21 (i) NO INDIVIDUAL ELIGIBILITY DE-
22 TERMINATIONS BY GRANTEES OR SUB-
23 GRANTEES.—Neither a grantee to which
24 the State provides the funds nor any sub-
25 grantee of such a grantee may exercise in-

dividual eligibility determinations for the purpose of administering short-term, non-cash, in-kind emergency disaster relief to communities.

(ii) APPLICABILITY OF CERTAIN SOCIAL SERVICES BLOCK GRANT FUNDS USE LIMITATIONS.—The State shall use the funds subject to the limitations in section 2005 of the Social Security Act, except that, for purposes of this clause, section 2005(a)(2) and 2005(a)(8) of such Act shall not apply.

(iii) NO SUPPLANTATION OF CERTAIN STATE FUNDS.—The State may use the funds to supplement, not supplant, State general revenue funds for social services.

(iv) BAN ON USE FOR CERTAIN COSTS REIMBURSABLE BY FEMA.—The State may not use the funds for costs that are reimbursable by the Federal Emergency Management Agency, under a contract for insurance, or by self-insurance.

(b) FUNDING FOR FEDERALLY RECOGNIZED INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—

(1) GRANTS.—

1 (A) IN GENERAL.—Within 90 days after
2 the date of the enactment of this Act, the Sec-
3 retary of Health and Human Services shall
4 make grants to federally recognized Indian
5 Tribes and Tribal organizations.

6 (B) AMOUNT OF GRANT.—The amount of
7 the grant for an Indian Tribe or Tribal organi-
8 zation shall bear the same ratio to the amount
9 appropriated by paragraph (3) as the total
10 amount of grants awarded to the Indian Tribe
11 or Tribal organization under the Low-Income
12 Home Energy Assistance Act of 1981 and the
13 Community Service Block Grant for fiscal year
14 2020 bears to the total amount of grants
15 awarded to all Indian Tribes and Tribal organi-
16 zations under such Act and such Grant for the
17 fiscal year.

18 (2) RULES GOVERNING USE OF FUNDS.—An
19 entity to which a grant is made under paragraph (1)
20 shall obligate the funds not later than December 31,
21 2020, and the funds shall be expended by grantees
22 and subgrantees not later than December 31, 2021,
23 and used in accordance with the following:

24 (A) PURPOSE.—

1 (i) IN GENERAL.—The grantee shall
2 use the funds only to support the provision
3 of emergency services to disadvantaged
4 households.

5 (ii) DISADVANTAGED DEFINED.—In
6 clause (i), the term “disadvantaged”
7 means, with respect to an entity, that the
8 entity—

9 (I) is an individual, or is located
10 in a community, that is experiencing
11 material hardship;

12 (II) is a household in which there
13 is a child (as defined in section 12(d)
14 of the Richard B. Russell National
15 School Lunch Act) or a child served
16 under section 11(a)(1) of such Act,
17 who, if not for the closure of the
18 school attended by the child during a
19 public health emergency designation
20 and due to concerns about a COVID–
21 19 outbreak, would receive free or re-
22 duced price school meals pursuant to
23 such Act;

1 (III) is an individual, or is lo-
2 cated in a community, with barriers to
3 employment; or

4 (IV) is located in a community
5 that, as of the date of the enactment
6 of this Act, is not experiencing a 56-
7 day downward trajectory of—

8 (aa) influenza-like illnesses;

9 (bb) COVID-like syndromic
10 cases;

11 (cc) documented COVID–19
12 cases; or

13 (dd) positive test results as
14 a percentage of total COVID–19
15 tests.

16 (B) METHODS.—

17 (i) IN GENERAL.—The grantee shall
18 use the funds only for—

19 (I) administering emergency serv-
20 ices;

21 (II) providing short-term, non-
22 cash, in-kind emergency disaster re-
23 lief; and

24 (III) tribal emergency social serv-
25 ice operations.

1 (ii) ADMINISTERING EMERGENCY
2 SERVICES DEFINED.—In clause (i), the
3 term “administering emergency services”
4 means—

5 (I) providing basic economic and
6 well-being necessities to ensure com-
7 munities are able to safely observe
8 shelter-in-place and social distancing
9 orders;

10 (II) providing necessary supplies
11 such as masks, gloves, and soap, to
12 protect the public against infectious
13 disease; and

14 (III) connecting individuals, chil-
15 dren, and families to services or pay-
16 ments for which they may already be
17 eligible.

18 (C) PROHIBITIONS.—

19 (i) NO INDIVIDUAL ELIGIBILITY DE-
20 TERMINATIONS BY GRANTEES OR SUB-
21 GRANTEES.—Neither the grantee nor any
22 subgrantee may exercise individual eligi-
23 bility determinations for the purpose of ad-
24 ministering short-term, non-cash, in-kind
25 emergency disaster relief to communities.

1 (ii) BAN ON USE FOR CERTAIN COSTS
2 REIMBURSABLE BY FEMA.—The grantee
3 may not use the funds for costs that are
4 reimbursable by the Federal Emergency
5 Management Agency, under a contract for
6 insurance, or by self-insurance.

7 (3) APPROPRIATION.—Out of any money in the
8 Treasury of the United States not otherwise appro-
9 priated, there are appropriated to the Secretary of
10 Health and Human Services \$400,000,000 to carry
11 out this subsection.

12 **SEC. 606. SUPPLEMENTAL NUTRITION ASSISTANCE PRO-**
13 **GRAM.**

14 (a) VALUE OF BENEFITS.—Notwithstanding any
15 other provision of law, beginning on June 1, 2020, and
16 for each subsequent month through September 30, 2021,
17 the value of benefits determined under section 8(a) of the
18 Food and Nutrition Act of 2008 (7 U.S.C. 2017(a)), and
19 consolidated block grants for Puerto Rico and American
20 Samoa determined under section 19(a) of such Act (7
21 U.S.C. 2028(a)), shall be calculated using 115 percent of
22 the June 2019 value of the thrifty food plan (as defined
23 in section 3 of such Act (7 U.S.C. 2012)) if the value of
24 the benefits and block grants would be greater under that
25 calculation than in the absence of this subsection.

1 (b) MINIMUM AMOUNT.—

2 (1) IN GENERAL.—The minimum value of bene-
3 fits determined under section 8(a) of the Food and
4 Nutrition Act of 2008 (7 U.S.C. 2017(a)) for a
5 household of not more than 2 members shall be \$30.

6 (2) EFFECTIVENESS.—Paragraph (1) shall re-
7 main in effect until the date on which 8 percent of
8 the value of the thrifty food plan for a household
9 containing 1 member, rounded to the nearest whole
10 dollar increment, is equal to or greater than \$30.

11 (c) REQUIREMENTS FOR THE SECRETARY.—In car-
12 rying out this section, the Secretary shall—

13 (1) consider the benefit increases described in
14 each of subsections (a) and (b) to be a “mass
15 change”;

16 (2) require a simple process for States to notify
17 households of the increase in benefits;

18 (3) consider section 16(c)(3)(A) of the Food
19 and Nutrition Act of 2008 (7 U.S.C. 2025(c)(3)(A))
20 to apply to any errors in the implementation of this
21 section, without regard to the 120-day limit de-
22 scribed in that section;

23 (4) disregard the additional amount of benefits
24 that a household receives as a result of this section
25 in determining the amount of overissuances under

1 section 13 of the Food and Nutrition Act of 2008
2 (7 U.S.C. 2022); and

3 (5) set the tolerance level for excluding small
4 errors for the purposes of section 16(c) of the Food
5 and Nutrition Act of 2008 (7 U.S.C. 2025(c)) at
6 \$50 through September 30, 2021.

7 (d) PROVISIONS FOR IMPACTED WORKERS.—Not-
8 withstanding any other provision of law, the requirements
9 under subsections (d)(1)(A)(ii) and (o) of section 6 of the
10 Food and Nutrition Act of 2008 (7 U.S.C. 2015) shall
11 not be in effect during the period beginning on June 1,
12 2020, and ending 2 years after the date of enactment of
13 this Act.

14 (e) ADMINISTRATIVE EXPENSES.—

15 (1) IN GENERAL.—For the costs of State ad-
16 ministrative expenses associated with carrying out
17 this section and administering the supplemental nu-
18 trition assistance program established under the
19 Food and Nutrition Act of 2008 (7 U.S.C. 2011 et
20 seq.), the Secretary shall make available
21 \$150,000,000 for fiscal year 2020 and
22 \$150,000,000 for fiscal year 2021.

23 (2) TIMING FOR FISCAL YEAR 2020.—Not later
24 than 60 days after the date of the enactment of this

1 Act, the Secretary shall make available to States
2 amounts for fiscal year 2020 under paragraph (1).

3 (3) ALLOCATION OF FUNDS.—Funds described
4 in paragraph (1) shall be made available as grants
5 to State agencies for each fiscal year as follows:

6 (A) 75 percent of the amounts available
7 for each fiscal year shall be allocated to States
8 based on the share of each State of households
9 that participate in the supplemental nutrition
10 assistance program as reported to the Depart-
11 ment of Agriculture for the most recent 12-
12 month period for which data are available, ad-
13 justed by the Secretary (as of the date of the
14 enactment of this Act) for participation in dis-
15 aster programs under section 5(h) of the Food
16 and Nutrition Act of 2008 (7 U.S.C. 2014(h));
17 and

18 (B) 25 percent of the amounts available
19 for each fiscal year shall be allocated to States
20 based on the increase in the number of house-
21 holds that participate in the supplemental nu-
22 trition assistance program as reported to the
23 Department of Agriculture over the most recent
24 12-month period for which data are available,
25 adjusted by the Secretary (as of the date of the

1 enactment of this Act) for participation in dis-
2 aster programs under section 5(h) of the Food
3 and Nutrition Act of 2008 (7 U.S.C. 2014(h)).

4 (f) SNAP RULES.—No funds (including fees) made
5 available under this Act or any other Act for any fiscal
6 year may be used to finalize, implement, administer, en-
7 force, carry out, or otherwise give effect to—

8 (1) the final rule entitled “Supplemental Nutri-
9 tion Assistance Program: Requirements for Able-
10 Bodied Adults Without Dependents” published in
11 the Federal Register on December 5, 2019 (84 Fed.
12 Reg. 66782);

13 (2) the proposed rule entitled “Revision of Cat-
14 egorical Eligibility in the Supplemental Nutrition
15 Assistance Program (SNAP)” published in the Fed-
16 eral Register on July 24, 2019 (84 Fed. Reg.
17 35570); or

18 (3) the proposed rule entitled “Supplemental
19 Nutrition Assistance Program: Standardization of
20 State Heating and Cooling Standard Utility Allow-
21 ances” published in the Federal Register on October
22 3, 2019 (84 Fed. Reg. 52809).

23 (g) CERTAIN EXCLUSIONS FROM SNAP INCOME.—
24 A Federal pandemic unemployment compensation pay-
25 ment made to an individual under section 2104 of the

1 CARES Act (Public Law 116–136) shall not be regarded
2 as income and shall not be regarded as a resource for the
3 month of receipt and the following 9 months, for the pur-
4 pose of determining eligibility for such individual or any
5 other individual for benefits or assistance, or the amount
6 of benefits or assistance, under any programs authorized
7 under the Food and Nutrition Act of 2008 (7 U.S.C. 2011
8 et seq.).

9 (h) PUBLIC AVAILABILITY.—Not later than 10 days
10 after the date of the receipt or issuance of each document
11 listed below, the Secretary shall make publicly available
12 on the website of the Department of Agriculture the fol-
13 lowing documents:

14 (1) Any State agency request to participate in
15 the supplemental nutrition assistance program on-
16 line program under section 7(k).

17 (2) Any State agency request to waive, adjust,
18 or modify statutory or regulatory requirements
19 under the Food and Nutrition Act of 2008 related
20 to the COVID–19 outbreak.

21 (3) The Secretary’s approval or denial of each
22 such request under paragraphs (1) or (2).

23 (i) FUNDING.—There are hereby appropriated to the
24 Secretary, out of any money not otherwise appropriated,
25 such sums as may be necessary to carry out this section.

1 **TITLE VII—CULTURALLY AND**
2 **LINGUISTICALLY COM-**
3 **PETENT CARE**

4 **SEC. 701. ENSURING STANDARDS FOR CULTURALLY AND**
5 **LINGUISTICALLY APPROPRIATE SERVICES IN**
6 **HEALTH CARE.**

7 (a) **APPLICABILITY.**—This section shall apply to any
8 health program or activity, any part of which is receiving
9 Federal financial assistance, including credits, subsidies,
10 or contracts of insurance, or any program or activity that
11 is administered by an executive agency or any entity estab-
12 lished under title I of the Patient Protection and Afford-
13 able Care Act (42 U.S.C. 18001 et seq.) (or amendments
14 made thereby).

15 (b) **STANDARDS.**—Each program or activity de-
16 scribed in subsection (a)—

17 (1) shall implement strategies to recruit, retain,
18 and promote individuals at all levels to maintain a
19 diverse staff and leadership that can provide cul-
20 turally and linguistically appropriate health care to
21 patient populations of the service area of the pro-
22 gram or activity;

23 (2) shall educate and train governance, leader-
24 ship, and workforce at all levels and across all dis-
25 ciplines of the program or activity in culturally and

1 linguistically appropriate policies and practices on an
2 ongoing basis at least yearly;

3 (3) shall offer and provide language assistance,
4 including trained and competent bilingual staff and
5 interpreter services, to individuals with limited
6 English proficiency or who have other communica-
7 tion needs, at no cost to the individual at all points
8 of contact, and during all hours of operation, to fa-
9 cilitate timely access to health care services and
10 health-care-related services;

11 (4) shall for each language group consisting of
12 individuals with limited English proficiency that con-
13 stitutes 5 percent or 500 individuals, whichever is
14 less, of the population of persons eligible to be
15 served or likely to be affected or encountered in the
16 service area of the program or activity, make avail-
17 able at a fifth grade reading level—

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

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

23 (C) signage; and

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

1 (5) shall develop and implement clear goals,
2 policies, operational plans, and management, ac-
3 countability, and oversight mechanisms to provide
4 culturally and linguistically appropriate services and
5 infuse them throughout the planning and operations
6 of the program or activity;

7 (6) shall conduct initial and ongoing organiza-
8 tional assessments of culturally and linguistically ap-
9 propriate services-related activities and integrate
10 valid linguistic, competence-related National Stand-
11 ards for Culturally and Linguistically Appropriate
12 Services (CLAS) measures into the internal audits,
13 performance improvement programs, patient satis-
14 faction assessments, continuous quality improvement
15 activities, and outcomes-based evaluations of the
16 program or activity and develop ways to standardize
17 the assessments, and such assessments must occur
18 at least yearly;

19 (7) shall ensure that, consistent with the pri-
20 vacy protections provided for under the regulations
21 promulgated under section 264(c) of the Health In-
22 surance Portability and Accountability Act of 1996
23 (42 U.S.C. 1320–2 note), data on an individual re-
24 quired to be collected pursuant to section 3101, in-

cluding the individual's alternative format preferences and policy modification needs, are—

(A) collected in health records;

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

(C) periodically updated;

(8) shall maintain a current demographic, cultural, and epidemiological profile of the community, conduct regular assessments of community health assets and needs, and use the results of such assessments to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area of the program or activity;

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

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

1 (11) shall regularly make available to the public
2 information about their progress and successful in-
3 novations in implementing the standards under this
4 section and provide public notice in their commu-
5 nities about the availability of this information; and

6 (12) shall, if requested, regularly make avail-
7 able to the head of each Federal entity from which
8 Federal funds are provided, information about the
9 progress and successful innovations of the program
10 or activity in implementing the standards under this
11 section as required by the head of such entity.

12 (c) COMMENTS ACCEPTED THROUGH NOTICE AND
13 COMMENT RULEMAKING.—An agency carrying out a pro-
14 gram described in subsection (a) shall ensure that com-
15 ments with respect to such program that are accepted
16 through notice and comment rulemaking be accepted in
17 all languages, may not require such comments to be sub-
18 mitted only in English, and must ensure these comments
19 are considered equally as comments submitted in English
20 during the agency’s review of comments submitted.

1 **SEC. 702. CULTURALLY AND LINGUISTICALLY APPRO-**
2 **PRIATE HEALTH CARE IN THE PUBLIC**
3 **HEALTH SERVICE ACT.**

4 Title XXXIV of the Public Health Service Act, as
5 amended by section 104, is further amended by adding
6 at the end the following:

7 **“Subtitle B—CULTURALLY AND**
8 **LINGUISTICALLY APPRO-**
9 **PRIATE HEALTH CARE**

10 **“SEC. 3403. DEFINITIONS.**

11 “(a) IN GENERAL.—In this title:

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

15 “(2) CULTURAL.—The term ‘cultural’ means
16 relating to integrated patterns of human behavior
17 that include the language, thoughts, communica-
18 tions, actions, customs, beliefs, values, and institu-
19 tions of racial, ethnic, religious, or social groups, in-
20 cluding lesbian, gay, bisexual, transgender, queer,
21 and questioning individuals, and individuals with
22 physical and mental disabilities.

23 “(3) CULTURALLY AND LINGUISTICALLY AP-
24 PROPRIATE.—The term ‘culturally and linguistically
25 appropriate’ means being respectful of and respon-

1 sive to the cultural and linguistic needs of all indi-
2 viduals.

3 “(4) EFFECTIVE COMMUNICATION.—The term
4 ‘effective communication’ means an exchange of in-
5 formation between the provider of health care or
6 health-care-related services and the recipient of such
7 services who is limited in English proficiency, or has
8 a communication impairment such as a hearing, vi-
9 sion, speaking, or learning impairment, that enables
10 access to, understanding of, and benefit from health
11 care or health-care-related services, and full partici-
12 pation in the development of their treatment plan.

13 “(5) GRIEVANCE RESOLUTION PROCESS.—The
14 term ‘grievance resolution process’ means all aspects
15 of dispute resolution including filing complaints,
16 grievance and appeal procedures, and court action.

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

1 any such program that is affiliated with the health
2 care group.

3 “(7) HEALTH CARE SERVICES.—The term
4 ‘health care services’ means services that address
5 physical as well as mental health conditions in all
6 care settings.

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

11 “(9) HEALTH EDUCATOR.—The term ‘health
12 educator’ includes a professional with a bacca-
13 laureate degree who is responsible for designing, im-
14 plementing, and evaluating individual and population
15 health promotion and chronic disease prevention pro-
16 grams.

17 “(10) INDIAN; INDIAN TRIBE.—The terms ‘In-
18 dian’ and ‘Indian Tribe’ have the meanings given
19 such terms in section 4 of the Indian Self-Deter-
20 mination and Education Assistance Act.

21 “(11) INDIVIDUAL WITH A DISABILITY.—The
22 term ‘individual with a disability’ means any indi-
23 vidual who has a disability as defined for the pur-
24 pose of section 504 of the Rehabilitation Act of
25 1973.

1 “(12) INDIVIDUAL WITH LIMITED ENGLISH
2 PROFICIENCY.—The term ‘individual with limited
3 English proficiency’ means an individual whose pri-
4 mary language for communication is not English
5 and who has a limited ability to read, write, speak,
6 or understand English.

7 “(13) INTEGRATED HEALTH CARE DELIVERY
8 SYSTEM.—The term ‘integrated health care delivery
9 system’ means an interdisciplinary system that
10 brings together providers from the primary health,
11 mental health, substance use disorder, and related
12 disciplines to improve the health outcomes of an in-
13 dividual. Such providers may include hospitals,
14 health, mental health, or substance use disorder clin-
15 ics and providers, home health agencies, ambulatory
16 surgery centers, skilled nursing facilities, rehabilita-
17 tion centers, and employed, independent, or con-
18 tracted physicians.

19 “(14) INTERPRETING; INTERPRETATION.—The
20 terms ‘interpreting’ and ‘interpretation’ mean the
21 transmission of a spoken, written, or signed message
22 from one language or format into another, faithfully,
23 accurately, and objectively.

24 “(15) LANGUAGE ACCESS.—The term ‘language
25 access’ means the provision of language services to

1 an individual with limited English proficiency or an
2 individual with communication disabilities designed
3 to enhance that individual's access to, understanding
4 of, or benefit from health care services or health-
5 care-related services.

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

8 “(A) oral language assistance, including in-
9 terpretation in non-English languages provided
10 in-person or remotely by a qualified interpreter
11 for an individual with limited English pro-
12 ficiency, and the use of qualified bilingual or
13 multilingual staff to communicate directly with
14 individuals with limited English proficiency;

15 “(B) written translation, performed by a
16 qualified and competent translator, of written
17 content in paper or electronic form into lan-
18 guages other than English; and

19 “(C) taglines.

20 “(17) MINORITY.—

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

24 “(B) POPULATIONS.—The term ‘minority’,
25 with respect to populations, refers to racial and

1 ethnic minority groups, members of sexual and
2 gender minority groups, and individuals with a
3 disability.

4 “(18) MINORITY GROUP.—The term ‘minority
5 group’ has the meaning given the term ‘racial and
6 ethnic minority group’.

7 “(19) ONSITE INTERPRETATION.—The term
8 ‘onsite interpretation’ means a method of inter-
9 preting or interpretation for which the interpreter is
10 in the physical presence of the provider of health
11 care services or health-care-related services and the
12 recipient of such services who is limited in English
13 proficiency or has a communication impairment such
14 as an impairment in hearing, vision, or learning.

15 “(20) QUALIFIED INDIVIDUAL WITH A DIS-
16 ABILITY.—The term ‘qualified individual with a dis-
17 ability’ means, with respect to a health program or
18 activity, an individual with a disability who, with or
19 without reasonable modifications to policies, prac-
20 tices, or procedures, the removal of architectural,
21 communication, or transportation barriers, or the
22 provision of auxiliary aids and services, meets the es-
23 sential eligibility requirements for the receipt of aids,
24 benefits, or services offered or provided by the health
25 program or activity.

1 “(21) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH A DISABILITY.—The term ‘qualified interpreter for an individual with a disability’, for an individual with a disability—

2 “(A) means an interpreter who by means of a remote interpreting service or an on-site appearance;

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

4 “(ii) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology; and

5 “(B) may include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

6 “(22) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY.—The term ‘qualified interpreter for an individual with limited English proficiency’ means an interpreter

1 who via a remote interpreting service or an on-site
2 appearance—

3 “(A) adheres to generally accepted inter-
4 preter ethics principles, including client con-
5 fidentiality;

6 “(B) has demonstrated proficiency in
7 speaking and understanding both spoken
8 English and one or more other spoken lan-
9 guages; and

10 “(C) is able to interpret effectively, accu-
11 rately, and impartially, both receptively and ex-
12 pressly, to and from such languages and
13 English, using any necessary specialized vocab-
14 ulary, terminology, and phraseology.

15 “(23) QUALIFIED TRANSLATOR.—The term
16 ‘qualified translator’ means a translator who—

17 “(A) adheres to generally accepted trans-
18 lator ethics principles, including client confiden-
19 tiality;

20 “(B) has demonstrated proficiency in writ-
21 ing and understanding both written English
22 and one or more other written non-English lan-
23 guages; and

24 “(C) is able to translate effectively, accu-
25 rately, and impartially to and from such lan-

1 guages and English, using any necessary spe-
2 cialized vocabulary, terminology, and phrase-
3 ology.

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

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

18 “(26) SIGHT TRANSLATION.—The term ‘sight
19 translation’ means the transmission of a written
20 message in one language into a spoken or signed
21 message in another language, or an alternative for-
22 mat in English or another language.

23 “(27) STATE.—Notwithstanding section 2, the
24 term ‘State’ means each of the several States, the
25 District of Columbia, the Commonwealth of Puerto

1 Rico, the United States Virgin Islands, Guam,
2 American Samoa, and the Commonwealth of the
3 Northern Mariana Islands.

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

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

20 “(30) VIDEO REMOTE INTERPRETING SERV-
21 ICES.—The term ‘video remote interpreting services’
22 means the provision, in health care services or
23 health-care-related services, through a qualified in-
24 terpreter for an individual with limited English pro-

1 ficiency, of video remote interpreting services that
2 are—

3 “(A) in real-time, full-motion video, and
4 audio over a dedicated high-speed, wide-band-
5 width video connection or wireless connection
6 that delivers high quality video images that do
7 not produce lags, choppy, blurry, or grainy im-
8 ages, or irregular pauses in communication; and

9 “(B) in a sharply delineated image that is
10 large enough to display.

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

1 “(b) REFERENCE.—In any reference in this title to
2 a regulatory provision applicable to a ‘handicapped indi-
3 vidual’, the term ‘handicapped individual’ in such provi-
4 sion shall have the same meaning as the term ‘individual
5 with a disability’ as defined in subsection (a).

6 **“CHAPTER 1—RESOURCES AND INNOVA-**
7 **TION FOR CULTURALLY AND LINGUIS-**
8 **TICALLY APPROPRIATE HEALTH CARE**

9 **“SEC. 3404. ROBERT T. MATSUI CENTER FOR CULTURALLY**
10 **AND LINGUISTICALLY APPROPRIATE HEALTH**
11 **CARE.**

12 “(a) ESTABLISHMENT.—The Secretary, acting
13 through the Director of the Agency for Healthcare Re-
14 search and Quality, shall establish and support a center
15 to be known as the ‘Robert T. Matsui Center for Cul-
16 turally and Linguistically Appropriate Health Care’ (re-
17 ferred to in this section as the ‘Center’) to carry out each
18 of the following activities:

19 “(1) INTERPRETATION SERVICES.—The Center
20 shall provide resources via the internet to identify
21 and link health care providers to competent inter-
22 preter and translation services.

23 “(2) TRANSLATION OF WRITTEN MATERIAL.—

24 “(A) VITAL DOCUMENTS.—The Center
25 shall provide, directly or through contract, vital

documents from competent translation services for providers of health care services and health-care-related services at no cost to such providers. Such documents may be submitted by covered entities (as defined in section 92.4 of title 42, Code of Federal Regulations, as in effect on May 16, 2016) for translation into non-English languages or alternative formats at a fifth-grade reading level. Such translation services shall be provided in a timely and reasonable manner. The quality of such translation services shall be monitored and reported publicly.

“(B) FORMS.—For each form developed or revised by the Secretary that will be used by individuals with limited English proficiency in health care or health-care-related settings, the Center shall translate the form, at a minimum, into the top 15 non-English languages in the United States according to the most recent data from the American Community Survey or its replacement. The translation shall be completed within 45 calendar days of the Secretary receiving final approval of the form from the Office of Management and Budget. The Center shall

1 post all translated forms on its website so that
2 other entities may use the same translations.

3 “(3) TOLL-FREE CUSTOMER SERVICE TELE-
4 PHONE NUMBER.—The Center shall provide,
5 through a toll-free number, a customer service line
6 for individuals with limited English proficiency—

7 “(A) to obtain information about federally
8 conducted or funded health programs, including
9 the Medicare program under title XVIII of the
10 Social Security Act, the Medicaid program
11 under title XIX of such Act, and the State Chil-
12 dren’s Health Insurance Program under title
13 XXI of such Act, marketplace coverage avail-
14 able pursuant to title XXVII of this Act and
15 the Patient Protection and Affordable Care Act,
16 and other sources of free or reduced care in-
17 cluding federally qualified health centers, title
18 X clinics, and public health departments;

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

22 “(C) to learn how to access language serv-
23 ices.

24 “(4) HEALTH INFORMATION CLEARING-
25 HOUSE.—

1 “(A) IN GENERAL.—The Center shall de-
2 velop and maintain an information clearing-
3 house to facilitate the provision of language
4 services by providers of health care services and
5 health-care-related services to reduce medical
6 errors, improve medical outcomes, improve cul-
7 tural competence, reduce health care costs
8 caused by miscommunication with individuals
9 with limited English proficiency, and reduce or
10 eliminate the duplication of efforts to translate
11 materials. The clearinghouse shall include the
12 information described in subparagraphs (B)
13 through (F) and make such information avail-
14 able on the internet and in print.

15 “(B) DOCUMENT TEMPLATES.—The Cen-
16 ter shall collect and evaluate for accuracy, de-
17 velop, and make available templates for stand-
18 ard documents that are necessary for patients
19 and consumers to access and make educated de-
20 cisions about their health care, including tem-
21 plates for each of the following:

22 “(i) Administrative and legal docu-
23 ments, including—

24 “(I) intake forms;

1 “(II) forms related to the Medi-
2 care program under title XVIII of the
3 Social Security Act, the Medicaid pro-
4 gram under title XIX of such Act,
5 and the State Children’s Health In-
6 surance Program under title XXI of
7 such Act, including eligibility informa-
8 tion for such programs;

9 “(III) forms informing patients
10 of the compliance and consent re-
11 quirements pursuant to the regula-
12 tions under section 264(c) of the
13 Health Insurance Portability and Ac-
14 countability Act of 1996 (42 U.S.C.
15 1320–2 note); and

16 “(IV) documents concerning in-
17 formed consent, advanced directives,
18 and waivers of rights.

19 “(ii) Clinical information, such as how
20 to take medications, how to prevent trans-
21 mission of a contagious disease, and other
22 prevention and treatment instructions.

23 “(iii) Public health, patient education,
24 and outreach materials, such as immuniza-

tion notices, health warnings, or screening notices.

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

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

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

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

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

“(iv) facilitate access to these documents;

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

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

1 “(D) LANGUAGE ASSISTANCE PRO-
2 GRAMS.—The Center shall provide for the col-
3 lection and dissemination of information on cur-
4 rent examples of language assistance programs
5 and strategies to improve language services for
6 individuals with limited English proficiency, in-
7 cluding case studies using de-identified patient
8 information, program summaries, and program
9 evaluations.

10 “(E) CULTURALLY AND LINGUISTICALLY
11 APPROPRIATE MATERIALS.—The Center shall
12 provide information relating to culturally and
13 linguistically appropriate health care for minor-
14 ity populations residing in the United States to
15 all health care providers and health-care-related
16 services at no cost. Such information shall in-
17 clude—

18 “(i) tenets of culturally and linguis-
19 tically appropriate care;

20 “(ii) culturally and linguistically ap-
21 propriate self-assessment tools;

22 “(iii) culturally and linguistically ap-
23 propriate training tools;

24 “(iv) strategic plans to increase cul-
25 tural and linguistic appropriateness in dif-

ferent types of providers of health care services and health-care-related services, including regional collaborations among health care organizations; and

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

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

“(i) develop and publish on its website translation glossaries that provide standardized translations of commonly used terms and phrases utilized in documents translated by the Center; and

“(ii) make these glossaries available—

“(I) free of charge;

“(II) in the 15 languages in which the Center translates materials; and

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

“(G) INFORMATION ABOUT PROGRESS.—The Center shall regularly collect and make

1 publicly available information about the
2 progress of entities receiving grants under sec-
3 tion 3402 regarding successful innovations in
4 implementing the obligations under this sub-
5 section and provide public notice in the entities’
6 communities about the availability of this infor-
7 mation.

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

12 “(c) AVAILABILITY OF LANGUAGE ACCESS.—The Di-
13 rector shall collaborate with the Deputy Assistant Sec-
14 retary for Minority Health, the Administrator of the Cen-
15 ters for Medicare & Medicaid Services, and the Adminis-
16 trator of the Health Resources and Services Administra-
17 tion to notify health care providers and health care organi-
18 zations about the availability of language access services
19 by the Center.

20 “(d) EDUCATION.—The Secretary, directly or
21 through contract, shall undertake a national education
22 campaign to inform providers, individuals with limited
23 English proficiency, individuals with hearing or vision im-
24 pairments, health professionals, graduate schools, and
25 community health centers about—

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

3 “(2) the value of using trained and competent
4 interpreters and the risks associated with using fam-
5 ily members, friends, minors, and untrained bilin-
6 gual staff;

7 “(3) funding sources for developing and imple-
8 menting language services; and

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

11 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section
13 \$5,000,000 for each of fiscal years 2021 through 2025.

14 **“SEC. 3405. INNOVATIONS IN CULTURALLY AND LINGUIS-**
15 **TICALLY APPROPRIATE HEALTH CARE**
16 **GRANTS.**

17 “(a) IN GENERAL.—

18 “(1) GRANTS.—The Secretary, acting through
19 the Director of the Agency for Healthcare Research
20 and Quality, shall award grants to eligible entities to
21 enable such entities to design, implement, and evalu-
22 ate innovative, cost-effective programs to improve
23 culturally and linguistically appropriate access to
24 health care services for individuals with limited
25 English proficiency.

1 “(2) COORDINATION.—The Director of the
2 Agency for Healthcare Research and Quality shall
3 coordinate with, and ensure the participation of,
4 other agencies including the Health Resources and
5 Services Administration, the National Institute on
6 Minority Health and Health Disparities at the Na-
7 tional Institutes of Health, and the Office of Minor-
8 ity Health, regarding the design and evaluation of
9 the grants program.

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

12 “(1) be—

13 “(A) a city, county, Indian Tribe, State, or
14 subdivision thereof;

15 “(B) an organization described in section
16 501(c)(3) of the Internal Revenue Code of 1986
17 and exempt from tax under section 501(a) of
18 such Code;

19 “(C) a community health, mental health,
20 or substance use disorder center or clinic;

21 “(D) a solo or group physician practice;

22 “(E) an integrated health care delivery
23 system;

24 “(F) a public hospital;

1 “(G) a health care group, university, or
2 college; or

3 “(H) any other entity designated by the
4 Secretary; and

5 “(2) prepare and submit to the Secretary an
6 application, at such time, in such manner, and con-
7 taining such additional information as the Secretary
8 may reasonably require.

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

11 “(1) develop, implement, and evaluate models of
12 providing competent interpretation services through
13 onsite interpretation, telephonic interpretation, or
14 video remote interpreting services;

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

20 “(3) develop and maintain a needs assessment
21 that identifies the current demographic, cultural,
22 and epidemiological profile of the community to ac-
23 curately plan for and implement language services
24 needed in the service area of the entity;

1 “(4) develop a strategic plan to implement lan-
2 guage services;

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

8 “(6) develop and implement grievance resolu-
9 tion processes that are culturally and linguistically
10 appropriate and capable of identifying, preventing,
11 and resolving complaints by individuals with limited
12 English proficiency;

13 “(7) develop short-term medical and mental
14 health interpretation training courses and incentives
15 for bilingual health care staff who are asked to pro-
16 vide interpretation services in the workplace;

17 “(8) develop formal training programs, includ-
18 ing continued professional development and edu-
19 cation programs as well as supervision, for individ-
20 uals interested in becoming dedicated health care in-
21 terpreters and culturally and linguistically appro-
22 priate providers;

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

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

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

6 “(12) develop, implement, and evaluate models
7 of improving cultural competence, including cultural
8 competence programs for community health workers;
9 and

10 “(13) ensure that, consistent with the privacy
11 protections provided for under the regulations pro-
12 mulgated under section 264(c) of the Health Insur-
13 ance Portability and Accountability Act of 1996 and
14 any applicable State privacy laws, data on the indi-
15 vidual patient or recipient’s race, ethnicity, and pri-
16 mary language are collected (and periodically up-
17 dated) in health records and integrated into the or-
18 ganization’s information management systems or
19 any similar system used to store and retrieve data.

20 “(d) PRIORITY.—In awarding grants under this sec-
21 tion, the Secretary shall give priority to entities that pri-
22 marily engage in providing direct care and that have devel-
23 oped partnerships with community organizations or with
24 agencies with experience in improving language access.

25 “(e) EVALUATION.—

1 “(1) BY GRANTEES.—An entity that receives a
2 grant under this section shall submit to the Sec-
3 retary an evaluation that describes, in the manner
4 and to the extent required by the Secretary, the ac-
5 tivities carried out with funds received under the
6 grant, and how such activities improved access to
7 health care services and health-care-related services
8 and the quality of health care for individuals with
9 limited English proficiency. Such evaluation shall be
10 collected and disseminated through the Robert T.
11 Matsui Center for Culturally and Linguistically Ap-
12 propriate Health Care established under section
13 3401. The Director of the Agency for Healthcare
14 Research and Quality shall notify grantees of the
15 availability of technical assistance for the evaluation
16 and provide such assistance upon request.

17 “(2) BY SECRETARY.—The Director of the
18 Agency for Healthcare Research and Quality shall
19 evaluate or arrange with other individuals or organi-
20 zations to evaluate projects funded under this sec-
21 tion.

22 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
23 is authorized to be appropriated to carry out this section,
24 \$5,000,000 for each of fiscal years 2021 through 2025.

1 **“SEC. 3406. RESEARCH ON CULTURAL AND LANGUAGE COM-**
2 **PETENCE.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Director of the Agency for Healthcare Research and
5 Quality, shall expand research concerning language access
6 in the provision of health care services.

7 “(b) ELIGIBILITY.—The Director of the Agency for
8 Healthcare Research and Quality may conduct the re-
9 search described in subsection (a) or enter into contracts
10 with other individuals or organizations to conduct such re-
11 search.

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

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

18 “(2) To identify health care providers’ and
19 health administrators’ attitudes, knowledge, and
20 awareness of the barriers to quality health care serv-
21 ices that are faced by individuals with limited
22 English proficiency.

23 “(3) To identify optimal approaches for deliv-
24 ering language access.

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

1 “(A) the collection by providers of health
2 care services and health-care-related services of
3 data on the race, ethnicity, and primary lan-
4 guage of recipients of such services, taking into
5 account existing research conducted by the Gov-
6 ernment or private sector;

7 “(B) the development and implementation
8 of data collection and reporting systems; and

9 “(C) effective privacy safeguards for col-
10 lected data.

11 “(5) To develop a minimum data collection set
12 for primary language.

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

19 “(A) provider type;

20 “(B) languages needed and their frequency
21 of use;

22 “(C) type of encounter;

23 “(D) time of encounter, including regular
24 business hours and after hours; and

25 “(E) location of encounter.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 2 are authorized to be appropriated to carry out this section
 3 \$5,000,000 for each of fiscal years 2021 through 2025.”.

4 **SEC. 703. TRAINING TOMORROW’S DOCTORS FOR CUL-**
 5 **TURALLY AND LINGUISTICALLY APPRO-**
 6 **PRIATE CARE: GRADUATE MEDICAL EDU-**
 7 **CATION.**

8 (a) DIRECT GRADUATE MEDICAL EDUCATION.—Sec-
 9 tion 1886(h)(4) of the Social Security Act (42 U.S.C.
 10 1395ww(h)(4)) is amended by adding at the end the fol-
 11 lowing new subparagraph:

12 “(L) TREATMENT OF CULTURALLY AND
 13 LINGUISTICALLY APPROPRIATE TRAINING.—In
 14 determining a hospital’s number of full-time
 15 equivalent residents for purposes of this sub-
 16 section, all the time that is spent by an intern
 17 or resident in an approved medical residency
 18 training program for education and training in
 19 culturally and linguistically appropriate service
 20 delivery, which shall include all diverse popu-
 21 lations including people with disabilities and the
 22 Lesbian, gay, bisexual, transgender, queer,
 23 questioning, questioning and intersex
 24 (LGBTQIA) community, shall be counted to-

1 ward the determination of full-time equiva-
2 lency.”.

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

6 (1) by redesignating the clause (x) added by
7 section 5505(b) of the Patient Protection and Af-
8 fordable Care Act as clause (xi); and

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

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

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

19 **SEC. 704. FEDERAL REIMBURSEMENT FOR CULTURALLY**
20 **AND LINGUISTICALLY APPROPRIATE SERV-**
21 **ICES UNDER THE MEDICARE, MEDICAID, AND**
22 **STATE CHILDREN’S HEALTH INSURANCE**
23 **PROGRAMS.**

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

1 (1) ESTABLISHMENT.—

2 (A) IN GENERAL.—Not later than 6
3 months after the date of the enactment of this
4 Act, the Secretary of Health and Human Serv-
5 ices, acting through the Centers for Medicare &
6 Medicaid Services and in consultation with the
7 Center for Medicare and Medicaid Innovation
8 (as referred to in section 1115A of the Social
9 Security Act (42 U.S.C. 1315a)), shall establish
10 a demonstration program under which the Sec-
11 retary shall award grants to eligible Medicare
12 service providers to improve communication be-
13 tween such providers and Medicare beneficiaries
14 who are limited English proficient, including
15 beneficiaries who live in diverse and under-
16 served communities.

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

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

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

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

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

10 (i) a provider of services under part A
11 of title XVIII of the Social Security Act
12 (42 U.S.C. 1395c et seq.);

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

15 (iii) a Medicare Advantage organiza-
16 tion offering a Medicare Advantage plan
17 under part C of such title (42 U.S.C.
18 1395w–21 et seq.); or

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

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

1 English learners, is disproportionately under-
2 served.

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

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

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

21 (A) at least 6 grants to providers of serv-
22 ices described in paragraph (2)(A)(i);

23 (B) at least 6 grants to service providers
24 described in paragraph (2)(A)(ii);

1 (C) at least 6 grants to organizations de-
2 scribed in paragraph (2)(A)(iii); and

3 (D) at least 6 grants to sponsors described
4 in paragraph (2)(A)(iv).

5 (4) CONSIDERATIONS IN AWARDING GRANTS.—

6 (A) VARIATION IN GRANTEES.—In award-
7 ing grants under this subsection, the Secretary
8 shall select grantees to ensure the following:

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

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

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

18 (iv) The grantees serve Medicare
19 beneficiaries in at least two geographic re-
20 gions, as defined by the Secretary.

21 (v) The grantees serve Medicare bene-
22 ficiaries in at least two large metropolitan
23 statistical areas with racial, ethnic, sexual,
24 gender, disability, and economically diverse
25 populations.

1 (B) PRIORITY FOR PARTNERSHIPS WITH
2 COMMUNITY ORGANIZATIONS AND AGENCIES.—

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

6 (i) a community organization; or

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

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

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

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

22 (i) interpreter and translation services
23 that—

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

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

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

20 (II) that, in the case of inter-
21 preter services, are provided
22 through—

23 (aa) onsite interpretation;

24 (bb) telephonic interpreta-
25 tion; or

1 (cc) video interpretation;

2 and

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

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

10 (i) in the case of a Medicare bene-
11 ficiary who is an English learner if—

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

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

22 (ii) in the case of a medical emergency
23 where the delay directly associated with ob-
24 taining a competent interpreter or trans-

1 lation services would jeopardize the health
2 of the patient.

3 Clause (ii) shall not be construed to exempt
4 emergency rooms or similar entities that regu-
5 larly provide health care services in medical
6 emergencies to patients who are English learn-
7 ers from any applicable legal or regulatory re-
8 quirements related to providing competent in-
9 terpreter and translation services without undue
10 delay.

11 (D) MEDICARE ADVANTAGE ORGANIZA-
12 TIONS AND PDP SPONSORS.—If a grantee is a
13 Medicare Advantage organization offering a
14 Medicare Advantage plan under part C of title
15 XVIII of the Social Security Act (42 U.S.C.
16 1395w–21 et seq.) or a PDP sponsor offering
17 a prescription drug plan under part D of such
18 title (42 U.S.C. 1395w–101 et seq.), such entity
19 must provide at least 50 percent of the grant
20 funds that the entity receives under this sub-
21 section directly to the entity’s network providers
22 (including all health providers and pharmacists)
23 for the purpose of providing support for such
24 providers to provide competent language serv-

1 ices to Medicare beneficiaries who are English
2 learners.

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

9 (6) DETERMINATION OF AMOUNT OF GRANT
10 PAYMENTS.—

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

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

24 (ii) data provided by the grantee, if
25 the grantee routinely collects data on the

1 primary language of the Medicare bene-
2 ficiaries that the grantee serves and the
3 Secretary determines that the data is accu-
4 rate and shows a greater number of
5 English learners than would be estimated
6 using the data under clause (i).

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

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

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

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

1 (B) ensure the linguistic competence of bi-
2 lingual providers;

3 (C) offer and provide appropriate language
4 services at no additional charge to each patient
5 who is an English learner for all points of con-
6 tact between the patient and the grantee, in a
7 timely manner during all hours of operation;

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

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

14 (F) ensure that—

15 (i) primary language data are col-
16 lected for recipients of language services
17 and such data are consistent with stand-
18 ards developed under title XXXIV of the
19 Public Health Service Act, as added by
20 section 202 of this Act, to the extent such
21 standards are available upon the initiation
22 of the demonstration program; and

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

1 Health Insurance Portability and Account-
2 ability Act of 1996 (42 U.S.C. 1320d–2
3 note), if the recipient of language services
4 is a minor or is incapacitated, primary lan-
5 guage data are collected on the parent or
6 legal guardian of such recipient.

7 (8) NO COST SHARING.—Medicare beneficiaries
8 who are English learners shall not have to pay cost
9 sharing or co-payments for competent language serv-
10 ices provided under this demonstration program.

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

16 (A) The number of Medicare beneficiaries
17 to whom competent language services are pro-
18 vided.

19 (B) The primary languages of those Medi-
20 care beneficiaries.

21 (C) The types of language services pro-
22 vided to such beneficiaries.

23 (D) Whether such language services were
24 provided by employees of the grantee or

1 through a contract with external contractors or
2 agencies.

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

7 (F) The costs of providing competent lan-
8 guage services.

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

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

19 (A) An analysis of the patient outcomes
20 and the costs of furnishing care to the Medicare
21 beneficiaries who are English learners partici-
22 pating in the project as compared to such out-
23 comes and costs for such Medicare beneficiaries
24 not participating, based on the data provided

1 under paragraph (9) and any other information
2 available to the Secretary.

3 (B) The effect of delivering language serv-
4 ices on—

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

7 (ii) the efficiency and cost effective-
8 ness of health care delivery;

9 (iii) patient satisfaction;

10 (iv) health outcomes; and

11 (v) the provision of culturally appro-
12 priate services provided to such bene-
13 ficiaries.

14 (C) The extent to which bilingual staff, in-
15 terpreters, and translators providing services
16 under such demonstration were trained or ac-
17 credited and the nature of accreditation or
18 training needed by type of provider, service, or
19 other category as determined by the Secretary
20 to ensure the provision of high-quality interpre-
21 tation, translation, or other language services to
22 Medicare beneficiaries if such services are ex-
23 panded pursuant to section 1115A(c) of the So-
24 cial Security Act (42 U.S.C. 1315a(c)).

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

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

13 (12) ENGLISH LEARNER DEFINED.—In this
14 subsection, the term “English learner” has the
15 meaning given such term in section 8101(20) of the
16 Elementary and Secondary Education Act of 1965,
17 except that subparagraphs (A), (B), and (D) of such
18 section shall not apply.

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

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

24 (A) in subsection (aa)(1)—

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

3 (ii) by adding “and” at the end of
4 subparagraph (C); and

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

7 “(D) language assistance services as defined in
8 subsection (jjj)(1),”; and

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

11 “Language Assistance Services and Related Terms

12 “(kkk)(1) The term ‘language assistance services’
13 means ‘language access’ or ‘language assistance services’
14 (as those terms are defined in section 3400 of the Public
15 Health Service Act) furnished by a ‘qualified interpreter
16 for an individual with limited English proficiency’ or a
17 ‘qualified translator’ (as those terms are defined in such
18 section 3400) to an ‘individual with limited English pro-
19 ficiency’ (as defined in such section 3400) or an ‘English
20 learner’ (as defined in paragraph (2)).

21 “(2) The term ‘English learner’ has the meaning
22 given that term in section 8101(20) of the Elementary and
23 Secondary Education Act of 1965, except that subpara-
24 graphs (A), (B), and (D) of such section shall not apply.”.

1 (2) COVERAGE.—Section 1832(a)(2) of the So-
2 cial Security Act (42 U.S.C. 1395k(a)(2)) is amend-
3 ed—

4 (A) by striking “and” at the end of sub-
5 paragraph (I);

6 (B) by striking the period at the end of
7 subparagraph (J) and inserting “; and”; and

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

10 “(K) language assistance services (as de-
11 fined in section 1861(jjj)(1)).”.

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

14 (A) by striking “and” at the end of para-
15 graph (8);

16 (B) by striking the period at the end of
17 paragraph (9) and inserting “; and”; and

18 (C) by inserting after paragraph (9) the
19 following new paragraph:

20 “(10) in the case of language assistance serv-
21 ices (as defined in section 1861(jjj)(1)), 100 percent
22 of the reasonable charges for such services, as deter-
23 mined in consultation with the Medicare Payment
24 Advisory Commission.”.

1 (4) WAIVER OF BUDGET NEUTRALITY.—For
2 the 3-year period beginning on the date of enact-
3 ment of this section, the budget neutrality provision
4 of section 1848(c)(2)(B)(ii) of the Social Security
5 Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not
6 apply with respect to language assistance services
7 (as defined in section 1861(kkk)(1) of such Act).

8 (c) MEDICARE PARTS C AND D.—

9 (1) IN GENERAL.—Medicare Advantage plans
10 under part C of title XVIII of the Social Security
11 Act (42 U.S.C. 1395w–21 et seq.) and prescription
12 drug plans under part D of such title (42 U.S.C.
13 1395q–101) shall comply with title VI of the Civil
14 Rights Act of 1964 (42 U.S.C. 2000d et seq.) and
15 section 1557 of the Patient Protection and Afford-
16 able Care Act (42 U.S.C. 18116) to provide effective
17 language services to enrollees of such plans.

18 (2) MEDICARE ADVANTAGE PLANS AND PRE-
19 SCRIPTION DRUG PLANS REPORTING REQUIRE-
20 MENT.—Section 1857(e) of the Social Security Act
21 (42 U.S.C. 1395w–27(e)) is amended by adding at
22 the end the following new paragraph:

23 “(5) REPORTING REQUIREMENTS RELATING TO
24 EFFECTIVE LANGUAGE SERVICES.—A contract under
25 this part shall require a Medicare Advantage organi-

1 zation (and, through application of section 1860D–
2 12(b)(3)(D), a contract under section 1860D–12
3 shall require a PDP sponsor) to annually submit
4 (for each year of the contract) a report that contains
5 information on the internal policies and procedures
6 of the organization (or sponsor) related to recruit-
7 ment and retention efforts directed to workforce di-
8 versity and linguistically and culturally appropriate
9 provision of services in each of the following con-
10 texts:

11 “(A) The collection of data in a manner
12 that meets the requirements of title I of the
13 Ending Health Disparities During COVID–19
14 Act of 2020, regarding the enrollee population.

15 “(B) Education of staff and contractors
16 who have routine contact with enrollees regard-
17 ing the various needs of the diverse enrollee
18 population.

19 “(C) Evaluation of the language services
20 programs and services offered by the organiza-
21 tion (or sponsor) with respect to the enrollee
22 population, such as through analysis of com-
23 plaints or satisfaction survey results.

1 “(D) Methods by which the plan provides
2 to the Secretary information regarding the eth-
3 nic diversity of the enrollee population.

4 “(E) The periodic provision of educational
5 information to plan enrollees on the language
6 services and programs offered by the organiza-
7 tion (or sponsor).”.

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

10 (1) PAYMENTS TO STATES.—Section
11 1903(a)(2)(E) of the Social Security Act (42 U.S.C.
12 1396b(a)(2)(E)), as amended by section 203(g)(3),
13 is further amended by—

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

15 (B) striking “translation or interpretation
16 services” and inserting “language assistance
17 services”; and

18 (C) striking “children of families” and in-
19 serting “individuals”.

20 (2) STATE PLAN REQUIREMENTS.—Section
21 1902(a)(10)(A) of the Social Security Act (42
22 U.S.C. 1396a(a)(10)(A)) is amended by striking
23 “and (29)” and inserting “(29), and (30)”.

1 (3) DEFINITION OF MEDICAL ASSISTANCE.—

2 Section 1905(a) of the Social Security Act (42
3 U.S.C. 1396d(a)) is amended by—

4 (A) in paragraph (29), by striking “and”
5 at the end;

6 (B) by redesignating paragraph (30) as
7 paragraph (31); and

8 (C) by inserting after paragraph (29) the
9 following new paragraph:

10 “(30) language assistance services, as such
11 term is defined in section 1861(kkk)(1), provided in
12 a timely manner to individuals with limited English
13 proficiency as defined in section 3400 of the Public
14 Health Service Act; and”.

15 (4) USE OF DEDUCTIONS AND COST SHAR-
16 ING.—Section 1916(a)(2) of the Social Security Act
17 (42 U.S.C. 1396o(a)(2)) is amended by—

18 (A) by striking “or” at the end of subpara-
19 graph (D);

20 (B) by striking “; and” at the end of sub-
21 paragraph (E) and inserting “, or”; and

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

24 “(F) language assistance services described
25 in section 1905(a)(29); and”.

1 (5) CHIP COVERAGE REQUIREMENTS.—Section
2 2103 of the Social Security Act (42 U.S.C. 1397cc)
3 is amended—

4 (A) in subsection (a), in the matter before
5 paragraph (1), by striking “and (7)” and in-
6 serting “(7), and (10)”; and

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

9 “(10) LANGUAGE ASSISTANCE SERVICES.—The
10 child health assistance provided to a targeted low-in-
11 come child shall include coverage of language assist-
12 ance services, as such term is defined in section
13 1861(jjj)(1), provided in a timely manner to individ-
14 uals with limited English proficiency (as defined in
15 section 3400 of the Public Health Service Act).”;
16 and

17 (C) in subsection (e)(2)—

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

20 (ii) by inserting “or subsection
21 (c)(10)” after “subsection (c)(1)(D)”.

22 (6) DEFINITION OF CHILD HEALTH ASSIST-
23 ANCE.—Section 2110(a)(27) of the Social Security
24 Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-

1 ing “translation” and inserting “language assistance
2 services as described in section 2103(c)(10)”.

3 (7) STATE DATA COLLECTION.—Pursuant to
4 the reporting requirement described in section
5 2107(b)(1) of the Social Security Act (42 U.S.C.
6 1397gg(b)(1)), the Secretary of Health and Human
7 Services shall require that States collect data on—

8 (A) the primary language of individuals re-
9 ceiving child health assistance under title XXI
10 of the Social Security Act (42 U.S.C. 1397aa et
11 seq.); and

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

15 (8) CHIP PAYMENTS TO STATES.—Section
16 2105 of the Social Security Act (42 U.S.C. 1397ee)
17 is amended—

18 (A) in subsection (a)(1), by striking “75”
19 and inserting “90”; and

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

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

5 (1) PAYMENT OF COSTS.—

6 (A) IN GENERAL.—Subject to subpara-
7 graph (B), the Secretary of Health and Human
8 Services (referred to in this subsection as the
9 “Secretary”) shall make payments (on a quar-
10 terly basis) directly to eligible entities to sup-
11 port the provision of language assistance serv-
12 ices to English learners in an amount equal to
13 an eligible entity’s eligible costs for providing
14 such services for the quarter.

15 (B) FUNDING.—Out of any funds in the
16 Treasury not otherwise appropriated, there are
17 appropriated to the Secretary of Health and
18 Human Services such sums as may be nec-
19 essary for each of fiscal years 2021 through
20 2025.

21 (C) RELATION TO MEDICAID DSH.—Pay-
22 ments under this subsection shall not offset or
23 reduce payments under section 1923 of the So-
24 cial Security Act (42 U.S.C. 1396r–4), nor
25 shall payments under such section be consid-

1 ered when determining uncompensated costs as-
2 sociated with the provision of language assist-
3 ance services for the purposes of this section.

4 (2) METHODODOLOGY FOR PAYMENT OF
5 CLAIMS.—

6 (A) IN GENERAL.—The Secretary shall es-
7 tablish a methodology to determine the average
8 per person cost of language assistance services.

9 (B) DIFFERENT ENTITIES.—In estab-
10 lishing such methodology, the Secretary may es-
11 tablish different methodologies for different
12 types of eligible entities.

13 (C) NO INDIVIDUAL CLAIMS.—The Sec-
14 retary may not require eligible entities to sub-
15 mit individual claims for language assistance
16 services for individual patients as a requirement
17 for payment under this subsection.

18 (3) DATA COLLECTION INSTRUMENT.—For pur-
19 poses of this subsection, the Secretary shall create a
20 standard data collection instrument that is con-
21 sistent with any existing reporting requirements by
22 the Secretary or relevant accrediting organizations
23 regarding the number of individuals to whom lan-
24 guage access are provided.

1 (4) GUIDELINES.—Not later than 6 months
2 after the date of enactment of this Act, the Sec-
3 retary shall establish and distribute guidelines con-
4 cerning the implementation of this subsection.

5 (5) REPORTING REQUIREMENTS.—

6 (A) REPORT TO SECRETARY.—Entities re-
7 ceiving payment under this subsection shall pro-
8 vide the Secretary with a quarterly report on
9 how the entity used such funds. Such report
10 shall contain aggregate (and may not contain
11 individualized) data collected using the instru-
12 ment under paragraph (3) and shall otherwise
13 be in a form and manner determined by the
14 Secretary.

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

20 (6) DEFINITIONS.—In this subsection:

21 (A) ELIGIBLE COSTS.—The term “eligible
22 costs” means, with respect to an eligible entity
23 that provides language assistance services to
24 English learners, the product of—

1 (i) the average per person cost of lan-
2 guage assistance services, determined ac-
3 cording to the methodology devised under
4 paragraph (2); and

5 (ii) the number of English learners
6 who are provided language assistance serv-
7 ices by the entity and for whom no reim-
8 bursement is available for such services
9 under the amendments made by sub-
10 sections (a), (b), (c), or (d) or by private
11 health insurance.

12 (B) ELIGIBLE ENTITY.—The term “eligible
13 entity” means an entity that—

14 (i) is a Medicaid provider that is—

15 (I) a physician;

16 (II) a hospital with a low-income
17 utilization rate (as defined in section
18 1923(b)(3) of the Social Security Act
19 (42 U.S.C. 1396r–4(b)(3))) of greater
20 than 25 percent; or

21 (III) a Federally qualified health
22 center (as defined in section
23 1905(l)(2)(B) of the Social Security
24 Act (42 U.S.C. 1396d(l)(2)(B)));

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

6 (iii) prepares and submits an applica-
7 tion to the Secretary, at such time, in such
8 manner, and accompanied by such infor-
9 mation as the Secretary may require, to
10 ascertain the entity's eligibility for funding
11 under this subsection.

12 (C) ENGLISH LEARNER.—The term
13 “English learner” has the meaning given such
14 term in section 8101(20) of the Elementary
15 and Secondary Education Act of 1965 (20
16 U.S.C. 7801(20)), except that subparagraphs
17 (A), (B), and (D) of such section shall not
18 apply.

19 (D) LANGUAGE ASSISTANCE SERVICES.—
20 The term “language assistance services” has
21 the meaning given such term in section
22 1861(kkk)(1) of the Social Security Act, as
23 added by subsection (b).

24 (f) APPLICATION OF CIVIL RIGHTS ACT OF 1964,
25 SECTION 1557 OF THE AFFORDABLE CARE ACT, AND

1 OTHER LAWS.—Nothing in this section shall be construed
2 to limit otherwise existing obligations of recipients of Fed-
3 eral financial assistance under title VI of the Civil Rights
4 Act of 1964 (42 U.S.C. 2000d et seq.), section 1557 of
5 the Affordable Care Act, or other laws that protect the
6 civil rights of individuals.

7 (g) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Except as otherwise pro-
9 vided and subject to paragraph (2), the amendments
10 made by this section shall take effect on January 1,
11 2021.

12 (2) EXCEPTION IF STATE LEGISLATION RE-
13 QUIRED.—In the case of a State plan for medical as-
14 sistance under title XIX of the Social Security Act
15 (42 U.S.C. 1396 et seq.) which the Secretary of
16 Health and Human Services determines requires
17 State legislation (other than legislation appro-
18 priating funds) in order for the plan to meet the ad-
19 ditional requirement imposed by the amendments
20 made by this section, the State plan shall not be re-
21 garded as failing to comply with the requirements of
22 such title solely on the basis of its failure to meet
23 this additional requirement before the first day of
24 the first calendar quarter beginning after the close
25 of the first regular session of the State legislature

1 that begins after the date of the enactment of this
2 Act. For purposes of the previous sentence, in the
3 case of a State that has a 2-year legislative session,
4 each year of such session shall be deemed to be a
5 separate regular session of the State legislature.

6 **SEC. 705. REQUIREMENTS FOR HEALTH PROGRAMS OR AC-**
7 **TIVITIES RECEIVING FEDERAL FUNDS.**

8 (a) COVERED ENTITY; COVERED PROGRAM OR AC-
9 TIVITY.—In this section—

10 (1) the term “covered entity” has the meaning
11 given such term in section 92.4 of title 42, Code of
12 Federal Regulations, as in effect on May 16, 2016;
13 and

14 (2) the term “covered program or activity” has
15 the meaning given such term in section 92.4 of title
16 42, Code of Federal Regulations, as in effect on May
17 16, 2016.

18 (b) REQUIREMENTS.—A covered entity, in order to
19 ensure the right of individuals with limited English pro-
20 ficiency to receive access to high-quality health care
21 through the covered program or activity, shall—

22 (1) ensure that appropriate clinical and support
23 staff receive ongoing education and training in cul-
24 turally and linguistically appropriate service delivery;

1 (2) offer and provide appropriate language as-
2 sistance services at no additional charge to each pa-
3 tient that is an individual with limited English pro-
4 ficiency at all points of contact, in a timely manner
5 during all hours of operation;

6 (3) notify patients of their right to receive lan-
7 guage services in their primary language; and

8 (4) utilize only qualified interpreters for an in-
9 dividual with limited English proficiency or qualified
10 translators, except as provided in subsection (c).

11 (c) EXEMPTIONS.—The requirements of subsection
12 (b)(4) shall not apply as follows:

13 (1) When a patient requests the use of family,
14 friends, or other persons untrained in interpretation
15 or translation if each of the following conditions are
16 met:

17 (A) The interpreter requested by the pa-
18 tient is over the age of 18.

19 (B) The covered entity informs the patient
20 in the primary language of the patient that he
21 or she has the option of having the entity pro-
22 vide to the patient an interpreter and trans-
23 lation services without charge.

24 (C) The covered entity informs the patient
25 that the entity may not require an individual

1 with a limited English proficiency to use a fam-
2 ily member or friend as an interpreter.

3 (D) The covered entity evaluates whether
4 the person the patient wishes to use as an in-
5 terpreter is competent. If the covered entity has
6 reason to believe that such person is not com-
7 petent as an interpreter, the entity provides its
8 own interpreter to protect the covered entity
9 from liability if the patient's interpreter is later
10 found not competent.

11 (E) If the covered entity has reason to be-
12 lieve that there is a conflict of interest between
13 the interpreter and patient, the covered entity
14 may not use the patient's interpreter.

15 (F) The covered entity has the patient sign
16 a waiver, witnessed by at least 1 individual not
17 related to the patient, that includes the infor-
18 mation stated in subparagraphs (A) through
19 (E) and is translated into the patient's primary
20 language.

21 (2) When a medical emergency exists and the
22 delay directly associated with obtaining competent
23 interpreter or translation services would jeopardize
24 the health of the patient, but only until a competent
25 interpreter or translation service is available.

1 (d) RULE OF CONSTRUCTION.—Subsection (c)(2)
2 shall not be construed to mean that emergency rooms or
3 similar entities that regularly provide health care services
4 in medical emergencies are exempt from legal or regu-
5 latory requirements related to competent interpreter serv-
6 ices.

7 **SEC. 706. REPORT ON FEDERAL EFFORTS TO PROVIDE CUL-**
8 **TURALLY AND LINGUISTICALLY APPRO-**
9 **PRIATE HEALTH CARE SERVICES.**

10 (a) REPORT.—Not later than 1 year after the date
11 of enactment of this Act and annually thereafter, the Sec-
12 retary of Health and Human Services shall enter into a
13 contract with the National Academy of Medicine for the
14 preparation and publication of a report that describes
15 Federal efforts to ensure that all individuals with limited
16 English proficiency have meaningful access to health care
17 services and health-care-related services that are culturally
18 and linguistically appropriate. Such report shall include—

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

21 (2) a description and analysis of best practices,
22 model programs, guidelines, and other effective
23 strategies for providing access to culturally and lin-
24 guistically appropriate health care services;

1 (3) recommendations on the development and
2 implementation of policies and practices by providers
3 of health care services and health-care-related serv-
4 ices for individuals with limited English proficiency,
5 including people with cognitive, hearing, vision, or
6 print impairments;

7 (4) recommend guidelines or standards for
8 health literacy and plain language, informed consent,
9 discharge instructions, and written communications,
10 and for improvement of health care access;

11 (5) a description of the effect of providing lan-
12 guage services on quality of health care and access
13 to care; and

14 (6) a description of the costs associated with or
15 savings related to the provision of language services.

16 (b) **AUTHORIZATION OF APPROPRIATIONS.**—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary for each of fiscal years
19 2021 through 2025.

20 **SEC. 707. HEALTH PROFESSIONS COMPETENCIES TO AD-**
21 **DRESS RACIAL AND ETHNIC MENTAL HEALTH**
22 **DISPARITIES.**

23 (a) **IN GENERAL.**—The Secretary of Health and
24 Human Services, acting through the Assistant Secretary

1 for Mental Health and Substance Use, shall award grants
2 to qualified national organizations for the purposes of—

3 (1) developing, and disseminating to health pro-
4 fessional educational programs curricula or core
5 competencies addressing mental health inequities
6 among racial and ethnic minority groups for use in
7 the training of students in the professions of social
8 work, psychology, psychiatry, marriage and family
9 therapy, mental health counseling, peer support, and
10 substance abuse counseling; and

11 (2) certifying community health workers and
12 peer wellness specialists with respect to such cur-
13 ricula and core competencies and integrating and ex-
14 panding the use of such workers and specialists into
15 health care and community-based settings to address
16 mental health disparities among racial and ethnic
17 minority groups.

18 (b) CURRICULA; CORE COMPETENCIES.—Organiza-
19 tions receiving funds under subsection (a) may use the
20 funds to engage in the following activities related to the
21 development and dissemination of curricula or core com-
22 petencies described in subsection (a)(1):

23 (1) Formation of committees or working groups
24 comprised of experts from accredited health profes-
25 sions schools to identify core competencies relating

1 to mental health disparities among racial and ethnic
2 minority groups.

3 (2) Planning of workshops in national fora to
4 allow for public input, including input from commu-
5 nities of color with lived experience, into the edu-
6 cational needs associated with mental health dispari-
7 ties among racial and ethnic minority groups.

8 (3) Dissemination and promotion of the use of
9 curricula or core competencies in undergraduate and
10 graduate health professions training programs na-
11 tionwide.

12 (4) Establishing external stakeholder advisory
13 boards to provide meaningful input into policy and
14 program development and best practices to reduce
15 mental health inequities among racial and ethnic
16 groups, including participation from communities of
17 color with lived experience of the impacts of mental
18 health disparities.

19 (c) DEFINITIONS.—In this section:

20 (1) QUALIFIED NATIONAL ORGANIZATION.—The
21 term “qualified national organization” means a na-
22 tional organization that focuses on the education of
23 students in programs of social work, occupational
24 therapy, psychology, psychiatry, and marriage and
25 family therapy.

1 (2) RACIAL AND ETHNIC MINORITY GROUP.—

2 The term “racial and ethnic minority group” has the
3 meaning given to such term in section 1707(g) of
4 the Public Health Service Act (42 U.S.C. 300u–
5 6(g)).

6 (d) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2021 through 2025.

10 **SEC. 708. STUDY ON THE UNINSURED.**

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services (in this section referred to as the “Sec-
13 retary”) shall—

14 (1) conduct a study, in accordance with the
15 standards under section 3101 of the Public Health
16 Service Act (42 U.S.C. 300kk), on the demographic
17 characteristics of the population of individuals who
18 do not have health insurance coverage or oral health
19 coverage; and

20 (2) predict, based on such study, the demo-
21 graphic characteristics of the population of individ-
22 uals who would remain without health insurance cov-
23 erage after the end of any annual open enrollment
24 or any special enrollment period or upon enactment
25 and implementation of any legislative changes to the

1 Patient Protection and Affordable Care Act (Public
2 Law 111–148) that affect the number of persons eli-
3 gible for coverage.

4 (b) REPORTING REQUIREMENTS.—

5 (1) IN GENERAL.—Not later than 12 months
6 after the date of the enactment of this Act, the Sec-
7 retary shall submit to the Congress the results of
8 the study under subsection (a)(1) and the prediction
9 made under subsection (a)(2).

10 (2) REPORTING OF DEMOGRAPHIC CHARACTER-
11 ISTICS.—The Secretary shall—

12 (A) report the demographic characteristics
13 under paragraphs (1) and (2) of subsection (a)
14 on the basis of racial and ethnic group, and
15 shall stratify the reporting on each racial and
16 ethnic group by other demographic characteris-
17 tics that can impact access to health insurance
18 coverage, such as sexual orientation, gender
19 identity, primary language, disability status,
20 sex, socioeconomic status, age group, and citi-
21 zenship and immigration status, in a manner
22 consistent with title I of this Act, including the
23 amendments made by such title; and

24 (B) not use such report to engage in or an-
25 ticipate any deportation or immigration related

enforcement action by any entity, including the
Department of Homeland Security.

TITLE VIII—AID TO PROVIDERS SERVING MINORITY COMMU- NITIES

SEC. 801. TEMPORARY INCREASE IN MEDICAID DSH ALLOT- MENTS.

(a) IN GENERAL.—Section 1923(f)(3) of the Social
Security Act (42 U.S.C. 1396r–4(f)(3)) is amended—

(1) in subparagraph (A), by striking “and sub-
paragraph (E)” and inserting “and subparagraphs
(E) and (F)”; and

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

“(F) TEMPORARY INCREASE IN ALLOT-
MENTS DURING CERTAIN PUBLIC HEALTH
EMERGENCY.—The DSH allotment for any
State for each of fiscal years 2020 and 2021 is
equal to 102.5 percent of the DSH allotment
that would be determined under this paragraph
for the State for each respective fiscal year
without application of this subparagraph, not-
withstanding subparagraphs (B) and (C). For
each fiscal year after fiscal year 2021, the DSH
allotment for a State for such fiscal year is

1 equal to the DSH allotment that would have
2 been determined under this paragraph for such
3 fiscal year if this subparagraph had not been
4 enacted.”.

5 (b) DSH ALLOTMENT ADJUSTMENT FOR TEN-
6 NESSEE.—Section 1923(f)(6)(A)(vi) of the Social Security
7 Act (42 U.S.C. 1396r–4(f)(6)(A)(vi)) is amended—

8 (1) by striking “Notwithstanding any other pro-
9 vision of this subsection” and inserting the fol-
10 lowing:

11 “(I) IN GENERAL.—Notwith-
12 standing any other provision of this
13 subsection (except as provided in sub-
14 clause (II) of this clause)”;

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

16 “(II) TEMPORARY INCREASE IN
17 ALLOTMENTS.—The DSH allotment
18 for Tennessee for each of fiscal years
19 2020 and 2021 shall be equal to
20 \$54,427,500.”.

21 (c) SENSE OF CONGRESS.—It is the sense of Con-
22 gress that a State should prioritize making payments
23 under the State plan of the State under title XIX of the
24 Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver
25 of such plan) to disproportionate share hospitals that have

1 a higher share of COVID–19 patients relative to other
2 such hospitals in the State.

3 **SEC. 802. COVID–19-RELATED TEMPORARY INCREASE OF**
4 **MEDICAID FMAP.**

5 (a) IN GENERAL.—Section 6008 of the Families
6 First Coronavirus Response Act (42 U.S.C. 1396d note)
7 is amended—

8 (1) in subsection (a)—

9 (A) by inserting “(or, if later, June 30,
10 2021)” after “last day of such emergency pe-
11 riod occurs”; and

12 (B) by striking “6.2 percentage points.”
13 and inserting “the percentage points specified
14 in subsection (e). In no case may the applica-
15 tion of this section result in the Federal medical
16 assistance percentage determined for a State
17 being more than 95 percent.”; and

18 (2) by adding at the end the following new sub-
19 sections:

20 “(e) SPECIFIED PERCENTAGE POINTS.—For pur-
21 poses of subsection (a), the percentage points specified in
22 this subsection are—

23 “(1) for each calendar quarter occurring during
24 the period beginning on the first day of the emer-
25 gency period described in paragraph (1)(B) of sec-

1 tion 1135(g) of the Social Security Act (42 U.S.C.
2 1320b–5(g)) and ending on June 30, 2020, 6.2 per-
3 centage points;

4 “(2) for each calendar quarter occurring during
5 the period beginning on July 1, 2020, and ending on
6 June 30, 2021, 14 percentage points; and

7 “(3) for each calendar quarter, if any, occurring
8 during the period beginning on July 1, 2021, and
9 ending on the last day of the calendar quarter in
10 which the last day of such emergency period occurs,
11 6.2 percentage points.

12 “(f) CLARIFICATIONS.—

13 “(1) In the case of a State that treats an indi-
14 vidual described in subsection (b)(3) as eligible for
15 the benefits described in such subsection, for the pe-
16 riod described in subsection (a), expenditures for
17 medical assistance and administrative costs attrib-
18 utable to such individual that would not otherwise be
19 included as expenditures under section 1903 of the
20 Social Security Act shall be regarded as expendi-
21 tures under the State plan approved under title XIX
22 of the Social Security Act or for administration of
23 such State plan.

24 “(2) The limitations on payment under sub-
25 sections (f) and (g) of section 1108 of the Social Se-

1 security Act (42 U.S.C. 1308) shall not apply to Fed-
2 eral payments made under section 1903(a)(1) of the
3 Social Security Act (42 U.S.C. 1396b(a)(1)) attrib-
4 utable to the increase in the Federal medical assist-
5 ance percentage under this section.

6 “(3) Expenditures attributable to the increased
7 Federal medical assistance percentage under this
8 section shall not be counted for purposes of the limi-
9 tations under section 2104(b)(4) of such Act (42
10 U.S.C. 1397dd(b)(4)).

11 “(4) Notwithstanding the first sentence of sec-
12 tion 2105(b) of the Social Security Act (42 U.S.C.
13 1397ee(b)), the application of the increase under
14 this section may result in the enhanced FMAP of a
15 State for a fiscal year under such section exceeding
16 85 percent, but in no case may the application of
17 such increase before application of the second sen-
18 tence of such section result in the enhanced FMAP
19 of the State exceeding 95 percent.

20 “(g) SCOPE OF APPLICATION.—An increase in the
21 Federal medical assistance percentage for a State under
22 this section shall not be taken into account for purposes
23 of payments under part D of title IV of the Social Security
24 Act (42 U.S.C. 651 et seq.).”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall take effect and apply as if included
3 in the enactment of section 6008 of the Families First
4 Coronavirus Response Act (Public Law 116–127).

5 **SEC. 803. APPROPRIATION FOR PRIMARY HEALTH CARE.**

6 For an additional amount for “Department of Health
7 and Human Services—Health Resources and Services Ad-
8 ministration—Primary Health Care”, \$7,600,000,000, to
9 remain available until September 30, 2025, for necessary
10 expenses to prevent, prepare for, and respond to
11 coronavirus, for grants and cooperative agreements under
12 the Health Centers Program, as defined by section 330
13 of the Public Health Service Act, and for grants to Feder-
14 ally qualified health centers, as defined in section
15 1861(aa)(4)(B) of the Social Security Act, and for eligible
16 entities under the Native Hawaiian Health Care Improve-
17 ment Act, including maintenance or expansion of health
18 center and system capacity and staffing levels: *Provided*,
19 That sections 330(r)(2)(B), 330(e)(6)(A)(iii), and
20 330(e)(6)(B)(iii) shall not apply to funds provided under
21 this heading in this section: *Provided further*, That funds
22 provided under this heading in this section may be used
23 to (1) purchase equipment and supplies to conduct mobile
24 testing for SARS-CoV-2 or COVID-19; (2) purchase and
25 maintain mobile vehicles and equipment to conduct such

1 testing; and (3) hire and train laboratory personnel and
2 other staff to conduct such mobile testing: *Provided fur-*
3 *ther*, That such amount is designated by the Congress as
4 being for an emergency requirement pursuant to section
5 251(b)(2)(A)(i) of the Balanced Budget and Emergency
6 Deficit Control Act of 1985.

7 **SEC. 804. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
8 **ACT.**

9 Title XXXIV of the Public Health Service Act, as
10 amended by sections 104 and 702, is further amended by
11 adding at the following:

12 **“Subtitle C—Reconstruction and**
13 **Improvement Grants for Public**
14 **Health Care Facilities Serving**
15 **Pacific Islanders and the Insu-**
16 **lar Areas**

17 **“SEC. 3407. GRANT SUPPORT FOR QUALITY IMPROVEMENT**
18 **INITIATIVES.**

19 “(a) IN GENERAL.—The Secretary, in collaboration
20 with the Administrator of the Health Resources and Serv-
21 ices Administration, the Director of the Agency for
22 Healthcare Research and Quality, and the Administrator
23 of the Centers for Medicare & Medicaid Services, shall
24 award grants to eligible entities for the conduct of dem-

1 onstration projects to improve the quality of and access
2 to health care.

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

5 “(1) be a health center, hospital, health plan,
6 health system, community clinic, or other health en-
7 tity determined appropriate by the Secretary—

8 “(A) that, by legal mandate or explicitly
9 adopted mission, provides patients with access
10 to services regardless of their ability to pay;

11 “(B) that provides care or treatment for a
12 substantial number of patients who are unin-
13 sured, are receiving assistance under a State
14 plan under title XIX of the Social Security Act
15 (or under a waiver of such plan), or are mem-
16 bers of vulnerable populations, as determined
17 by the Secretary; and

18 “(C)(i) with respect to which, not less than
19 50 percent of the entity’s patient population is
20 made up of racial and ethnic minority groups;
21 or

22 “(ii) that—

23 “(I) serves a disproportionate percent-
24 age of local patients that are from a racial
25 and ethnic minority group, or that has a

1 patient population, at least 50 percent of
2 which is composed of individuals with lim-
3 ited English proficiency; and

4 “(II) provides an assurance that
5 amounts received under the grant will be
6 used only to support quality improvement
7 activities in the racial and ethnic minority
8 population served; and

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

13 “(c) PRIORITY.—In awarding grants under sub-
14 section (a), the Secretary shall give priority to applicants
15 under subsection (b)(2) that—

16 “(1) demonstrate an intent to operate as part
17 of a health care partnership, network, collaborative,
18 coalition, or alliance where each member entity con-
19 tributes to the design, implementation, and evalua-
20 tion of the proposed intervention; or

21 “(2) intend to use funds to carry out system-
22 wide changes with respect to health care quality im-
23 provement, including—

24 “(A) improved systems for data collection
25 and reporting;

1 “(B) innovative collaborative or similar
2 processes;

3 “(C) group programs with behavioral or
4 self-management interventions;

5 “(D) case management services;

6 “(E) physician or patient reminder sys-
7 tems;

8 “(F) educational interventions; or

9 “(G) other activities determined appro-
10 priate by the Secretary.

11 “(d) USE OF FUNDS.—An entity shall use amounts
12 received under a grant under subsection (a) to support
13 the implementation and evaluation of health care quality
14 improvement activities or minority health and health care
15 disparity reduction activities that include—

16 “(1) with respect to health care systems, activi-
17 ties relating to improving—

18 “(A) patient safety;

19 “(B) timeliness of care;

20 “(C) effectiveness of care;

21 “(D) efficiency of care;

22 “(E) patient centeredness; and

23 “(F) health information technology; and

24 “(2) with respect to patients, activities relating
25 to—

1 “(A) staying healthy;

2 “(B) getting well, mentally and physically;

3 “(C) living effectively with illness or dis-
4 ability;

5 “(D) coping with end-of-life issues; and

6 “(E) shared decision making.

7 “(e) COMMON DATA SYSTEMS.—The Secretary shall
8 provide financial and other technical assistance to grant-
9 ees under this section for the development of common data
10 systems.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this section
13 such sums as may be necessary for each of fiscal years
14 2021 through 2026.

15 **“SEC. 3408. CENTERS OF EXCELLENCE.**

16 “(a) IN GENERAL.—The Secretary, acting through
17 the Administrator of the Health Resources and Services
18 Administration, shall designate centers of excellence at
19 public hospitals, and other health systems serving large
20 numbers of minority patients, that—

21 “(1) meet the requirements of section
22 3451(b)(1);

23 “(2) demonstrate excellence in providing care to
24 minority populations; and

1 “(3) demonstrate excellence in reducing dispari-
2 ties in health and health care.

3 “(b) REQUIREMENTS.—A hospital or health system
4 that serves as a center of excellence under subsection (a)
5 shall—

6 “(1) design, implement, and evaluate programs
7 and policies relating to the delivery of care in ra-
8 cially, ethnically, and linguistically diverse popu-
9 lations;

10 “(2) provide training and technical assistance
11 to other hospitals and health systems relating to the
12 provision of quality health care to minority popu-
13 lations; and

14 “(3) develop activities for graduate or con-
15 tinuing medical education that institutionalize a
16 focus on cultural competence training for health care
17 providers.

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
19 are authorized to be appropriated to carry out this section,
20 such sums as may be necessary for each of fiscal years
21 2021 through 2026.

1 **“SEC. 3409. RECONSTRUCTION AND IMPROVEMENT GRANTS**
2 **FOR PUBLIC HEALTH CARE FACILITIES SERV-**
3 **ING PACIFIC ISLANDERS AND THE INSULAR**
4 **AREAS.**

5 “(a) IN GENERAL.—The Secretary shall provide di-
6 rect financial assistance to designated health care pro-
7 viders and community health centers in American Samoa,
8 Guam, the Commonwealth of the Northern Mariana Is-
9 lands, the United States Virgin Islands, Puerto Rico, and
10 Hawaii for the purposes of reconstructing and improving
11 health care facilities and services in a culturally competent
12 and sustainable manner.

13 “(b) ELIGIBILITY.—To be eligible to receive direct fi-
14 nancial assistance under subsection (a), an entity shall be
15 a public health facility or community health center located
16 in American Samoa, Guam, the Commonwealth of the
17 Northern Mariana Islands, the United States Virgin Is-
18 lands, Puerto Rico, or Hawaii that—

19 “(1) is owned or operated by—

20 “(A) the Government of American Samoa,
21 Guam, the Commonwealth of the Northern
22 Mariana Islands, the United States Virgin Is-
23 lands, Puerto Rico, or Hawaii or a unit of local
24 government; or

25 “(B) a nonprofit organization; and

1 “(2)(A) provides care or treatment for a sub-
2 stantial number of patients who are uninsured, re-
3 ceiving assistance under title XVIII of the Social Se-
4 curity Act, or a State plan under title XIX of such
5 Act (or under a waiver of such plan), or who are
6 members of a vulnerable population, as determined
7 by the Secretary; or

8 “(B) serves a disproportionate percentage of
9 local patients that are from a racial and ethnic mi-
10 nority group.

11 “(c) REPORT.—Not later than 180 days after the
12 date of enactment of this title and annually thereafter, the
13 Secretary shall submit to the Congress and the President
14 a report that includes an assessment of health resources
15 and facilities serving populations in American Samoa,
16 Guam, the Commonwealth of the Northern Mariana Is-
17 lands, the United States Virgin Islands, Puerto Rico, and
18 Hawaii. In preparing such report, the Secretary shall—

19 “(1) consult with and obtain information on all
20 health care facilities needs from the entities receiv-
21 ing direct financial assistance under subsection (a);

22 “(2) include all amounts of Federal assistance
23 received by each such entity in the preceding fiscal
24 year;

1 “(3) review the total unmet needs of health care
2 facilities serving American Samoa, Guam, the Com-
3 monwealth of the Northern Mariana Islands, the
4 United States Virgin Islands, Puerto Rico, and Ha-
5 waii, including needs for renovation and expansion
6 of existing facilities;

7 “(4) include a strategic plan for addressing the
8 needs of each such population identified in the re-
9 port; and

10 “(5) evaluate the effectiveness of the care pro-
11 vided by measuring patient outcomes and cost meas-
12 ures.

13 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated such sums as necessary
15 to carry out this section.”.

16 **SEC. 805. PANDEMIC PREMIUM PAY FOR ESSENTIAL WORK-**
17 **ERS.**

18 (a) IN GENERAL.— Beginning 3 days after an essen-
19 tial work employer receives a grant under section 806
20 from the Secretary of the Treasury, the essential work em-
21 ployer shall—

22 (1) be required to comply with subsections (b)
23 through (h); and

24 (2) be subject to the enforcement requirements
25 of section 807.

1 (b) PANDEMIC PREMIUM PAY.—

2 (1) IN GENERAL.—An essential work employer
3 receiving a grant under section 806 shall, in accord-
4 ance with this subsection, provide each essential
5 worker of the essential work employer with premium
6 pay at a rate equal to \$13 for each hour of work
7 performed by the essential worker for the employer
8 from January 27, 2020, until the date that is 60
9 days after the last day of the COVID–19 Public
10 Health Emergency.

11 (2) MAXIMUM AMOUNTS.—The total amount of
12 all premium pay under this subsection that an essen-
13 tial work employer is required to provide to an es-
14 sential worker, including through any retroactive
15 payment under paragraph (3), shall not exceed—

16 (A) for an essential worker who is not a
17 highly-compensated essential worker, \$10,000
18 reduced by employer payroll taxes with respect
19 to such premium pay; or

20 (B) for a highly-compensated essential
21 worker, \$5,000 reduced by employer payroll
22 taxes with respect to such premium pay.

23 (3) RETROACTIVE PAYMENT.—For all work
24 performed by an essential worker during the period
25 from January 27, 2020, through the date on which

1 the essential work employer of the worker receives a
2 grant under this title, the essential work employer
3 shall use a portion of the amount of such grant to
4 provide such worker with premium pay under this
5 subsection for such work at the rate provided under
6 paragraph (1). Such amount shall be provided to the
7 essential worker as a lump sum in the next paycheck
8 (or other payment form) that immediately follows
9 the receipt of the grant by the essential work em-
10 ployer. In any case where it is impossible for the em-
11 ployer to arrange for payment of the amount due in
12 such paycheck (or other payment form), such
13 amounts shall be paid as soon as practicable, but in
14 no event later than the second paycheck (or other
15 payment form) following the receipt of the grant by
16 the essential work employer.

17 (4) NO EMPLOYER DISCRETION.—An essential
18 work employer receiving a grant under section 806
19 shall not have any discretion to determine which
20 portions of work performed by an essential worker
21 qualify for premium pay under this subsection, but
22 shall pay such premium pay for any increment of
23 time worked by the essential worker for the essential
24 work employer up to the maximum amount applica-
25 ble to the essential worker under paragraph (2).

1 (c) PROHIBITION ON REDUCING COMPENSATION AND
2 DISPLACEMENT.—

3 (1) IN GENERAL.—Any payments made to an
4 essential worker as premium pay under subsection
5 (b) shall be in addition to all other compensation, in-
6 cluding all wages, remuneration, or other pay and
7 benefits, that the essential worker otherwise receives
8 from the essential work employer.

9 (2) REDUCTION OF COMPENSATION.—An essen-
10 tial work employer receiving a grant under section
11 806 shall not, during the period beginning on the
12 date of enactment of this Act and ending on the
13 date that is 60 days after the last day of the
14 COVID–19 Public Health Emergency, reduce or in
15 any other way diminish, any other compensation, in-
16 cluding the wages, remuneration, or other pay or
17 benefits, that the essential work employer provided
18 to the essential worker on the day before the date
19 of enactment of this Act.

20 (3) DISPLACEMENT.—An essential work em-
21 ployer shall not take any action to displace an essen-
22 tial worker (including partial displacement such as a
23 reduction in hours, wages, or employment benefits)
24 for purposes of hiring an individual for an equivalent
25 position at a rate of compensation that is less than

1 is required to be provided to an essential worker
2 under paragraph (2).

3 (d) DEMARCATION FROM OTHER COMPENSATION.—

4 The amount of any premium pay paid under subsection
5 (b) shall be clearly demarcated as a separate line item in
6 each paystub or other document provided to an essential
7 worker that details the remuneration the essential worker
8 received from the essential work employer for a particular
9 period of time. If any essential worker does not otherwise
10 regularly receive any such paystub or other document from
11 the employer, the essential work employer shall provide
12 such paystub or other document to the essential worker
13 for the duration of the period in which the essential work
14 employer provides premium pay under subsection (b).

15 (e) EXCLUSION FROM WAGE-BASED CALCULA-
16 TIONS.—Any premium pay under subsection (b) paid to
17 an essential worker under this section by an essential work
18 employer receiving a grant under section 806 shall be ex-
19 cluded from the amount of remuneration for work paid
20 to the essential worker for purposes of—

21 (1) calculating the essential worker's eligibility
22 for any wage-based benefits offered by the essential
23 work employer;

24 (2) computing the regular rate at which such
25 essential worker is employed under section 7 of the

1 Fair Labor Standards Act of 1938 (29 U.S.C. 207);
2 and

3 (3) determining whether such essential worker
4 is exempt from application of such section 7 under
5 section 13(a)(1) of such Act (29 U.S.C. 213(a)(1)).

6 (f) ESSENTIAL WORKER DEATH.—

7 (1) IN GENERAL.—In any case in which an es-
8 sential worker of an essential work employer receiv-
9 ing a grant under section 806 exhibits symptoms of
10 COVID–19 and dies, the essential work employer
11 shall pay as a lump sum to the next of kin of the
12 essential worker for premium pay under subsection
13 (b)—

14 (A) for an essential worker who is not a
15 highly-compensated essential worker, the
16 amount determined under subsection (b)(2)(A)
17 minus the total amount of any premium pay the
18 worker received under subsection (b) prior to
19 the death; or

20 (B) for a highly-compensated essential
21 worker, the amount determined under sub-
22 section (b)(2)(B) minus the amount of any pre-
23 mium pay the worker received under subsection
24 (b) prior to the death.

25 (2) TREATMENT OF LUMP SUM PAYMENTS.—

1 (A) TREATMENT AS PREMIUM PAY.—For
2 purposes of this title, any payment made under
3 this subsection shall be treated as a premium
4 pay under subsection (b).

5 (B) TREATMENT FOR PURPOSES OF IN-
6 TERNAL REVENUE CODE OF 1986.—For pur-
7 poses of the Internal Revenue Code of 1986,
8 any payment made under this subsection shall
9 be treated as a payment for work performed by
10 the essential worker.

11 (g) APPLICATION TO SELF-DIRECTED CARE WORK-
12 ERS FUNDED THROUGH MEDICAID OR THE VETERAN-DI-
13 RECTED CARE PROGRAM.—

14 (1) MEDICAID.—In the case of an essential
15 work employer receiving a grant under section 806
16 that is a covered employer described in paragraph
17 (4) who, under a State Medicaid plan under title
18 XIX of the Social Security Act (42 U.S.C. 1396 et
19 seq.) or under a waiver of such plan, has opted to
20 receive items or services using a self-directed service
21 delivery model, the preceding requirements of this
22 section, including the requirements to provide pre-
23 mium pay under subsection (b) (including a lump
24 sum payment in the event of an essential worker
25 death under subsection (f)) and the requirements of

1 sections 806 and 807, shall apply to the State Med-
2 icaid agency responsible for the administration of
3 such plan or waiver with respect to self-directed care
4 workers employed by that employer. In admin-
5 istering payments made under this title to such self-
6 directed care workers on behalf of such employers,
7 a State Medicaid agency shall—

8 (A) exclude and disregard any payments
9 made under this title to such self-directed work-
10 ers from the individualized budget that applies
11 to the items or services furnished to the indi-
12 vidual client employer under the State Medicaid
13 plan or waiver;

14 (B) to the extent practicable, administer
15 and provide payments under this title directly
16 to such self-directed workers through arrange-
17 ments with entities that provide financial man-
18 agement services in connection with the self-di-
19 rected service delivery models used under the
20 State Medicaid plan or waiver; and

21 (C) ensure that individual client employers
22 of such self-directed workers are provided notice
23 of, and comply with, the prohibition under sec-
24 tion 807(b)(1)(B).

1 (2) VETERAN-DIRECTED CARE PROGRAM.—In
2 the case of an essential work employer that is a cov-
3 ered employer described in paragraph (4) who is a
4 veteran participating in the Veteran Directed Care
5 program administered by the VA Office of Geriatrics
6 & Extended Care of the Veterans Health Adminis-
7 tration, the preceding requirements of this section
8 and sections 806 and 807, shall apply to such VA
9 Office of Geriatrics & Extended Care with respect to
10 self-directed care workers employed by that em-
11 ployer. Paragraph (1) of this subsection shall apply
12 to the administration by the VA Office of Geriatrics
13 & Extended Care of payments made under this title
14 to such self-directed care workers on behalf of such
15 employers in the same manner as such requirements
16 apply to State Medicaid agencies.

17 (3) PENALTY ENFORCEMENT.—The Secretary
18 of Labor shall consult with the Secretary of Health
19 and Human Services and the Secretary of Veterans
20 Affairs regarding the enforcement of penalties im-
21 posed under section 807(b)(2) with respect to viola-
22 tions of subparagraph (A) or (B) of section
23 807(b)(1) that involve self-directed workers for
24 which the requirements of this section and sections
25 806 and 807 are applied to a State Medicaid agency

1 under paragraph (1) or the VA Office of Geriatrics
2 & Extended Care under paragraph (2).

3 (4) COVERED EMPLOYER DESCRIBED.—For
4 purposes of paragraphs (1) and (2), a covered em-
5 ployer described in this paragraph means—

6 (A) an entity or person that contracts di-
7 rectly with a State, locality, Tribal government,
8 or the Federal Government, to provide care
9 (which may include items and services) through
10 employees of such entity or person to individ-
11 uals under the Medicare program under title
12 XVIII of the Social Security Act (42 U.S.C.
13 1395 et seq.), under a State Medicaid plan
14 under title XIX of such Act (42 U.S.C. 1396 et
15 seq.) or under a waiver of such plan, or under
16 any other program established or administered
17 by a State, locality, Tribal government, or the
18 Federal Government;

19 (B) a subcontractor of an entity or person
20 described in subparagraph (A);

21 (C) an individual client (or a representa-
22 tive on behalf of an individual client), an entity,
23 or a person, that employs an individual to pro-
24 vide care (which may include items and serv-
25 ices) to the individual client under a self-di-

1 rected service delivery model through a program
2 established or administered by a State, locality,
3 Tribal government, or the Federal Government;
4 or

5 (D) an individual client (or a representa-
6 tive on behalf of an individual client) that, on
7 their own accord, employs an individual to pro-
8 vide care (which may include items and serv-
9 ices) to the individual client using the individual
10 client's own finances.

11 (h) INTERACTION WITH STAFFORD ACT.—Nothing
12 in this section shall nullify, supersede, or otherwise change
13 a State's ability to seek reimbursement under section 403
14 of the Robert T. Stafford Disaster Relief and Emergency
15 Assistance Act (42 U.S.C. 5170b) for the costs of pre-
16 mium pay based on pre-disaster labor policies for eligible
17 employees.

18 (i) CALCULATION OF PAID LEAVE UNDER FFCRA
19 AND FMLA.—

20 (1) FAMILIES FIRST CORONAVIRUS RESPONSE
21 ACT.—Section 5110(5)(B) of the Families First
22 Coronavirus Response Act (29 U.S.C. 2601 note) is
23 amended by adding at the end the following:

24 “(iii) PANDEMIC PREMIUM PAY.—
25 Compensation received by an employee

1 under section 807(b) of the EHDC Act of
2 2020 shall be included as remuneration for
3 employment paid to the employee for pur-
4 poses of computing the regular rate at
5 which such employee is employed.”.

6 (2) FAMILY AND MEDICAL LEAVE ACT OF
7 1993.—Section 110(b)(2)(B) of the Family and Med-
8 ical Leave Act of 1993 (29 U.S.C. 2620(b)(2)(B)) is
9 amended by adding at the end the following:

10 “(iii) PANDEMIC PREMIUM PAY.—
11 Compensation received by an employee
12 under section 807(b) of the EHDC Act of
13 2020 shall be included as remuneration for
14 employment paid to the employee for pur-
15 poses of computing the regular rate at
16 which such employee is employed.”.

17 **SEC. 806. COVID-19 HEROES FUND GRANTS.**

18 (a) GRANTS.—

19 (1) FOR PANDEMIC PREMIUM PAY.—The Sec-
20 retary of the Treasury shall, subject to the avail-
21 ability of amounts provided in this title, award a
22 grant to each essential work employer that applies
23 for a grant, in accordance with this section, for the
24 purpose of providing premium pay to essential work-

ers under section 805(b), including amounts paid under section 805(f).

(2) ELIGIBILITY.—

(A) ELIGIBLE EMPLOYERS GENERALLY.—

Any essential work employer shall be eligible for a grant under paragraph (1).

(B) SELF-DIRECTED CARE WORKERS.—A

self-directed care worker employed by an essential work employer other than an essential work employer described in section 805(g), shall be eligible to apply for a grant under paragraph (1) in the same manner as an essential work employer. Such a worker shall provide premium pay to himself or herself in accordance with this section, including the recordkeeping and refund requirements of this section.

(b) AMOUNT OF GRANTS.—

(1) IN GENERAL.—The maximum amount available for making a grant under subsection (a)(1) to an essential work employer shall be equal to the sum of—

(A) the amount obtained by multiplying \$10,000 by the number of essential workers the employer certifies, in the application submitted under subsection (c)(1), as employing, or pro-

1 viding remuneration to for services or labor,
2 who are paid wages or remuneration by the em-
3 ployer at a rate that is less than the equivalent
4 of \$200,000 per year; and

5 (B) the amount obtained by multiplying
6 \$5,000 by the number of highly-compensated
7 essential workers the employer certifies, in the
8 application submitted under subsection (c)(1),
9 as employing, or providing remuneration to for
10 services or labor, who are paid wages or remu-
11 neration by the employer at a rate that is equal
12 to or greater than the equivalent of \$200,000
13 per year.

14 (2) NO PARTIAL GRANTS.—The Secretary of
15 the Treasury shall not award a grant under this sec-
16 tion in an amount less than the maximum described
17 in paragraph (1).

18 (c) GRANT APPLICATION AND DISBURSAL.—

19 (1) APPLICATION.—Any essential work em-
20 ployer seeking a grant under subsection (a)(1) shall
21 submit an application to the Secretary of the Treas-
22 ury at such time, in such manner, and complete with
23 such information as the Secretary may require.

24 (2) NOTICE AND CERTIFICATION.—

1 (A) IN GENERAL.—The Secretary of the
2 Treasury shall, within 15 days after receiving a
3 complete application from an essential work em-
4 ployer eligible for a grant under this section—

5 (i) notify the employer of the Sec-
6 retary’s findings with respect to the re-
7 quirements for the grant; and

8 (ii)(I) if the Secretary finds that the
9 essential work employer meets the require-
10 ments under this section for a grant under
11 subsection (a), provide a certification to
12 the employer—

13 (aa) that the employer has met
14 such requirements;

15 (bb) of the amount of the grant
16 payment that the Secretary has deter-
17 mined the employer shall receive
18 based on the requirements under this
19 section; or

20 (II) if the Secretary finds that the es-
21 sential work employer does not meet the
22 requirements under this section for a grant
23 under subsection (a), provide a notice of
24 denial stating the reasons for the denial
25 and provide an opportunity for administra-

1 tive review by not later than 10 days after
2 the denial.

3 (B) TRANSFER.—Not later than 7 days
4 after making a certification under subpara-
5 graph (A)(ii) with respect to an essential work
6 employer, the Secretary of the Treasury shall
7 make the appropriate transfer to the employer
8 of the amount of the grant.

9 (d) USE OF FUNDS.—

10 (1) IN GENERAL.—An essential work employer
11 receiving a grant under this section shall use the
12 amount of the grant solely for the following pur-
13 poses:

14 (A) Providing premium pay under section
15 805(b) to essential workers in accordance with
16 the requirements for such payments under such
17 section, including providing payments described
18 in section 805(f) to the next of kin of essential
19 workers in accordance with the requirements
20 for such payments under such section.

21 (B) Paying employer payroll taxes with re-
22 spect to premium pay amounts described in
23 subparagraph (A), including such payments de-
24 scribed in section 805(f).

1 Each dollar of a grant received by an essential work
2 employer under this title shall be used as provided
3 in subparagraph (A) or (B) or returned to the Sec-
4 retary of the Treasury.

5 (2) NO OTHER USES AUTHORIZED.—An essen-
6 tial work employer who uses any amount of a grant
7 for a purpose not required under paragraph (1) shall
8 be—

9 (A) considered to have misused funds in
10 violation of section 805; and

11 (B) subject to the enforcement and rem-
12 edies provided under section 807.

13 (3) REFUND.—

14 (A) IN GENERAL.—If an essential work
15 employer receives a grant under this section
16 and, for any reason, does not provide every dol-
17 lar of such grant to essential workers in accord-
18 ance with the requirements of this title, then
19 the employer shall refund any such dollars to
20 the Secretary of the Treasury not later than
21 June 30, 2021. Any amounts returned to the
22 Secretary shall be deposited into the Fund and
23 be available for any additional grants under this
24 section.

1 (B) REQUIREMENT FOR NOT REDUCING
2 COMPENSATION.—An essential work employer
3 who is required to refund any amount under
4 this paragraph shall not reduce or otherwise di-
5 minish an eligible worker’s compensation or
6 benefits in response to or otherwise due to such
7 refund.

8 (e) RECORDKEEPING.—An essential work employer
9 that receives a grant under this section shall—

10 (1) maintain records, including payroll records,
11 demonstrating how each dollar of funds received
12 through the grant were provided to essential work-
13 ers; and

14 (2) provide such records to the Secretary of the
15 Treasury or the Secretary of Labor upon the request
16 of either such Secretary.

17 (f) RECOUPMENT.—In addition to all other enforce-
18 ment and remedies available under this title or any other
19 law, the Secretary of the Treasury shall establish a process
20 under which the Secretary shall recoup the amount of any
21 grant awarded under subsection (a)(1) if the Secretary de-
22 termines that the essential work employer receiving the
23 grant—

24 (1) did not provide all of the dollars of such
25 grant to the essential workers of the employer;

1 (2) did not, in fact, have the number of essen-
2 tial workers certified by the employer in accordance
3 with subparagraphs (A) and (B) of subsection
4 (b)(1);

5 (3) did not pay the essential workers for the
6 number of hours the employer claimed to have paid;
7 or

8 (4) otherwise misused funds or violated this
9 title.

10 (g) SPECIAL RULE FOR CERTAIN EMPLOYEES OF
11 TRIBAL EMPLOYERS.—Essential workers of Tribal em-
12 ployers who receive funds under title II shall not be eligi-
13 ble to receive funds from grants under this section.

14 (h) TAX TREATMENT.—

15 (1) EXCLUSION FROM INCOME.—For purposes
16 of the Internal Revenue Code of 1986, any grant re-
17 ceived by an essential work employer under this sec-
18 tion shall not be included in the gross income of
19 such essential work employer.

20 (2) DENIAL OF DOUBLE BENEFIT.—

21 (A) IN GENERAL.—In the case of an essen-
22 tial work employer that receives a grant under
23 this section—

24 (i) amounts paid under subsections

25 (b) or (f) of section 805 shall not be taken

1 into account as wages for purposes of sec-
2 tions 41, 45A, 51, or 1396 of the Internal
3 Revenue Code of 1986 or section 2301 of
4 the CARES Act (Public Law 116–136);
5 and

6 (ii) any deduction otherwise allowable
7 under such Code for applicable payments
8 during any taxable year shall be reduced
9 (but not below zero) by the excess (if any)
10 of—

11 (I) the aggregate amounts of
12 grants received under this section;
13 over

14 (II) the sum of any amount re-
15 funded under subsection (d) plus the
16 aggregate amount of applicable pay-
17 ments made for all preceding taxable
18 years.

19 (B) APPLICABLE PAYMENTS.—For pur-
20 poses of this paragraph, the term “applicable
21 payments” means amounts paid as premium
22 pay under subsections (b) or (f) of section 805
23 and amounts paid for employer payroll taxes
24 with respect to such amounts.

1 (C) AGGREGATION RULE.—Rules similar
2 to the rules of subsections (a) and (b) of section
3 52 of the Internal Revenue Code of 1986 shall
4 apply for purposes of this section.

5 (3) INFORMATION REPORTING.—The Secretary
6 of the Treasury shall submit to the Commissioner of
7 Internal Revenue statements containing—

8 (A) the name and tax identification num-
9 ber of each essential work employer receiving a
10 grant under this section;

11 (B) the amount of such grant; and

12 (C) any amounts refunded under sub-
13 section (d)(3).

14 (i) REPORTS.—

15 (1) IN GENERAL.—Not later than 30 days after
16 obligating the last dollar of the funds appropriated
17 under this title, the Secretary of the Treasury shall
18 submit a report, to the Committees of Congress de-
19 scribed in paragraph (2), that—

20 (A) certifies that all funds appropriated
21 under this title have been obligated; and

22 (B) indicates the number of pending appli-
23 cations for grants under this section that will
24 be rejected due to the lack of funds.

1 (2) COMMITTEES OF CONGRESS.—The Commit-
2 tees of Congress described in this paragraph are—

3 (A) the Committee on Ways and Means of
4 the House of Representatives;

5 (B) the Committee on Education and
6 Labor of the House of Representatives;

7 (C) the Committee on Finance of the Sen-
8 ate; and

9 (D) the Committee on Health, Education,
10 Labor, and Pensions of the Senate.

11 **SEC. 807. ENFORCEMENT AND OUTREACH.**

12 (a) DUTIES OF SECRETARY OF LABOR.—The Sec-
13 retary of Labor shall—

14 (1) have authority to enforce the requirements
15 of section 805, in accordance with subsections (b)
16 through (e);

17 (2) conduct outreach as described in subsection
18 (f); and

19 (3) coordinate with the Secretary of the Treas-
20 ury as needed to carry out the Secretary of Labor's
21 responsibilities under this section.

22 (b) PROHIBITED ACTS, PENALTIES, AND ENFORCE-
23 MENT.—

24 (1) PROHIBITED ACTS.—It shall be unlawful for
25 a person to—

1 (A) violate any provision of section 805 ap-
2 plicable to such person; or

3 (B) discharge or in any other manner dis-
4 criminate against any essential worker because
5 such essential worker has filed any complaint or
6 instituted or caused to be instituted any pro-
7 ceeding under or related to this title, or has tes-
8 tified or is about to testify in any such pro-
9 ceeding.

10 (2) ENFORCEMENT AND PENALTIES.—

11 (A) PREMIUM PAY VIOLATIONS.—A viola-
12 tion described in paragraph (1)(A) shall be
13 deemed a violation of section 7 of the Fair
14 Labor Standards Act of 1938 (29 U.S.C. 207)
15 and unpaid amounts required under this section
16 shall be treated as unpaid overtime compensa-
17 tion under such section 7 for the purposes of
18 sections 15 and 16 of such Act (29 U.S.C. 215
19 and 216).

20 (B) DISCHARGE OR DISCRIMINATION.—A
21 violation of paragraph (1)(B) shall be deemed a
22 violation of section 15(a)(3) of the Fair Labor
23 Standards Act of 1938 (29 U.S.C. 215(a)(3)).

24 (c) INVESTIGATION.—

1 (1) IN GENERAL.—To ensure compliance with
2 the provisions of section 805, including any regula-
3 tion or order issued under that section, the Sec-
4 retary of Labor shall have the investigative authority
5 provided under section 11(a) of the Fair Labor
6 Standards Act of 1938 (29 U.S.C. 211(a)). For the
7 purposes of any investigation provided for in this
8 subsection, the Secretary of Labor shall have the
9 subpoena authority provided for under section 9 of
10 such Act (29 U.S.C. 209).

11 (2) STATE AGENCIES.—The Secretary of Labor
12 may, for the purpose of carrying out the functions
13 and duties under this section, utilize the services of
14 State and local agencies in accordance with section
15 11(b) of the Fair Labor Standards Act of 1938 (29
16 U.S.C. 211(b)).

17 (d) ESSENTIAL WORKER ENFORCEMENT.—

18 (1) RIGHT OF ACTION.—An action alleging a
19 violation of paragraph (1) or (2) of subsection (b)
20 may be maintained against an essential work em-
21 ployer receiving a grant under section 806 in any
22 Federal or State court of competent jurisdiction by
23 one or more essential workers or their representative
24 for and on behalf of the essential workers, or the es-
25 sential workers and others similarly situated, in the

1 same manner, and subject to the same remedies (in-
2 cluding attorney's fees and costs of the action), as
3 an action brought by an employee alleging a viola-
4 tion of section 7 or 15(a)(3), respectively, of the
5 Fair Labor Standards Act of 1938 (29 U.S.C. 207,
6 215(a)(3)).

7 (2) NO WAIVER.—In an action alleging a viola-
8 tion of paragraph (1) or (2) of subsection (b)
9 brought by one or more essential workers or their
10 representative for and on behalf of the persons as
11 described in paragraph (1), to enforce the rights in
12 section 805, no court of competent jurisdiction may
13 grant the motion of an essential work employer re-
14 ceiving a grant under section 806 to compel arbitra-
15 tion, under chapter 1 of title 9, United States Code,
16 or any analogous State arbitration statute, of the
17 claims involved. An essential worker's right to bring
18 an action described in paragraph (1) or subsection
19 (b)(2)(A) on behalf of similarly situated essential
20 workers to enforce such rights may not be subject to
21 any private agreement that purports to require the
22 essential workers to pursue claims on an individual
23 basis.

24 (e) RECORDKEEPING.—An essential work employer
25 receiving a grant under section 806 shall make, keep, and

1 preserve records pertaining to compliance with section 805
2 in accordance with section 11(c) of the Fair Labor Stand-
3 ards Act of 1938 (29 U.S.C. 211(c)) and in accordance
4 with regulations prescribed by the Secretary of Labor.

5 (f) OUTREACH AND EDUCATION.—Out of amounts
6 appropriated to the Secretary of the Treasury under sec-
7 tion 805 for a fiscal year, the Secretary of the Treasury
8 shall transfer to the Secretary of Labor, \$3,000,000, of
9 which the Secretary of Labor shall use—

10 (1) \$2,500,000 for outreach to essential work
11 employers and essential workers regarding the pre-
12 mium pay under section 805; and

13 (2) \$500,000 to implement an advertising cam-
14 paign encouraging large essential work employers to
15 provide the same premium pay provided for by sec-
16 tion 805 using the large essential work employers'
17 own funds and without utilizing grants under this
18 title.

19 (g) CLARIFICATION OF ENFORCING OFFICIAL.—
20 Nothing in the Government Employee Rights Act of 1991
21 (42 U.S.C. 2000e–16a et seq.) or section 3(e)(2)(C) of the
22 Fair Labor Standards Act of 1938 (29 U.S.C.
23 203(e)(2)(C)) shall be construed to prevent the Secretary
24 of Labor from carrying out the authority of the Secretary
25 under this section in the case of State employees described

1 in section 304(a) of the Government Employee Rights Act
2 of 1991 (42 U.S.C. 2000e–16c(a)).

3 **TITLE IX—HEALTH IT AND**
4 **BRIDGING THE DIGITAL DI-**
5 **VIDE IN HEALTH CARE**

6 **SEC. 901. HRSA ASSISTANCE TO HEALTH CENTERS FOR**
7 **PROMOTION OF HEALTH IT.**

8 The Secretary of Health and Human Services, acting
9 through the Administrator of the Health Resources and
10 Services Administration, shall expand and intensify the
11 programs and activities of the Administration (directly or
12 through grants or contracts) to provide technical assist-
13 ance and resources to health centers (as defined in section
14 330(a) of the Public Health Service Act (42 U.S.C.
15 254b(a))) to adopt and meaningfully use certified EHR
16 technology for the management of chronic diseases and
17 health conditions and reduction of health disparities.

18 **SEC. 902. ASSESSMENT OF IMPACT OF HEALTH IT ON RA-**
19 **CIAL AND ETHNIC MINORITY COMMUNITIES;**
20 **OUTREACH AND ADOPTION OF HEALTH IT IN**
21 **SUCH COMMUNITIES.**

22 (a) NATIONAL COORDINATOR FOR HEALTH INFOR-
23 MATION TECHNOLOGY.—Not later than 18 months after
24 the date of enactment of this Act, the National Coordi-

1 nator for Health Information Technology (referred to in
2 this section as the “National Coordinator”) shall—

3 (1) conduct an evaluation of the level of inter-
4 operability, access, use, and accessibility of electronic
5 health records in racial and ethnic minority commu-
6 nities, focusing on whether patients in such commu-
7 nities have providers who use electronic health
8 records, and the degree to which patients in such
9 communities can access, exchange, and use without
10 special effort their health information in those elec-
11 tronic health records, and indicating whether such
12 providers—

13 (A) are participating in the Medicare pro-
14 gram under title XVIII of the Social Security
15 Act (42 U.S.C. 1395 et seq.) or a State plan
16 under title XIX of such Act (42 U.S.C. 1396 et
17 seq.) (or a waiver of such plan);

18 (B) have received incentive payments or in-
19 centive payment adjustments under Medicare
20 and Medicaid Electronic Health Records Incen-
21 tive Programs (as defined in subsection (c)(2));

22 (C) are MIPS eligible professionals, as de-
23 fined in paragraph (1)(C) of section 1848(q) of
24 the Social Security Act (42 U.S.C. 1395w—

1 4(q)), for purposes of the Merit-Based Incentive
2 Payment System under such section; or

3 (D) have been recruited by any of the
4 Health Information Technology Regional Ex-
5 tension Centers established under section 3012
6 of the Public Health Service Act (42 U.S.C.
7 300jj–32);

8 (2) publish the results of such evaluation in-
9 cluding the race and ethnicity of such providers and
10 the populations served by such providers; and

11 (3) not later than 12 months after the enact-
12 ment of this Act, shall promulgate a certification cri-
13 terion and module of certified EHR technology that
14 stratifies quality measures by disparity characteris-
15 tics, including race, ethnicity, language, gender, gen-
16 der identity, sexual orientation, socioeconomic sta-
17 tus, and disability status, as those characteristics
18 are defined in certified EHR technology; and reports
19 to Centers for Medicare & Medicaid Services the
20 quality measures stratified by race and at least two
21 other disparity characteristics.

22 The term “quality measures” refers to the quality meas-
23 ures specified in MIPS.

24 (b) NATIONAL CENTER FOR HEALTH STATISTICS.—

25 As soon as practicable after the date of enactment of this

1 Act, the Director of the National Center for Health Statis-
2 tics shall provide to Congress a more detailed analysis of
3 the data presented in National Center for Health Statis-
4 tics data brief entitled “Adoption of Certified Electronic
5 Health Record Systems and Electronic Information Shar-
6 ing in Physician Offices: United States, 2013 and 2014”
7 (NCHS Data Brief No. 236).

8 (c) CENTERS FOR MEDICARE & MEDICAID SERV-
9 ICES.—

10 (1) IN GENERAL.—As part of the process of
11 collecting information, with respect to a provider, at
12 registration and attestation for purposes of Medicare
13 and Medicaid Electronic Health Records Incentive
14 Programs (as defined in paragraph (2)) or the
15 Merit-Based Incentive Payment System under sec-
16 tion 1848(q) of the Social Security Act (42 U.S.C.
17 1395w–4(q)), the Secretary of Health and Human
18 Services shall collect the race and ethnicity of such
19 provider.

20 (2) MEDICARE AND MEDICAID ELECTRONIC
21 HEALTH RECORDS INCENTIVE PROGRAMS DE-
22 FINED.—For purposes of paragraph (1), the term
23 “Medicare and Medicaid Electronic Health Records
24 Incentive Programs” means the incentive programs
25 under section 1814(l)(3), subsections (a)(7) and (o)

1 of section 1848, subsections (l) and (m) of section
2 1853, subsections (b)(3)(B)(ix)(I) and (n) of section
3 1886, and subsections (a)(3)(F) and (t) of section
4 1903 of the Social Security Act (42 U.S.C.
5 1395f(l)(3), 1395w-4, 1395w-23, 1395ww, and
6 1396b).

7 (d) NATIONAL COORDINATOR’S ASSESSMENT OF IM-
8 PACT OF HIT.—Section 3001(c)(6)(C) of the Public
9 Health Service Act (42 U.S.C. 300jj-11(c)(6)(C)) is
10 amended—

11 (1) in the heading by inserting “, RACIAL AND
12 ETHNIC MINORITY COMMUNITIES,” after “HEALTH
13 DISPARITIES”;

14 (2) by inserting “, in communities with a high
15 proportion of individuals from racial and ethnic mi-
16 nority groups (as defined in section 1707(g)), in-
17 cluding people with disabilities in these groups,”
18 after “communities with health disparities”;

19 (3) by striking “The National Coordinator” and
20 inserting the following:

21 “(i) IN GENERAL.—The National Co-
22 ordinator”; and

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

24 “(ii) CRITERIA.—In any publication
25 under clause (i), the National Coordinator

1 shall include best practices for encouraging
2 partnerships between the Federal Govern-
3 ment, States, and private entities to ex-
4 pand outreach for and the adoption of cer-
5 tified EHR technology in communities with
6 a high proportion of individuals from racial
7 and ethnic minority groups (as so defined),
8 while also maintaining the accessibility re-
9 quirements of section 508 of the Rehabili-
10 tation Act of 1973 to encourage patient in-
11 volvement in patient health care. The Na-
12 tional Coordinator shall—

13 “(I) not later than 6 months
14 after the submission of the report re-
15 quired under section 822 of the End-
16 ing Health Disparities During
17 COVID–19 Act of 2020, establish cri-
18 teria for evaluating the impact of
19 health information technology on com-
20 munities with a high proportion of in-
21 dividuals from racial and ethnic mi-
22 nority groups (as so defined) taking
23 into account the findings in such re-
24 port; and

1 “(II) not later than 1 year after
2 the submission of such report, conduct
3 and publish the results of an evalua-
4 tion of such impact.”.

5 **SEC. 903. EXTENDING FUNDING TO STRENGTHEN THE**
6 **HEALTH IT INFRASTRUCTURE IN RACIAL**
7 **AND ETHNIC MINORITY COMMUNITIES.**

8 Section 3011 of the Public Health Service Act (42
9 U.S.C. 300jj–31) is amended—

10 (1) in subsection (a), in the matter preceding
11 paragraph (1), by inserting “, including with respect
12 to communities with a high proportion of individuals
13 from racial and ethnic minority groups (as defined
14 in section 1707(g))” before the colon; and

15 (2) by adding at the end the following new sub-
16 section:

17 “(e) ANNUAL REPORT ON EXPENDITURES.—The
18 National Coordinator shall report annually to Congress on
19 activities and expenditures under this section.”.

1 **SEC. 904. EXTENDING COMPETITIVE GRANTS FOR THE DE-**
2 **VELOPMENT OF LOAN PROGRAMS TO FACILI-**
3 **TATE ADOPTION OF CERTIFIED EHR TECH-**
4 **NOLOGY BY PROVIDERS SERVING RACIAL**
5 **AND ETHNIC MINORITY GROUPS.**

6 Section 3014(e) of the Public Health Service Act (42
7 U.S.C. 300jj–34(e)) is amended, in the matter preceding
8 paragraph (1), by inserting “, including with respect to
9 communities with a high proportion of individuals from
10 racial and ethnic minority groups (as defined in section
11 1707(g))” after “health care provider to”.

12 **SEC. 905. AUTHORIZATION OF APPROPRIATIONS.**

13 Section 3018 of the Public Health Service Act (42
14 U.S.C. 300jj–38) is amended by striking “fiscal years
15 2009 through 2013” and inserting “fiscal years 2021
16 through 2026”.

17 **SEC. 906. DATA COLLECTION AND ASSESSMENTS CON-**
18 **DUCTED IN COORDINATION WITH MINORITY-**
19 **SERVING INSTITUTIONS.**

20 Section 3001(c)(6) of the Public Health Service Act
21 (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the
22 end the following new subparagraph:

23 “(F) DATA COLLECTION AND ASSESS-

24 MENTS CONDUCTED IN COORDINATION WITH

25 MINORITY-SERVING INSTITUTIONS.—

“(i) IN GENERAL.—In carrying out subparagraph (C) with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), the National Coordinator shall, to the greatest extent possible, coordinate with an entity described in clause (ii).

“(ii) MINORITY-SERVING INSTITUTIONS.—For purposes of clause (i), an entity described in this clause is a Historically Black College or University, a Hispanic-serving institution, a tribal college or university, or an Asian-American-, Native American-, or Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.”.

**SEC. 907. STUDY OF HEALTH INFORMATION TECHNOLOGY
IN MEDICALLY UNDERSERVED COMMUNITIES.**

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

1 (1) enter into an agreement with the National
2 Academies of Sciences, Engineering, and Medicine to
3 conduct a study on the development, implementa-
4 tion, and effectiveness of health information tech-
5 nology within medically underserved areas (as de-
6 scribed in subsection (c)); and

7 (2) submit a report to Congress describing the
8 results of such study, including any recommenda-
9 tions for legislative or administrative action.

10 (b) STUDY.—The study described in subsection
11 (a)(1) shall—

12 (1) identify barriers to successful implementa-
13 tion of health information technology in medically
14 underserved areas;

15 (2) survey a cross-section of individuals in
16 medically underserved areas and report their opin-
17 ions about the various topics of study;

18 (3) examine the degree of interoperability
19 among health information technology and users of
20 health information technology in medically under-
21 served areas, including patients, providers, and com-
22 munity services;

23 (4) examine the impact of health information
24 technology on providing quality care and reducing
25 the cost of care to individuals in such areas, includ-

1 ing the impact of such technology on improved
2 health outcomes for individuals, including which
3 technology worked for which population and how it
4 improved health outcomes for that population;

5 (5) examine the impact of health information
6 technology on improving health care-related deci-
7 sions by both patients and providers in such areas;

8 (6) identify specific best practices for using
9 health information technology to foster the con-
10 sistent provision of physical accessibility and reason-
11 able policy accommodations in health care to individ-
12 uals with disabilities in such areas;

13 (7) assess the feasibility and costs associated
14 with the use of health information technology in
15 such areas;

16 (8) evaluate whether the adoption and use of
17 qualified electronic health records (as defined in sec-
18 tion 3000 of the Public Health Service Act (42
19 U.S.C. 300jj)) is effective in reducing health dispari-
20 ties, including analysis of clinical quality measures
21 reported by providers who are participating in the
22 Medicare program under title XVIII of the Social
23 Security Act (42 U.S.C. 1395 et seq.) or a State
24 plan under title XIX of such Act (42 U.S.C. 1396
25 et seq.) (or a waiver of such plan), pursuant to pro-

1 grams to encourage the adoption and use of certified
2 EHR technology;

3 (9) identify providers in medically underserved
4 areas that are not electing to adopt and use elec-
5 tronic health records and determine what barriers
6 are preventing those providers from adopting and
7 using such records; and

8 (10) examine urban and rural community
9 health systems and determine the impact that health
10 information technology may have on the capacity of
11 primary health providers in those systems.

12 (c) MEDICALLY UNDERSERVED AREA.—The term
13 “medically underserved area” means—

14 (1) a population that has been designated as a
15 medically underserved population under section
16 330(b)(3) of the Public Health Service Act (42
17 U.S.C. 254b(b)(3));

18 (2) an area that has been designated as a
19 health professional shortage area under section 332
20 of the Public Health Service Act (42 U.S.C. 254e);

21 (3) an area or population that has been des-
22 ignated as a medically underserved community under
23 section 799B of the Public Health Service Act (42
24 U.S.C. 295p); or

25 (4) another area or population that—

1 (A) experiences significant barriers to ac-
2 cessing quality health services; and

3 (B) has a high prevalence of diseases or
4 conditions described in title VII, with such dis-
5 eases or conditions having a disproportionate
6 impact on racial and ethnic minority groups (as
7 defined in section 1707(g) of the Public Health
8 Service Act (42 U.S.C. 300u-6(g))) or a sub-
9 group of people with disabilities who have spe-
10 cific functional impairments.

11 **SEC. 908. STUDY ON THE EFFECTS OF CHANGES TO TELE-**
12 **HEALTH UNDER THE MEDICARE AND MED-**
13 **ICAID PROGRAMS DURING THE COVID-19**
14 **EMERGENCY.**

15 (a) IN GENERAL.—Not later than 1 year after the
16 end of the emergency period described in section
17 1135(g)(1)(B) of the Social Security Act (42 U.S.C.
18 1320b-5(g)(1)(B)), the Secretary of Health and Human
19 Services (in this section referred to as the “Secretary”)
20 shall conduct a study and submit to the Committee on
21 Energy and Commerce and the Committee on Ways and
22 Means of the House of Representatives and the Committee
23 on Finance of the Senate an interim report on any
24 changes made to the provision or availability of telehealth
25 services under part A or B of title XVIII of the Social

1 Security Act (42 U.S.C. 1395 et seq.) during such period.

2 Such report shall include the following:

3 (1) A summary of utilization of all health care
4 services furnished under such part A or B during
5 such period, including the number of—

6 (A) in-person outpatient visits, inpatient
7 admissions, and in-person emergency depart-
8 ment visits; and

9 (B) telehealth visits, broken down by—

10 (i) the number of such visits furnished
11 via audio-visual technology compared to
12 the number of such visits furnished via
13 audio-only technology;

14 (ii) the number of such visits fur-
15 nished by each type of provider of services
16 or supplier (as defined in section 1861 of
17 such Act (42 U.S.C. 1395x) and including
18 a Federally qualified health center or rural
19 health clinic (as so defined)), including a
20 specification of the specialty of each such
21 provider or supplier (if applicable); and

22 (iii) the type of service provided, in-
23 cluding level of service and diagnoses asso-
24 ciated with the telehealth visit.

1 (2) A description of any changes in utilization
2 patterns for the care settings described in paragraph
3 (1) over the course of such period compared to such
4 patterns prior to such period.

5 (3) An analysis of utilization of telehealth serv-
6 ices under such part A or B during such period, bro-
7 ken down by age, sex (including sexual orientation
8 and gender identity where possible), race and eth-
9 nicity, disability status, primary language, geo-
10 graphic region (including by rural health areas (as
11 defined by the Health Resources & Services Admin-
12 istration), non-rural health areas, health professional
13 shortage areas (as defined in section 332(a)(1) of
14 the Public Health Service Act (42 U.S.C.
15 254e(a)(1))), medically underserved communities (as
16 defined in section 799B(6) of such Act (42 U.S.C.
17 295p(6))), areas with medically underserved popu-
18 lations (as defined in section 330(b)(3) of such Act
19 (42 U.S.C. 254b(b)(3))), and by State), and income
20 level (as measured directly or indirectly, such as by
21 patient's zip code tabulation area median income as
22 publicly reported by the United States Census Bu-
23 reau), and of any trends in such utilization during
24 such period, so broken down. Such analysis shall in-
25 clude the number of telehealth visits performed by

1 providers of services or suppliers licensed in a State
2 different from the State where the individual receiv-
3 ing such telehealth services is located at the time
4 such services are furnished. Such analysis may not
5 include any individually identifiable information or
6 protected health information.

7 (4) A description of expenditures and any sav-
8 ings under such part A or B attributable to use of
9 such telehealth services during such period.

10 (5) A description of any instances of fraud
11 identified by the Secretary, acting through the Office
12 of the Inspector General or other relevant agencies
13 and departments, with respect to such telehealth
14 services furnished under such part A or B during
15 such period and a comparison of the number of such
16 instances with the number of instances of fraud so
17 identified with respect to in-person services so fur-
18 nished during such period.

19 (6) A description of any privacy concerns with
20 respect to the furnishing of such telehealth services
21 (such as cybersecurity or ransomware concerns), in-
22 cluding a description of any actions taken by the
23 Secretary, acting through the Health Sector
24 Cybersecurity Coordination Center or other relevant
25 agencies and departments, during such period to as-

1 sist health care providers secure telecommunications
2 systems.

3 (7) An analysis of health care quality related to
4 telehealth (which may include patient health out-
5 comes (such as morbidity, mortality, healthcare utili-
6 zation, and disease-specific management metrics),
7 safety metrics, quality measures, health equity fo-
8 cused measures, patient satisfaction, provider satis-
9 faction, and other inputs and sources as determined
10 by the Secretary).

11 (8) An analysis of any other outcomes or
12 metrics related to telehealth, as determined appro-
13 priate by the Secretary.

14 (b) INPUT.—In conducting the study and submitting
15 the report under subsection (a), the Secretary—

16 (1)(A) consult with relevant stakeholders (such
17 as patients, caregivers, patient advocacy groups, mi-
18 nority or tribal groups (including Urban Indian Or-
19 ganization (UIOs)), health care professionals (in-
20 cluding behavioral health professionals), hospitals,
21 State medical boards, State nursing boards, the
22 Federation of State Medical Boards, National Coun-
23 cil of State Boards of Nursing, medical professional
24 employers (such as hospitals, medical groups, staff-
25 ing companies), telehealth groups, health profes-

1 sional liability providers, public and private payers,
2 and State leaders); and

3 (B) solicit public comments on such report be-
4 fore the submission of such report; and

5 (2) shall endeavor to include as many racially,
6 ethnically, geographically, linguistically, and profes-
7 sionally diverse perspectives as possible.

8 (c) FINAL REPORT.—Not later than December 31,
9 2024, the Secretary shall—

10 (1) update and finalize the interim report under
11 subsection (a); and

12 (2) submit such updated and finalized report to
13 the committees specified in such subsection.

14 (d) GRANTS FOR MEDICAID REPORTS.—

15 (1) IN GENERAL.—Not later than 2 years after
16 the end of the emergency period described in section
17 1135(g)(1)(B) of the Social Security Act (42 U.S.C.
18 1320b–5(g)(1)(B)), the Secretary shall award grants
19 to States with a State plan (or waiver of such plan)
20 in effect under title XIX of the Social Security Act
21 (42 U.S.C. 1396r) that submit an application under
22 this subsection for purposes of enabling such States
23 to study and submit reports to the Secretary on any
24 changes made to the provision or availability of tele-

1 health services under such plans (or such waivers)
2 during such period.

3 (2) ELIGIBILITY.—To be eligible to receive a
4 grant under paragraph (1), a State shall—

5 (A) provide benefits for telehealth services
6 under the State plan (or waiver of such plan)
7 in effect under title XIX of the Social Security
8 Act (42 U.S.C. 1396r);

9 (B) be able to differentiate telehealth from
10 in-person visits within claims data submitted
11 under such plan (or such waiver) during such
12 period; and

13 (C) submit to the Secretary an application
14 at such time, in such manner, and containing
15 such information (including the amount of the
16 grant requested) as the Secretary may require.

17 (3) USE OF FUNDS.—An State shall use
18 amounts received under a grant under this sub-
19 section to conduct a study and report findings re-
20 garding the effects of changes to telehealth services
21 offered under the State plan (or waiver of such plan)
22 of such State under title XIX of the Social Security
23 Act (42 U.S.C. 1396 et seq.) during such period in
24 accordance with paragraph (4).

25 (4) REPORTS.—

1 (A) INTERIM REPORT.—Not later 1 year
2 after the date a State receives a grant under
3 this subsection, the State shall submit to the
4 Secretary an interim report that—

5 (i) details any changes made to the
6 provision or availability of telehealth bene-
7 fits (such as eligibility, coverage, or pay-
8 ment changes) under the State plan (or
9 waiver of such plan) of the State under
10 title XIX of the Social Security Act (42
11 U.S.C. 1396 et seq.) during the emergency
12 period described in paragraph (1); and

13 (ii) contains—

14 (I) a summary and description of
15 the type described in paragraphs (1)
16 and (2), respectively, of subsection
17 (a); and

18 (II) to the extent practicable, an
19 analysis of the type described in para-
20 graph (3) of subsection (a),
21 except that any reference in such sub-
22 section to “such part A or B” shall, for
23 purposes of subclauses (I) and (II), be
24 treated as a reference to such State plan
25 (or waiver).

1 (B) FINAL REPORT.—Not later than 3
2 years after the date a State receives a grant
3 under this subsection, the State shall update
4 and finalize the interim report and submit such
5 final report to the Secretary.

6 (C) REPORT BY SECRETARY.—Not later
7 than the earlier of the date that is 1 year after
8 the submission of all final reports under sub-
9 paragraph (B) and December 31, 2028, the
10 Secretary shall submit to Congress a report on
11 the grant program, including a summary of the
12 reports received from States under this para-
13 graph.

14 (5) MODIFICATION AUTHORITY.—The Secretary
15 may modify any deadline described in paragraph (4)
16 or any information required to be included in a re-
17 port made under this subsection to provide flexibility
18 for States to modify the scope of the study and
19 timeline for such reports.

20 (6) TECHNICAL ASSISTANCE.—The Secretary
21 shall provide such technical assistance as may be
22 necessary to a State receiving a grant under this
23 subsection in order to assist such state in conducting
24 studies and submitting reports under this sub-
25 section.

1 (7) STATE.—For purposes of this subsection,
2 the term “State” means each of the several States,
3 the District of Columbia, and each territory of the
4 United States.

5 (e) AUTHORIZATION OF APPROPRIATIONS.—

6 (1) MEDICARE.—For the purpose of carrying
7 out subsections (a) through (c), there are authorized
8 to be appropriated such sums as may be necessary
9 for each of the fiscal years 2020 through 2024.

10 (2) MEDICAID.—For the purpose of carrying
11 out subsection (d), there are authorized to be appro-
12 priated such sums as may be necessary for each of
13 the fiscal years 2022 through 2028.

14 **SEC. 909. COVID-19 DESIGNATION OF IMMEDIATE SPECIAL**
15 **AUTHORITY OF SPECTRUM FOR TRIBES’**
16 **EMERGENCY RESPONSE IN INDIAN COUNTRY.**

17 (a) FINDINGS.—Congress finds the following:

18 (1) The immediate grant of emergency special
19 temporary authority of available spectrum that will
20 efficiently support temporary wireless broadband
21 networks and allow Indian Tribes to provide Tribal
22 members with wireless broadband service over Tribal
23 lands or Hawaiian Home Lands during the COVID–
24 19 crisis due to the increased demand for tele-

1 communications and disproportionate impacts of the
2 COVID–19 pandemic in Indian Country is essential.

3 (2) Reservations are the most digitally discon-
4 nected areas in the United States that lack basic ac-
5 cess to broadband and wireless services at rates
6 comparable to, and in some cases lower than, third-
7 world countries.

8 (3) In 2018, the Government Accountability Of-
9 fice and the Federal Communications Commission
10 reported that only 65 percent of American Indian
11 and Alaska Natives (AI/ANs) living on Tribal lands
12 had access to fixed broadband services, and only 68
13 percent of AI/AN households on rural Tribal lands
14 had telephone services. This is a stark comparison to
15 only 8 percent of the national average that lacks ac-
16 cess to fixed broadband services.

17 (4) Indian Tribes have previously encountered
18 substantial barriers to accessing broadband and
19 other communications services on Tribal lands to de-
20 ploy telecommunication services for the safety and
21 well-being of Tribal members and to decrease the
22 alarming rates of unnecessary loss of lives that AI/
23 ANs disproportionately experience, especially
24 through the lack of access to health care services
25 and emergency resources, as demonstrated during

1 the COVID–19 pandemic that continues to dis-
2 proportionately impact Indian Country.

3 (5) Indian Tribes’ lack of access to broadband
4 services on Tribal lands and Hawaiian Home Lands
5 during the COVID–19 pandemic further highlights
6 the digital divide in Indian Country.

7 (6) The Government Accountability Office
8 found that health information technology systems at
9 the Indian Health Service rank as the Federal Gov-
10 ernment’s third-highest need for agency system mod-
11 ernization, since 50 percent of Indian Health Service
12 facilities depend on outdated circuit connections
13 based on one or two TI circuit lines (3 Mbps), cre-
14 ating slower response times than any other health
15 facility system in the United States.

16 (7) A 2018 Tribal health reform comment filed
17 with the Federal Communications Commission has
18 further stated that approximately 1.5 million people
19 living on Tribal lands lack access to broadband and,
20 of the 75 percent of rural Indian Health Service fa-
21 cilities, many still lack reliable broadband networks
22 for American Indians and Alaska Natives (AI/ANs)
23 to access telehealth or clinical health care services,
24 which is a critical need in the most geographically
25 isolated areas of the country with some of the high-

1 est poverty rates, and lack of access to reliable
2 transportation.

3 (8) The Bureau of Indian Education has stated
4 that recent estimates from 142 out of 174 schools
5 have indicated that approximately 15 to 95 percent
6 of students do not have access to internet services
7 at home depending on Bureau school location and
8 limitations on data caps during the COVID–19 cri-
9 sis.

10 (b) DEPLOYMENT OF WIRELESS BROADBAND SERV-
11 ICE ON TRIBAL LANDS AND HAWAIIAN HOME LANDS.—

12 (1) FUNDING OF GRANTS FOR IMMEDIATE DE-
13 PLOYMENT OF WIRELESS BROADBAND SERVICE ON
14 TRIBAL LANDS AND HAWAIIAN HOME LANDS.—In
15 addition to any other amounts made available, out of
16 any money in the Treasury of the United States not
17 otherwise appropriated, there are appropriated—

18 (A) \$297,500,000 for grants under the
19 community facilities grant program under sec-
20 tion 306(a)(19) of the Consolidated Farm and
21 Rural Development Act to Indian Tribes, quali-
22 fying Tribal entities, and the Director of the
23 Department of Hawaiian Home Lands, for the
24 immediate deployment of wireless broadband
25 service on Tribal lands and Hawaiian Home

1 Lands, respectively, through the use of emer-
2 gency special temporary authority granted
3 under paragraph (2) of this subsection, includ-
4 ing backhaul costs, repairs to damaged infra-
5 structure, the cost of the repairs to which would
6 be less expensive than the cost of new infra-
7 structure and would support the emergency spe-
8 cial temporary use, and the Federal share appli-
9 cable to grants from such amount shall be 100
10 percent, which amount shall remain available
11 for one year from the enactment of this Act;
12 and

13 (B) \$3,000,000 for grants under the com-
14 munity facilities technical assistance and train-
15 ing grant program under section 306(a)(26) of
16 such Act, without regard to sections
17 306(a)(26)(B) and 306(a)(26)(C) of such Act,
18 to assist Indian Tribes, qualifying Tribal enti-
19 ties, and the Director of the Department of Ha-
20 waiian Home Lands in preparing applications
21 for the grants referred to in subparagraph (B)
22 of this paragraph, which amount shall remain
23 available for one year from the enactment of
24 this Act.

1 Grants referred to under subparagraph (B) shall be
2 available to Indian Tribes, qualifying Tribal entities
3 and shall also be available to inter-Tribal govern-
4 ment organizations, universities, and colleges with
5 Tribal serving institutions for the purposes stated
6 herein.

7 (2) EMERGENCY SPECIAL TEMPORARY AUTHOR-
8 ITY TO USE AVAILABLE AND EFFICIENT SPECTRUM
9 ON TRIBAL LANDS AND HAWAIIAN HOME LANDS.—

10 (A) GRANT OF AUTHORITY.—Not later
11 than 10 days after receiving a request from an
12 Indian Tribe, a qualifying Tribal entity, or the
13 Director of the Department of Hawaiian Home
14 Lands for emergency special temporary author-
15 ity to use electromagnetic spectrum described in
16 subparagraph (C) for the provision of wireless
17 broadband service over the Tribal lands over
18 which the Indian Tribe or qualifying Tribal en-
19 tity has jurisdiction or (in the case of a request
20 from the Director of the Department of Hawai-
21 ian Home Lands) over the Hawaiian Home
22 Lands, allowing unlicensed radio transmitters
23 to operate for such provision on such spectrum
24 at locations on such Tribal lands or Hawaiian
25 Home Lands where such spectrum is not being

1 used, the Commission shall grant such request
2 on a secondary non-interference basis.

3 (B) DURATION.—A grant of emergency
4 special temporary authority under subpara-
5 graph (A) shall be for a period of operation to
6 begin not later than 6 months after the date of
7 the enactment of this Act and to remain in op-
8 eration for not longer than 6 months, absent
9 extensions granted by the Commission pursuant
10 to the procedures of the Commission relating to
11 special temporary authority.

12 (C) ELECTROMAGNETIC SPECTRUM DE-
13 SCRIBED.—The electromagnetic spectrum de-
14 scribed in this subparagraph for utilization on
15 the temporary basis is any portion of the elec-
16 tromagnetic spectrum—

17 (i) that is—

18 (I) between the frequencies of
19 2496 megahertz and 2690 megahertz,
20 inclusive;

21 (II) in the white spaces of the
22 television broadcast spectrum between
23 the frequencies of 470 megahertz and
24 790 megahertz, inclusive, excluding
25 those frequencies utilized for other

purposes under subpart H of part 15
of title 47, Code of Federal Regula-
tions;

(III) between the frequencies of
5925 megahertz and 7125 megahertz,
inclusive; or

(IV) between frequencies of 3550
megahertz and 3700 megahertz, inclu-
sive; and

(ii) with respect to the Tribal lands or
Hawaiian Home Lands over which author-
ity to use such spectrum is requested
under subparagraph (A), is not assigned to
any licensee.

(3) DEFINITIONS.—In this subsection:

(A) COMMISSION.—The term “Commis-
sion” means the Federal Communications Com-
mission.

(B) HAWAIIAN HOME LANDS.—The term
“Hawaiian Home Lands” means lands held in
trust for Native Hawaiians by Hawaii pursuant
to the Hawaiian Homes Commission Act, 1920.

(C) INDIAN TRIBE.—The term “Indian
Tribe” means the governing body of any indi-
vidually identified and federally recognized In-

1 dian or Alaska Native Tribe, band, nation,
2 pueblo, village, community, affiliated tribal
3 group, or component reservation in the list pub-
4 lished pursuant to section 104(a) of the Feder-
5 ally Recognized Indian Tribe List Act of 1994
6 (25 U.S.C. 5131(a)).

7 (D) QUALIFYING TRIBAL ENTITY.—The
8 term “qualifying Tribal entity” means an entity
9 designated by the Indian Tribe with jurisdiction
10 over particular Tribal lands for which the spec-
11 trum access is sought. The following may be
12 designated as a qualifying Tribal entity:

13 (i) Indian Tribes.

14 (ii) Tribal consortia which consists of
15 two or more Indian Tribes, or an Indian
16 Tribe and an entity that is more than 50
17 percent owned and controlled by one or
18 more Indian Tribes.

19 (iii) Federally chartered Tribal cor-
20 porations created under section 17 of the
21 Indian Reorganization Act (25 U.S.C.
22 5124), and created under section 4 of the
23 Oklahoma Indian Welfare Act (25 U.S.C.
24 5204).

1 (iv) Entities that are more than 50
2 percent owned and controlled by an Indian
3 Tribe or Indian Tribes.

4 (E) ENTITY THAT IS MORE THAN 50 PER-
5 CENT OWNED AND CONTROLLED BY ONE OR
6 MORE INDIAN TRIBES.—The term “entity that
7 is more than 50 percent owned and controlled
8 by one or more Indian Tribes” means an entity
9 over which one or more Indian Tribes have both
10 de facto and de jure control of the entity. De
11 jure control of the entity is evidenced by owner-
12 ship of greater than 50 percent of the voting
13 stock of a corporation, or in the case of a part-
14 nership, general partnership interests. De facto
15 control of an entity is determined on a case-by-
16 case basis. An Indian Tribe or Indian Tribes
17 must demonstrate indicia of control to establish
18 that such Indian Tribe or Indian Tribes retain
19 de facto control of the applicant seeking eligi-
20 bility as a “qualifying Tribal entity”, including
21 the following:

22 (i) The Indian Tribe or Indian Tribes
23 constitute or appoint more than 50 percent
24 of the board of directors or management
25 committee of the entity.

1 (ii) The Indian Tribe or Indian Tribes
2 have authority to appoint, promote, de-
3 mote, and fire senior executives who con-
4 trol the day-to-day activities of the entity.

5 (iii) The Indian Tribe or Indian
6 Tribes play an integral role in the manage-
7 ment decisions of the entity.

8 (iv) The Indian Tribe or Indian
9 Tribes have the authority to make deci-
10 sions or otherwise engage in practices or
11 activities that determine or significantly in-
12 fluence—

13 (I) the nature or types of services
14 offered by such an entity;

15 (II) the terms upon which such
16 services are offered; or

17 (III) the prices charged for such
18 services.

19 (F) TRIBAL LANDS.—The term “Tribal
20 lands” has the meaning given that term in sec-
21 tion 73.7000 of title 47, Code of Federal Regu-
22 lations, as of April 16, 2020, and includes the
23 definition “Indian Country” as defined in sec-
24 tion 1151 of title 18, United States Code, and

1 includes fee simple and restricted fee land held
2 by an Indian Tribe.

3 (G) WIRELESS BROADBAND SERVICE.—

4 The term “wireless broadband service” means
5 wireless broadband internet access service that
6 is delivered—

7 (i) with a download speed of not less
8 than 25 megabits per second and an
9 upload speed of not less than 3 megabits
10 per second; and

11 (ii) through—

12 (I) mobile service;

13 (II) fixed point-to-point
14 multipoint service;

15 (III) fixed point-to-point service;

16 or

17 (IV) broadcast service.

18 **SEC. 910. FACILITATING THE PROVISION OF TELEHEALTH**

19 **SERVICES ACROSS STATE LINES.**

20 (a) IN GENERAL.—For purposes of expediting the
21 provision of telehealth services, for which payment is made
22 under the Medicare Program, across State lines, the Sec-
23 retary of Health and Human Services shall, in consulta-
24 tion with representatives of States, physicians, health care
25 practitioners, and patient advocates, encourage and facili-

1 tate the adoption of provisions allowing for multistate
2 practitioner practice across State lines.

3 (b) DEFINITIONS.—In subsection (a):

4 (1) TELEHEALTH SERVICE.—The term “tele-
5 health service” has the meaning given that term in
6 subparagraph (F) of section 1834(m)(4) of the So-
7 cial Security Act (42 U.S.C. 1395m(m)(4)).

8 (2) PHYSICIAN, PRACTITIONER.—The terms
9 “physician” and “practitioner” have the meaning
10 given those terms in subparagraphs (D) and (E), re-
11 spectively, of such section.

12 (3) MEDICARE PROGRAM.—The term “Medicare
13 Program” means the program of health insurance
14 administered by the Secretary of Health and Human
15 Services under title XVIII of the Social Security Act
16 (42 U.S.C. 1395 et seq.).

17 **TITLE X—PUBLIC AWARENESS**

18 **SEC. 1001. AWARENESS CAMPAIGNS.**

19 The Secretary of Health and Human Services, acting
20 through the Director of the Centers for Disease Control
21 and Prevention and in coordination with other offices and
22 agencies, as appropriate, shall award competitive grants
23 or contracts to one or more public or private entities, in-
24 cluding faith-based organizations, to carry out multi-

1 lingual and culturally appropriate awareness campaigns.

2 Such campaigns shall—

3 (1) be based on available scientific evidence;

4 (2) increase awareness and knowledge of
5 COVID–19, including countering stigma associated
6 with COVID–19;

7 (3) improve information on the availability of
8 COVID–19 diagnostic testing; and

9 (4) promote cooperation with contact tracing ef-
10 forts.

11 **SEC. 1002. INCREASING UNDERSTANDING OF AND IMPROV-**
12 **ING HEALTH LITERACY.**

13 (a) IN GENERAL.—The Secretary, acting through the
14 Director of the Agency for Healthcare Research and Qual-
15 ity with respect to grants under subsection (c)(1) and
16 through the Administrator of the Health Resources and
17 Services Administration with respect to grants under sub-
18 section (c)(2), in consultation with the Director of the Na-
19 tional Institute on Minority Health and Health Disparities
20 and the Deputy Assistant Secretary for Minority Health,
21 shall award grants to eligible entities to improve health
22 care for patient populations that have low functional
23 health literacy.

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

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

4 (2) prepare and submit to the Secretary an ap-
5 plication at such time, in such manner, and con-
6 taining such information as the Secretary may rea-
7 sonably require.

8 (c) USE OF FUNDS.—

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

13 (A) to define and increase the under-
14 standing of health literacy;

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

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

19 (D) for any other activity determined ap-
20 propriate by the Director.

21 (2) HEALTH RESOURCES AND SERVICES ADMIN-
22 ISTRATION.—A grant awarded under subsection (a)
23 through the Administrator of the Health Resources
24 and Services Administration shall be used to conduct

1 demonstration projects for interventions for patients
2 with low health literacy that may include—

3 (A) the development of new disease man-
4 agement programs for patients with low health
5 literacy;

6 (B) the tailoring of disease management
7 programs addressing mental, physical, oral, and
8 behavioral health conditions for patients with
9 low health literacy;

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

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

14 (E) the conduct of educational campaigns
15 for patients and providers about low health lit-
16 eracy;

17 (F) the conduct of educational campaigns
18 concerning health directed specifically at pa-
19 tients with mental disabilities, including those
20 with cognitive and intellectual disabilities, de-
21 signed to reduce the incidence of low health lit-
22 eracy among these populations, which shall
23 have instructional materials in the plain lan-
24 guage standards promulgated under the Plain

1 Writing Act of 2010 (5 U.S.C. 301 note) for
2 Federal agencies; and

3 (G) other activities determined appropriate
4 by the Administrator.

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

9 (e) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated to carry out this section,
11 such sums as may be necessary for each of fiscal years
12 2021 through 2025.

13 **SEC. 1003. ENGLISH FOR SPEAKERS OF OTHER LAN-**
14 **GUAGES.**

15 (a) GRANTS AUTHORIZED.—The Secretary of Edu-
16 cation is authorized to provide grants to eligible entities
17 for the provision of English as a second language (in this
18 section referred to “ESL”) instruction and shall deter-
19 mine, after consultation with appropriate stakeholders, the
20 mechanism for administering and distributing such
21 grants.

22 (b) ELIGIBLE ENTITY DEFINED.—In this section,
23 the term “eligible entity” means a State or community-
24 based organization that employs and serves minority popu-
25 lations.

1 (c) APPLICATION.—An eligible entity may apply for
2 a grant under this section by submitting such information
3 as the Secretary of Education may require and in such
4 form and manner as the Secretary may require.

5 (d) USE OF GRANT.—As a condition of receiving a
6 grant under this section, an eligible entity shall—

7 (1) develop and implement a plan for assuring
8 the availability of ESL instruction that effectively
9 integrates information about the nature of the
10 United States health care system, how to access
11 care, and any special language skills that may be re-
12 quired for individuals to access and regularly nego-
13 tiate the system effectively;

14 (2) develop a plan, including, where appro-
15 priate, public-private partnerships, for making ESL
16 instruction progressively available to all individuals
17 seeking instruction; and

18 (3) maintain current ESL instruction efforts by
19 using funds available under this section to supple-
20 ment rather than supplant any funds expended for
21 ESL instruction in the State as of January 1, 2020.

22 (e) ADDITIONAL DUTIES OF THE SECRETARY.—The
23 Secretary of Education shall—

1 (1) collect and publicize annual data on how
2 much Federal, State, and local governments spend
3 on ESL instruction;

4 (2) collect data from State and local govern-
5 ments to identify the unmet needs of English lan-
6 guage learners for appropriate ESL instruction, in-
7 cluding—

8 (A) the preferred written and spoken lan-
9 guage of such English language learners;

10 (B) the extent of waiting lists for ESL in-
11 struction, including how many programs main-
12 tain waiting lists and, for programs that do not
13 have waiting lists, the reasons why not;

14 (C) the availability of programs to geo-
15 graphically isolated communities;

16 (D) the impact of course enrollment poli-
17 cies, including open enrollment, on the avail-
18 ability of ESL instruction;

19 (E) the number individuals in the State
20 and each participating locality;

21 (F) the effectiveness of the instruction in
22 meeting the needs of individuals receiving in-
23 struction and those needing instruction;

24 (G) as assessment of the need for pro-
25 grams that integrate job training and ESL in-

1 instruction, to assist individuals to obtain better
2 jobs; and

3 (H) the availability of ESL slots by State
4 and locality;

5 (3) determine the cost and most appropriate
6 methods of making ESL instruction available to all
7 English language learners seeking instruction; and

8 (4) not later than 1 year after the date of en-
9 actment of this Act, issue a report to Congress that
10 assesses the information collected in paragraphs (1),
11 (2), and (3) and makes recommendations on steps
12 that should be taken to progressively realize the goal
13 of making ESL instruction available to all English
14 language learners seeking instruction.

15 (f) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated to the Secretary of Edu-
17 cation \$250,000,000 for each of fiscal years 2021 through
18 2024 to carry out this section.

19 **SEC. 1004. INFLUENZA, COVID-19, AND PNEUMONIA VAC-**
20 **CINATION CAMPAIGN.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services shall—

23 (1) enhance the annual campaign by the De-
24 partment of Health and Human Services to increase

1 the number of people vaccinated each year for influ-
2 enza, pneumonia, and COVID–19; and

3 (2) include in such campaign the use of written
4 educational materials, public service announcements,
5 physician education, and any other means which the
6 Secretary deems effective.

7 (b) MATERIALS AND ANNOUNCEMENTS.—In carrying
8 out the annual campaign described in subsection (a), the
9 Secretary of Health and Human Services shall ensure
10 that—

11 (1) educational materials and public service an-
12 nouncements are readily and widely available in
13 communities experiencing disparities in the incidence
14 and mortality rates of influenza, pneumonia, and
15 COVID–19; and

16 (2) the campaign uses targeted, culturally ap-
17 propriate messages and messengers to reach under-
18 served communities.

19 (c) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section
21 such sums as may be necessary for each of fiscal years
22 2021 through 2025.

TITLE XI—RESEARCH

SEC. 1101. RESEARCH AND DEVELOPMENT.

The Secretary of Health and Human Services, in coordination with the Director of the Centers for Disease Control and Prevention and in collaboration with the Director of the National Institutes of Health, the Director of the Agency for Healthcare Research and Quality, the Commissioner of Food and Drugs, and the Administrator of the Centers for Medicare & Medicaid Services, shall support research and development on more efficient and effective strategies—

(1) for the surveillance of SARS-CoV-2 and COVID-19;

(2) for the testing and identification of individuals infected with COVID-19; and

(3) for the tracing of contacts of individuals infected with COVID-19.

SEC. 1102. CDC FIELD STUDIES PERTAINING TO SPECIFIC HEALTH INEQUITIES.

(a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Centers for Disease Control and Prevention, in collaboration with State, local, Tribal, and territorial health departments, shall complete (by the

1 reporting deadline in subsection (b)) field studies to better
2 understand health inequities that are not currently
3 tracked by the Secretary. Such studies shall include an
4 analysis of—

5 (1) the impact of socioeconomic status on
6 health care access and disease outcomes, including
7 COVID–19 outcomes;

8 (2) the impact of disability status on health
9 care access and disease outcomes, including COVID–
10 19 outcomes;

11 (3) the impact of language preference on health
12 care access and disease outcomes, including COVID–
13 19 outcomes;

14 (4) factors contributing to disparities in health
15 outcomes for the COVID–19 pandemic; and

16 (5) other topics related to disparities in health
17 outcomes for the COVID–19 pandemic, as deter-
18 mined by the Secretary.

19 (b) REPORT.—Not later than December 31, 2021,
20 the Secretary shall submit to the Committee on Energy
21 and Commerce of the House of Representatives and the
22 Committee on Health, Education, Labor, and Pensions of
23 the Senate an initial report on the results of the field stud-
24 ies under this section.

1 (c) FINAL REPORT.—Not later than December 31,
2 2023, the Secretary shall—

3 (1) update and finalize the initial report under
4 subsection (b); and

5 (2) submit such final report to the committees
6 specified in such subsection.

7 (d) AUTHORIZATION OF APPROPRIATIONS.—There is
8 authorized to be appropriated to carry out this section
9 \$25,000,000, to remain available until expended.

10 **SEC. 1103. EXPANDING CAPACITY FOR HEALTH OUTCOMES.**

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services (referred to in this section as the “Sec-
13 retary”), acting through the Administrator of the Health
14 Resources and Services Administration, shall award
15 grants to eligible entities to develop and expand the use
16 of technology-enabled collaborative learning and capacity
17 building models to respond to ongoing and real-time learn-
18 ing, health care information sharing, and capacity building
19 needs related to COVID–19.

20 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
21 grant under this section, an entity shall have experience
22 providing technology-enabled collaborative learning and
23 capacity building health care services—

1 (1) in rural areas, frontier areas, health profes-
2 sional shortage areas, or medically underserved area;
3 or

4 (2) to medically underserved populations or In-
5 dian Tribes.

6 (c) USE OF FUNDS.—An eligible entity receiving a
7 grant under this section shall use funds received through
8 the grant—

9 (1) to advance quality of care in response to
10 COVID–19, with particular emphasis on rural and
11 underserved areas and populations;

12 (2) to protect medical personnel and first re-
13 sponders through sharing real-time learning through
14 virtual communities of practice;

15 (3) to improve patient outcomes for conditions
16 affected or exacerbated by COVID–19, including im-
17 provement of care for patients with complex chronic
18 conditions; and

19 (4) to support rapid uptake by health care pro-
20 fessionals of emerging best practices and treatment
21 protocols around COVID–19.

22 (d) OPTIONAL ADDITIONAL USES OF FUNDS.—An
23 eligible entity receiving a grant under this section may use
24 funds received through the grant for—

1 (1) equipment to support the use and expansion
2 of technology-enabled collaborative learning and ca-
3 pacity building models, including hardware and soft-
4 ware that enables distance learning, health care pro-
5 vider support, and the secure exchange of electronic
6 health information;

7 (2) the participation of multidisciplinary expert
8 team members to facilitate and lead technology-en-
9 abled collaborative learning sessions, and profes-
10 sionals and staff assisting in the development and
11 execution of technology-enabled collaborative learn-
12 ing;

13 (3) the development of instructional program-
14 ming and the training of health care providers and
15 other professionals that provide or assist in the pro-
16 vision of services through technology-enabled collabo-
17 rative learning and capacity building models; and

18 (4) other activities consistent with achieving the
19 objectives of the grants awarded under this section.

20 (e) TECHNOLOGY-ENABLED COLLABORATIVE
21 LEARNING AND CAPACITY BUILDING MODEL DEFINED.—

22 In this section, the term “technology-enabled collaborative
23 learning and capacity building model” has the meaning
24 given that term in section 2(7) of the Expanding Capacity

1 for Health Outcomes Act (Public Law 114–270; 130 Stat.
2 1395).

3 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
4 authorized to be appropriated to carry out this section
5 \$20,000,000, to remain available until expended.

6 **SEC. 1104. DATA COLLECTION AND ANALYSIS GRANTS TO**
7 **MINORITY-SERVING INSTITUTIONS.**

8 (a) AUTHORITY.—The Secretary of Health and
9 Human Services, acting through the Director of the Na-
10 tional Institute on Minority Health and Health Disparities
11 and the Deputy Assistant Secretary for Minority Health,
12 shall award grants to eligible entities to access and analyze
13 racial and ethnic data on disparities in health and health
14 care, and where possible other data on disparities in health
15 and health care, to monitor and report on progress to re-
16 duce and eliminate disparities in health and health care.

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

21 (1) A part B institution, as defined in section
22 322 of the Higher Education Act of 1965 (20
23 U.S.C. 1061).

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

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

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

6 (c) AUTHORIZATION OF APPROPRIATIONS.—To carry
7 out this section, there are authorized to be appropriated
8 such sums as may be necessary for fiscal years 2021
9 through 2025.

10 **SEC. 1105. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
11 **RESPECT TO RACIAL AND ETHNIC BACK-**
12 **GROUND.**

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

16 **“SEC. 505G. SAFETY AND EFFECTIVENESS OF DRUGS WITH**
17 **RESPECT TO RACIAL AND ETHNIC BACK-**
18 **GROUND.**

19 “(a) PREAPPROVAL STUDIES.—If there is evidence
20 that there may be a disparity on the basis of racial or
21 ethnic background or other demographic characteristics
22 (such as age, sex, gender) as to the safety or effectiveness
23 of a drug or biological product or if such product address-
24 es a disease that disproportionately impacts certain racial

1 or ethnic groups or other demographic characteristics
2 (such as age, sex, gender), then—

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

7 “(B) in the case of a biological product, the evi-
8 dence required under section 351(a) of the Public
9 Health Service Act for approval of a biologics license
10 application for the biological product shall include
11 adequate and well-controlled investigations of the
12 disparity; and

13 “(2) if the investigations described in subpara-
14 graph (A) or (B) of paragraph (1) confirm that
15 there is such a disparity, the labeling of the drug or
16 biological product shall include appropriate informa-
17 tion about the disparity.

18 “(b) POSTMARKET STUDIES.—

19 “(1) IN GENERAL.—If there is evidence that
20 there may be a disparity on the basis of racial or
21 ethnic background or other demographic characteris-
22 tics (such as age, sex, gender) as to the safety or ef-
23 fectiveness of a drug for which there is an approved
24 application under section 505 of this Act or of a bio-
25 logical product for which there is an approved li-

1 cense under section 351 of the Public Health Service
2 Act, the Secretary may by order require the holder
3 of the approved application or license to conduct, by
4 a date specified by the Secretary, postmarket studies
5 to investigate the disparity.

6 “(2) LABELING.—If the Secretary determines
7 that the postmarket studies confirm that there is a
8 disparity described in paragraph (1), the labeling of
9 the drug or biological product shall include appro-
10 priate information about the disparity.

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

18 “(4) MODIFICATIONS OF STUDY DESIGN.—The
19 Secretary may, by order and as necessary, modify
20 any aspect of the design of a postmarket study re-
21 quired in an order under paragraph (1) after issuing
22 such order.

23 “(5) STUDY RESULTS.—The results from a
24 study required under paragraph (1) shall be sub-

mitted to the Secretary as a supplement to the drug application or biologics license application.

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

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

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

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

3 “(d) DEFINITION.—The term ‘evidence that there
4 may be a disparity on the basis of racial or ethnic back-
5 ground or other demographic characteristics (such as age,
6 sex, gender) as to the safety or effectiveness’, with respect
7 to a drug or biological product, includes—

8 “(1) evidence that there is a disparity on the
9 basis of racial or ethnic background or other demo-
10 graphic characteristics (such as age, sex, gender) as
11 to safety or effectiveness of a drug or biological
12 product in the same chemical class as the drug or
13 biological product;

14 “(2) evidence that there is a disparity on the
15 basis of racial or ethnic background or other demo-
16 graphic characteristics (such as age, sex, gender) in
17 the way the drug or biological product is metabo-
18 lized;

19 “(3) other evidence as the Secretary may deter-
20 mine appropriate; and

21 “(4) if such product addresses a disease/condi-
22 tion that evidence shows disproportionately impacts
23 certain racial or ethnic groups or other demographic
24 characteristics (such as age, sex, gender).”.

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 “(ee) 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 505G.”.

9 (c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the
10 Federal Food, Drug, and Cosmetic Act (21 U.S.C.
11 379h(a)(1)(A)(ii)) is amended by inserting after “are not
12 required” the following: “, including postmarket studies
13 required under section 505G”.

14 **SEC. 1106. GAO AND NIH REPORTS.**

15 (b) GAO REPORT ON NIH GRANT RACIAL AND ETH-
16 NIC DIVERSITY.—

17 (1) IN GENERAL.—The Comptroller General of
18 the United States shall conduct a study on the racial
19 and ethnic diversity among the following groups:

20 (A) All applicants for grants, contracts,
21 and cooperative agreements awarded by the Na-
22 tional Institutes of Health during the period be-
23 ginning on January 1, 2009, and ending De-
24 cember 31, 2019.

1 (B) All recipients of such grants, con-
2 tracts, and cooperative agreements during such
3 period.

4 (C) All members of the peer review panels
5 of such applicants and recipients, respectively.

6 (2) REPORT.—Not later than 6 months after
7 the date of the enactment of this Act, the Comp-
8 troller General shall complete the study under para-
9 graph (1) and submit to Congress a report con-
10 taining the results of such study.

11 (c) GAO REPORT.—Not later than one year after the
12 date of the enactment of this Act and biennially thereafter
13 until 2024, the Comptroller General of the United States
14 shall submit to Congress a report that identifies—

15 (1) the racial and ethnic diversity of commu-
16 nity-based organizations that applied for Federal
17 funding provided pursuant to Coronavirus Prepared-
18 ness and Response Supplemental Appropriations Act
19 (Public Law 116–123), Families First Coronavirus
20 Response Act (Public Law 116–127), Coronavirus
21 Aid, Relief, and Economic Security Act (Public Law
22 116–136), and Paycheck Protection Program and
23 Health Care Enhancement Act (Public Law 116–
24 139);

1 (2) the percentage of such organizations that
2 were awarded such funding; and

3 (3) the impact of such community-based organi-
4 zations' efforts on reducing health disparities within
5 racial and ethnic minority groups.

6 (d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL
7 INSTITUTE ON MINORITY HEALTH AND HEALTH DIS-
8 PARITIES.—The Director of the National Institute on Mi-
9 nority Health and Health Disparities shall prepare an an-
10 nual report on the activities carried out or to be carried
11 out by such institute, and shall submit each such report
12 to the Committee on Health, Education, Labor, and Pen-
13 sions of the Senate, the Committee on Energy and Com-
14 merce of the House of Representatives, the Secretary of
15 Health and Human Services, and the Director of the Na-
16 tional Institutes of Health. With respect to the fiscal year
17 involved, the report shall—

18 (1) describe and evaluate the progress made in
19 health disparities research conducted or supported
20 by institutes and centers of the National Institutes
21 of Health;

22 (2) summarize and analyze expenditures made
23 for activities with respect to health disparities re-
24 search conducted or supported by the National Insti-
25 tutes of Health;

1 (3) include a separate statement applying the
2 requirements of paragraphs (1) and (2) specifically
3 to minority health disparities research; and

4 (4) contain such recommendations as the Direc-
5 tor of the Institute considers appropriate.

6 **SEC. 1107. HEALTH IMPACT ASSESSMENTS.**

7 (a) FINDINGS.—Congress makes the following find-
8 ings:

9 (1) Health Impact Assessment is a tool to help
10 planners, health officials, decision makers, and the
11 public make more informed decisions about the po-
12 tential health effects of proposed plans, policies, pro-
13 grams, and projects in order to maximize health
14 benefits and minimize harms.

15 (2) Health Impact Assessments fosters commu-
16 nity leadership, ownership and participation in deci-
17 sion-making processes.

18 (3) Health Impact Assessments can build com-
19 munity support and reduce opposition to a project or
20 policy, thereby facilitating economic growth by aid-
21 ing the development of consensus regarding new de-
22 velopment proposals.

23 (4) Health Impact Assessments facilitate col-
24 laboration across sectors.

25 (b) PURPOSES.—It is the purpose of this section to—

1 (1) provide more information about the poten-
2 tial human health effects of policy decisions and the
3 distribution of those effects;

4 (2) improve how health is considered in plan-
5 ning and decisionmaking processes; and

6 (3) build stronger, healthier communities
7 through the use of Health Impact Assessment.

8 (c) HEALTH IMPACT ASSESSMENTS.—Part P of title
9 III of the Public Health Service Act (42 U.S.C. 280g et
10 seq.), as amended by section 796A, is further amended
11 by adding at the end the following:

12 **“SEC. 399V-12. HEALTH IMPACT ASSESSMENTS.**

13 “(a) DEFINITIONS.—In this section:

14 “(1) ADMINISTRATOR.—The term ‘Adminis-
15 trator’ means the Administrator of the Environ-
16 mental Protection Agency.

17 “(2) DIRECTOR.—The term ‘Director’ means
18 the Director of the Centers for Disease Control and
19 Prevention.

20 “(3) HEALTH IMPACT ASSESSMENT.—The term
21 ‘health impact assessment’ means a systematic proc-
22 ess that uses an array of data sources and analytic
23 methods and considers input from stakeholders to
24 determine the potential effects of a proposed policy,
25 plan, program, or project on the health of a popu-

1 lation and the distribution of those effects within the
2 population. Such term includes identifying and rec-
3 ommending appropriate actions on monitoring and
4 maximizing potential benefits and minimizing the
5 potential harms.

6 “(4) HEALTH DISPARITY.—The term ‘health
7 disparity’ means a particular type of health dif-
8 ference that is closely linked with social, economic,
9 or environmental disadvantage and that adversely
10 affects groups of people who have systematically ex-
11 perienced greater obstacles to health based on their
12 racial or ethnic group; religion; socioeconomic status;
13 gender; age; mental health; cognitive, sensory, or
14 physical disability; sexual orientation or gender iden-
15 tity; geographic location; citizenship status; or other
16 characteristics historically linked to discrimination
17 or exclusion.

18 “(b) ESTABLISHMENT.—The Secretary, acting
19 through the Director and in collaboration with the Admin-
20 istrator, shall—

21 “(1) in consultation with the Director of the
22 National Center for Chronic Disease Prevention and
23 Health Promotion and relevant offices within the
24 Department of Housing and Urban Development,
25 the Department of Transportation, and the Depart-

1 ment of Agriculture, establish a program at the Na-
2 tional Center for Environmental Health at the Cen-
3 ters for Disease Control and Prevention focused on
4 advancing the field of health impact assessment that
5 includes—

6 “(A) collecting and disseminating best
7 practices;

8 “(B) administering capacity building
9 grants to States to support grantees in initi-
10 ating health impact assessments, in accordance
11 with subsection (d);

12 “(C) providing technical assistance;

13 “(D) developing training tools and pro-
14 viding training on conducting health impact as-
15 sessment and the implementation of built envi-
16 ronment and health indicators;

17 “(E) making information available, as ap-
18 propriate, regarding the existence of other com-
19 munity healthy living tools, checklists, and indi-
20 ces that help connect public health to other sec-
21 tors, and tools to help examine the effect of the
22 indoor built environment and building codes on
23 population health;

24 “(F) conducting research and evaluations
25 of health impact assessments; and

1 “(G) awarding competitive extramural re-
2 search grants;

3 “(2) develop guidance and guidelines to conduct
4 health impact assessments in accordance with sub-
5 section (c); and

6 “(3) establish a grant program to allow States
7 to fund eligible entities to conduct health impact as-
8 sessments.

9 “(c) GUIDANCE.—

10 “(1) IN GENERAL.—Not later than 1 year after
11 the date of enactment of the Ending Health Dispari-
12 ties during COVID-19 Act of 2020, the Secretary,
13 acting through the Director, shall issue final guid-
14 ance for conducting the health impact assessments.
15 In developing such guidance the Secretary shall—

16 “(A) consult with the Director of the Na-
17 tional Center for Environmental Health and,
18 the Director of the National Center for Chronic
19 Disease Prevention and Health Promotion, and
20 relevant offices within the Department of Hous-
21 ing and Urban Development, the Department of
22 Transportation, and the Department of Agri-
23 culture; and

24 “(B) consider available international health
25 impact assessment guidance, North American

1 health impact assessment practice standards,
2 and recommendations from the National Acad-
3 emy of Science.

4 “(2) CONTENT.—The guidance under this sub-
5 section shall include—

6 “(A) background on national and inter-
7 national efforts to bridge urban planning, cli-
8 mate forecasting, and public health institutions
9 and disciplines, including a review of health im-
10 pact assessment best practices internationally;

11 “(B) evidence-based direct and indirect
12 pathways that link land-use planning, transpor-
13 tation, and housing policy and objectives to
14 human health outcomes;

15 “(C) data resources and quantitative and
16 qualitative forecasting methods to evaluate both
17 the status of health determinants and health ef-
18 fects, including identification of existing pro-
19 grams that can disseminate these resources;

20 “(D) best practices for inclusive public in-
21 volvement in conducting health impact assess-
22 ments; and

23 “(E) technical assistance for other agen-
24 cies seeking to develop their own guidelines and
25 procedures for health impact assessment.

1 “(d) GRANT PROGRAM.—

2 “(1) IN GENERAL.—The Secretary, acting
3 through the Director and in collaboration with the
4 Administrator, shall—

5 “(A) award grants to States to fund eligi-
6 ble entities for capacity building or to prepare
7 health impact assessments; and

8 “(B) ensure that States receiving a grant
9 under this subsection further support training
10 and technical assistance for grantees under the
11 program by funding and overseeing appropriate
12 local, State, Tribal, Federal, institution of high-
13 er education, or nonprofit health impact assess-
14 ment experts to provide such technical assist-
15 ance.

16 “(2) APPLICATIONS.—

17 “(A) IN GENERAL.—To be eligible to re-
18 ceive a grant under this section, an eligible enti-
19 ty shall—

20 “(i) be a State, Indian tribe, or tribal
21 organization that includes individuals or
22 populations the health of which are, or will
23 be, affected by an activity or a proposed
24 activity; and

1 “(ii) submit to the Secretary an appli-
2 cation in accordance with this subsection,
3 at such time, in such manner, and con-
4 taining such additional information as the
5 Secretary may require.

6 “(B) INCLUSION.—An application under
7 this subsection shall include a list of proposed
8 activities that require or would benefit from
9 conducting a health impact assessment within
10 six months of awarding funds. The list should
11 be accompanied by supporting documentation,
12 including letters of support, from potential con-
13 ductors of health impact assessments for the
14 listed proposed activities. Each application
15 should also include an assessment by the eligi-
16 ble entity of the health of the population of its
17 jurisdiction and describe potential adverse or
18 positive effects on health that the proposed ac-
19 tivities may create.

20 “(C) PREFERENCE.—Preference in award-
21 ing funds under this section may be given to el-
22 igible entities that demonstrate the potential to
23 significantly improve population health or lower
24 health care costs as a result of potential health
25 impact assessment work.

1 “(3) USE OF FUNDS.—

2 “(A) IN GENERAL.—An entity receiving a
3 grant under this section shall use such grant
4 funds to conduct health impact assessment ca-
5 pacity building or to fund subgrantees in con-
6 ducting a health impact assessment for a pro-
7 posed activity in accordance with this sub-
8 section.

9 “(B) PURPOSES.—The purposes of a
10 health impact assessment under this subsection
11 are—

12 “(i) to facilitate the involvement of
13 tribal, State, and local public health offi-
14 cials in community planning, transpor-
15 tation, housing, and land use decisions and
16 other decisions affecting the built environ-
17 ment to identify any potential health con-
18 cern or health benefit relating to an activ-
19 ity or proposed activity;

20 “(ii) to provide for an investigation of
21 any health-related issue of concern raised
22 in a planning process, an environmental
23 impact assessment process, or policy ap-
24 praisal relating to a proposed activity;

1 “(iii) to describe and compare alter-
2 natives (including no-action alternatives) to
3 a proposed activity to provide clarification
4 with respect to the potential health out-
5 comes associated with the proposed activity
6 and, where appropriate, to the related ben-
7 efit-cost or cost-effectiveness of the pro-
8 posed activity and alternatives;

9 “(iv) to contribute, when applicable,
10 to the findings of a planning process, pol-
11 icy appraisal, or an environmental impact
12 statement with respect to the terms and
13 conditions of implementing a proposed ac-
14 tivity or related mitigation recommenda-
15 tions, as necessary;

16 “(v) to ensure that the dispropor-
17 tionate distribution of negative impacts
18 among vulnerable populations is minimized
19 as much as possible;

20 “(vi) to engage affected community
21 members and ensure adequate opportunity
22 for public comment on all stages of the
23 health impact assessment;

24 “(vii) where appropriate, to consult
25 with local and county health departments

1 and appropriate organizations, including
2 planning, transportation, and housing or-
3 ganizations and providing them with infor-
4 mation and tools regarding how to conduct
5 and integrate health impact assessment
6 into their work; and

7 “(viii) to inspect homes, water sys-
8 tems, and other elements that pose risks to
9 lead exposure, with an emphasis on areas
10 that pose a higher risk to children.

11 “(4) ASSESSMENTS.—Health impact assess-
12 ments carried out using grant funds under this sec-
13 tion shall—

14 “(A) take appropriate health factors into
15 consideration as early as practicable during the
16 planning, review, or decisionmaking processes;

17 “(B) assess the effect on the health of in-
18 dividuals and populations of proposed policies,
19 projects, or plans that result in modifications to
20 the built environment; and

21 “(C) assess the distribution of health ef-
22 fects across various factors, such as race, in-
23 come, ethnicity, age, disability status, gender,
24 and geography.

25 “(5) ELIGIBLE ACTIVITIES.—

1 “(A) IN GENERAL.—Eligible entities fund-
2 ed under this subsection shall conduct an eval-
3 uation of any proposed activity to determine
4 whether it will have a significant adverse or
5 positive effect on the health of the affected pop-
6 ulation in the jurisdiction of the eligible entity,
7 based on the criteria described in subparagraph
8 (B).

9 “(B) CRITERIA.—The criteria described in
10 this subparagraph include, as applicable to the
11 proposed activity, the following:

12 “(i) Any substantial adverse effect or
13 significant health benefit on health out-
14 comes or factors known to influence health,
15 including the following:

16 “(I) Physical activity.

17 “(II) Injury.

18 “(III) Mental health.

19 “(IV) Accessibility to health-pro-
20 moting goods and services.

21 “(V) Respiratory health.

22 “(VI) Chronic disease.

23 “(VII) Nutrition.

1 “(VIII) Land use changes that
2 promote local, sustainable food
3 sources.

4 “(IX) Infectious disease, includ-
5 ing COVID–19.

6 “(X) Health disparities.

7 “(XI) Existing air quality,
8 ground or surface water quality or
9 quantity, or noise levels.

10 “(XII) Lead exposure.

11 “(XIII) Drinking water quality
12 and accessibility.

13 “(ii) Other factors that may be con-
14 sidered, including—

15 “(I) the potential for a proposed
16 activity to result in systems failure
17 that leads to a public health emer-
18 gency, pandemic, or other infectious
19 or biochemical agent;

20 “(II) the probability that the pro-
21 posed activity will result in a signifi-
22 cant increase in tourism, economic de-
23 velopment, or employment in the ju-
24 risdiction of the eligible entity;

1 “(III) any other significant po-
2 tential hazard or enhancement to
3 human health, as determined by the
4 eligible entity; or

5 “(IV) whether the evaluation of a
6 proposed activity would duplicate an-
7 other analysis or study being under-
8 taken in conjunction with the pro-
9 posed activity.

10 “(C) FACTORS FOR CONSIDERATION.—In
11 evaluating a proposed activity under subpara-
12 graph (A), an eligible entity may take into con-
13 sideration any reasonable, direct, indirect, or
14 cumulative effect that can be clearly related to
15 potential health effects and that is related to
16 the proposed activity, including the effect of
17 any action that is—

18 “(i) included in the long-range plan
19 relating to the proposed activity;

20 “(ii) likely to be carried out in coordi-
21 nation with the proposed activity;

22 “(iii) dependent on the occurrence of
23 the proposed activity; or

1 “(iv) likely to have a disproportionate
2 impact on high-risk or vulnerable popu-
3 lations.

4 “(6) REQUIREMENTS.—A health impact assess-
5 ment prepared with funds awarded under this sub-
6 section shall incorporate the following, after con-
7 ducting the screening phase (identifying projects or
8 policies for which a health impact assessment would
9 be valuable and feasible) through the application
10 process:

11 “(A) SCOPING.—Identifying which health
12 effects to consider and the research methods to
13 be utilized.

14 “(B) ASSESSING RISKS AND BENEFITS.—
15 Assessing the baseline health status and factors
16 known to influence the health status in the af-
17 fected community, which may include aggre-
18 gating and synthesizing existing health assess-
19 ment evidence and data from the community.

20 “(C) DEVELOPING RECOMMENDATIONS.—
21 Suggesting changes to proposals to promote
22 positive or mitigate adverse health effects.

23 “(D) REPORTING.—Synthesizing the as-
24 sessment and recommendations and commu-
25 nicating the results to decision makers.

1 “(E) MONITORING AND EVALUATING.—

2 Tracking the decision and implementation effect
3 on health determinants and health status.

4 “(7) PLAN.—An eligible entity that is awarded
5 a grant under this section shall develop and imple-
6 ment a plan, to be approved by the Director, for
7 meaningful and inclusive stakeholder involvement in
8 all phases of the health impact assessment. Stake-
9 holders may include community leaders, community-
10 based organizations, youth-serving organizations,
11 planners, public health experts, State and local pub-
12 lic health departments and officials, health care ex-
13 perts or officials, housing experts or officials, and
14 transportation experts or officials.

15 “(8) SUBMISSION OF FINDINGS.—An eligible
16 entity that is awarded a grant under this section
17 shall submit the findings of any funded health im-
18 pact assessment activities to the Secretary and make
19 these findings publicly available.

20 “(9) ASSESSMENT OF IMPACTS.—An eligible en-
21 tity that is awarded a grant under this section shall
22 ensure the assessment of the distribution of health
23 impacts (related to the proposed activity) across
24 race, ethnicity, income, age, gender, disability status,
25 and geography.

1 “(10) CONDUCT OF ASSESSMENT.—To the
2 greatest extent feasible, a health impact assessment
3 shall be conducted under this section in a manner
4 that respects the needs and timing of the decision-
5 making process it evaluates.

6 “(11) METHODOLOGY.—In preparing a health
7 impact assessment under this subsection, an eligible
8 entity or partner shall follow the guidance published
9 under subsection (c).

10 “(e) HEALTH IMPACT ASSESSMENT DATABASE.—
11 The Secretary, acting through the Director and in collabo-
12 ration with the Administrator, shall establish, maintain,
13 and make publicly available a health impact assessment
14 database, including—

15 “(1) a catalog of health impact assessments re-
16 ceived under this section;

17 “(2) an inventory of tools used by eligible enti-
18 ties to conduct health impact assessments; and

19 “(3) guidance for eligible entities with respect
20 to the selection of appropriate tools described in
21 paragraph (2).

22 “(f) EVALUATION OF GRANTEE ACTIVITIES.—The
23 Secretary shall award competitive grants to Prevention
24 Research Centers, or nonprofit organizations or academic

1 institutions with expertise in health impact assessments
2 to—

3 “(1) assist grantees with the provision of train-
4 ing and technical assistance in the conducting of
5 health impact assessments;

6 “(2) evaluate the activities carried out with
7 grants under subsection (d); and

8 “(3) assist the Secretary in disseminating evi-
9 dence, best practices, and lessons learned from
10 grantees.

11 “(g) REPORT TO CONGRESS.—Not later than 1 year
12 after the date of enactment of the Ending Health Dispari-
13 ties During COVID–19 Act of 2020, the Secretary shall
14 submit to Congress a report concerning the evaluation of
15 the programs under this section, including recommenda-
16 tions as to how lessons learned from such programs can
17 be incorporated into future guidance documents developed
18 and provided by the Secretary and other Federal agencies,
19 as appropriate.

20 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 such sums as may be necessary.

1 **“SEC. 399V-13. IMPLEMENTATION OF RESEARCH FINDINGS**
2 **TO IMPROVE HEALTH OUTCOMES THROUGH**
3 **THE BUILT ENVIRONMENT.**

4 “(a) RESEARCH GRANT PROGRAM.—The Secretary,
5 in collaboration with the Administrator of the Environ-
6 mental Protection Agency (referred to in this section as
7 the ‘Administrator’), shall award grants to public agencies
8 or private nonprofit institutions to implement evidence-
9 based programming to improve human health through im-
10 provements to the built environment and subsequently
11 human health, by addressing—

12 “(1) levels of physical activity;

13 “(2) consumption of nutritional foods;

14 “(3) rates of crime;

15 “(4) air, water, and soil quality;

16 “(5) risk or rate of injury;

17 “(6) accessibility to health-promoting goods and
18 services;

19 “(7) chronic disease rates;

20 “(8) community design;

21 “(9) housing; or transportation options;

22 “(10) ability to reduce the spread of infectious
23 diseases (such as COVID-19); and

24 “(11) other factors, as the Secretary determines
25 appropriate.

1 “(b) APPLICATIONS.—A public agency or private
2 nonprofit institution desiring a grant under this section
3 shall submit to the Secretary an application at such time,
4 in such manner, and containing such agreements, assur-
5 ances, and information as the Secretary, in consultation
6 with the Administrator, may require.

7 “(c) RESEARCH.—The Secretary, in consultation
8 with the Administrator, shall support, through grants
9 awarded under this section, research that—

10 “(1) uses evidence-based research to improve
11 the built environment and human health;

12 “(2) examines—

13 “(A) the scope and intensity of the impact
14 that the built environment (including the var-
15 ious characteristics of the built environment)
16 has on the human health; or

17 “(B) the distribution of such impacts by—

18 “(i) location; and

19 “(ii) population subgroup;

20 “(3) is used to develop—

21 “(A) measures and indicators to address
22 health impacts and the connection of health to
23 the built environment;

24 “(B) efforts to link the measures to trans-
25 portation, land use, and health databases; and

1 “(C) efforts to enhance the collection of
2 built environment surveillance data;

3 “(4) distinguishes carefully between personal
4 attitudes and choices and external influences on be-
5 havior to determine how much the association be-
6 tween the built environment and the health of resi-
7 dents, versus the lifestyle preferences of the people
8 that choose to live in the neighborhood, reflects the
9 physical characteristics of the neighborhood; and

10 “(5)(A) identifies or develops effective interven-
11 tion strategies focusing on enhancements to the built
12 environment that promote increased use physical ac-
13 tivity, access to nutritious foods, or other health-pro-
14 moting activities by residents; and

15 “(B) in developing the intervention strategies
16 under subparagraph (A), ensures that the interven-
17 tion strategies will reach out to high-risk or vulner-
18 able populations, including low-income urban and
19 rural communities and aging populations, in addi-
20 tion to the general population.

21 “(d) SURVEYS.—The Secretary may allow recipients
22 of grants under this section to use such grant funds to
23 support the expansion of national surveys and data track-
24 ing systems to provide more detailed information about
25 the connection between the built environment and health.

1 “(e) PRIORITY.—In awarding grants under this sec-
2 tion, the Secretary and the Administrator shall give pri-
3 ority to entities with programming that incorporates—

4 “(1) interdisciplinary approaches; or

5 “(2) the expertise of the public health, physical
6 activity, urban planning, land use, and transpor-
7 tation research communities in the United States
8 and abroad.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this section. The Secretary may al-
12 locate not more than 20 percent of the amount so appro-
13 priated for a fiscal year for purposes of conducting re-
14 search under subsection (c).”.

15 **SEC. 1108. TRIBAL FUNDING TO RESEARCH HEALTH IN-**
16 **EQUITIES INCLUDING COVID-19.**

17 (a) IN GENERAL.—Not later than 6 months after the
18 date of enactment of this Act, the Director of the Indian
19 Health Service, in coordination with Tribal Epidemiology
20 Centers and other Federal agencies, as appropriate, shall
21 conduct or support research and field studies for the pur-
22 poses of improved understanding of Tribal health inequi-
23 ties among American Indians and Alaska Natives, includ-
24 ing with respect to—

25 (1) disparities related to COVID-19;

1 (2) public health surveillance and infrastructure
2 regarding unmet needs in Indian country and Urban
3 Indian communities;

4 (3) population-based health disparities;

5 (4) barriers to health care services;

6 (5) the impact of socioeconomic status; and

7 (6) factors contributing to Tribal health inequi-
8 ties.

9 (b) CONSULTATION, CONFER, AND COORDINATION.—

10 In carrying out this section, the Director of the Indian
11 Health Service shall—

12 (1) consult with Indian Tribes and Tribal orga-
13 nizations;

14 (2) confer with Urban Indian organizations;

15 (3) coordinate with the Director of the Centers
16 for Disease Control and Prevention and the Director
17 of the National Institutes of Health.

18 (c) PROCESS.—Not later than 60 days after the date
19 of enactment of this Act, the Director of the Indian Health
20 Service shall establish a nationally representative panel to
21 establish processes and procedures for the research and
22 field studies conducted or supported under subsection (a).
23 The Director shall ensure that, at a minimum, the panel
24 consists of the following individuals:

25 (1) Elected Tribal leaders or their designees.

1 (2) Tribal public health practitioners and ex-
2 perts from the national and regional levels.

3 (d) DUTIES.—The panel established under subsection
4 (c) shall, at a minimum—

5 (1) advise the Director of the Indian Health
6 Service on the processes and procedures regarding
7 the design, implementation, and evaluation of, and
8 reporting on, research and field studies conducted or
9 supported under this section;

10 (2) develop and share resources on Tribal pub-
11 lic health data surveillance and reporting, including
12 best practices; and

13 (3) carry out such other activities as may be
14 appropriate to establish processes and procedures for
15 the research and field studies conducted or sup-
16 ported under subsection (a).

17 (e) REPORT.—Not later than 1 year after expending
18 all funds made available to carry out this section, the Di-
19 rector of the Indian Health Service, in coordination with
20 the panel established under subsection (c), shall submit
21 an initial report on the results of the research and field
22 studies under this section to—

23 (1) the Committee on Energy and Commerce
24 and the Committee on Natural Resources of the
25 House of Representatives; and

1 (2) the Committee on Indian Affairs and the
2 Committee on Health, Education, Labor, and Pen-
3 sions of the Senate.

4 (f) TRIBAL DATA SOVEREIGNTY.—The Director of
5 the Indian Health Service shall ensure that all research
6 and field studies conducted or supported under this sec-
7 tion are tribally-directed and carried out in a manner
8 which ensures Tribal-direction of all data collected under
9 this section—

10 (1) according to Tribal best practices regarding
11 research design and implementation, including by
12 ensuring the consent of the Tribes involved to public
13 reporting of Tribal data;

14 (2) according to all relevant and applicable
15 Tribal, professional, institutional, and Federal
16 standards for conducting research and governing re-
17 search ethics;

18 (3) with the prior and informed consent of any
19 Indian Tribe participating in the research or sharing
20 data for use under this section; and

21 (4) in a manner that respects the inherent sov-
22 ereignty of Indian Tribes, including Tribal govern-
23 ance of data and research.

24 (g) FINAL REPORT.—Not later than December 31,
25 2023, the Director of the Indian Health Service shall—

1 (1) update and finalize the initial report under
2 subsection (e); and

3 (2) submit such final report to the committees
4 specified in such subsection.

5 (h) DEFINITIONS.—In this section:

6 (1) The terms “Indian Tribe” and “Tribal or-
7 ganization” have the meanings given to such terms
8 in section 4 of the Indian Self-Determination and
9 Education Assistance Act (25 U.S.C. 5304).

10 (2) The term “Urban Indian organization” has
11 the meaning given to such term in section 4 of the
12 Indian Health Care Improvement Act (25 U.S.C.
13 1603).

14 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
15 authorized to be appropriated to carry out this section
16 \$25,000,000, to remain available until expended.

17 **SEC. 1109. RESEARCH ENDOWMENTS AT BOTH CURRENT**
18 **AND FORMER CENTERS OF EXCELLENCE.**

19 Paragraph (1) of section 464z–3(h) of the Public
20 Health Service Act (42 U.S.C. 285t(h)) is amended to
21 read as follows:

22 “(1) IN GENERAL.—The Director of the Insti-
23 tute may carry out a program to facilitate minority
24 health disparities research and other health dispari-

1 ties research by providing for research endow-
2 ments—

3 “(A) at current or former centers of excel-
4 lence under section 736; and

5 “(B) at current or former centers of excel-
6 lence under section 464z-4.”.

7 **TITLE XII—EDUCATION**

8 **SEC. 1201. GRANTS FOR SCHOOLS OF MEDICINE IN DI-** 9 **VERSE AND UNDERSERVED AREAS.**

10 Subpart II of part C of title VII of the Public Health
11 Service Act is amended by inserting after section 749B
12 of such Act (42 U.S.C. 293m) the following:

13 **“SEC. 749C. SCHOOLS OF MEDICINE IN UNDERSERVED** 14 **AREAS.**

15 “(a) GRANTS.—The Secretary, acting through the
16 Administrator of the Health Resources and Services Ad-
17 ministration, may award grants to institutions of higher
18 education (including multiple institutions of higher edu-
19 cation applying jointly) for the establishment, improve-
20 ment, and expansion of an allopathic or osteopathic school
21 of medicine, or a branch campus of an allopathic or osteo-
22 pathic school of medicine.

23 “(b) PRIORITY.—In selecting grant recipients under
24 this section, the Secretary shall give priority to institutions
25 of higher education that—

1 “(1) propose to use the grant for an allopathic
2 or osteopathic school of medicine, or a branch cam-
3 pus of an allopathic or osteopathic school of medi-
4 cine, in a combined statistical area with fewer than
5 200 actively practicing physicians per 100,000 resi-
6 dents according to the medical board (or boards) of
7 the State (or States) involved;

8 “(2) have a curriculum that emphasizes care for
9 diverse and underserved populations; or

10 “(3) are minority-serving institutions described
11 in the list in section 371(a) of the Higher Education
12 Act of 1965.

13 “(c) USE OF FUNDS.—The activities for which a
14 grant under this section may be used include—

15 “(1) planning and constructing—

16 “(A) a new allopathic or osteopathic school
17 of medicine in an area in which no other school
18 is based; or

19 “(B) a branch campus of an allopathic or
20 osteopathic school of medicine in an area in
21 which no such school is based;

22 “(2) accreditation and planning activities for an
23 allopathic or osteopathic school of medicine or
24 branch campus;

1 “(3) hiring faculty and other staff to serve at
2 an allopathic or osteopathic school of medicine or
3 branch campus;

4 “(4) recruitment and enrollment of students at
5 an allopathic or osteopathic school of medicine or
6 branch campus;

7 “(5) supporting educational programs at an
8 allopathic or osteopathic school of medicine or
9 branch campus;

10 “(6) modernizing infrastructure or curriculum
11 at an existing allopathic or osteopathic school of
12 medicine or branch campus thereof;

13 “(7) expanding infrastructure or curriculum at
14 existing an allopathic or osteopathic school of medi-
15 cine or branch campus; and

16 “(8) other activities that the Secretary deter-
17 mines further the development, improvement, and
18 expansion of an allopathic or osteopathic school of
19 medicine or branch campus thereof.

20 “(d) DEFINITIONS.—In this section:

21 “(1) The term ‘branch campus’ means a geo-
22 graphically separate site at least 100 miles from the
23 main campus of a school of medicine where at least
24 one student completes at least 60 percent of the stu-

1 dent's training leading to a degree of doctor of medi-
2 cine.

3 “(2) The term ‘institution of higher education’
4 has the meaning given to such term in section
5 101(a) of the Higher Education Act of 1965.

6 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
7 carry out this section, there is authorized to be appro-
8 priated \$1,000,000,000, to remain available until ex-
9 pended.”.

10 **SEC. 1202. AMENDMENT TO THE PUBLIC HEALTH SERVICE**
11 **ACT.**

12 Title XXXIV of the Public Health Service Act, as
13 amended by as amended by sections 104, 702, and 806,
14 is amended by adding at the end the following:

15 **“Subtitle D—Diversifying the**
16 **Health Care Workplace**

17 **“SEC. 3410. NATIONAL WORKING GROUP ON WORKFORCE**
18 **DIVERSITY.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Bureau of Health Workforce of the Health Resources
21 and Services Administration, shall award a grant to an
22 entity determined appropriate by the Secretary for the es-
23 tablishment of a national working group on workforce di-
24 versity.

1 “(b) REPRESENTATION.—In establishing the national
2 working group under subsection (a):

3 “(1) The grantee shall ensure that the group
4 has representatives of each of the following:

5 “(A) The Health Resources and Services
6 Administration.

7 “(B) The Department of Health and
8 Human Services Data Council.

9 “(C) The Office of Minority Health of the
10 Department of Health and Human Services.

11 “(D) The Substance Abuse and Mental
12 Health Services Administration.

13 “(E) The Bureau of Labor Statistics of
14 the Department of Labor.

15 “(F) The National Institute on Minority
16 Health and Health Disparities.

17 “(G) The Agency for Healthcare Research
18 and Quality.

19 “(H) The Institute of Medicine Study
20 Committee for the 2004 workforce diversity re-
21 port.

22 “(I) The Indian Health Service.

23 “(J) The Department of Education.

24 “(K) Minority-serving academic institu-
25 tions.

1 “(L) Consumer organizations.

2 “(M) Health professional associations, in-
3 cluding those that represent underrepresented
4 minority populations.

5 “(N) Researchers in the area of health
6 workforce.

7 “(O) Health workforce accreditation enti-
8 ties.

9 “(P) Private (including nonprofit) founda-
10 tions that have sponsored workforce diversity
11 initiatives.

12 “(Q) Local and State health departments.

13 “(R) Representatives of community mem-
14 bers to be included on admissions committees
15 for health profession schools pursuant to sub-
16 section (c)(9).

17 “(S) National community-based organiza-
18 tions that serve as a national intermediary to
19 their urban affiliate members and have dem-
20 onstrated capacity to train health care profes-
21 sionals.

22 “(T) The Veterans Health Administration.

23 “(U) Other entities determined appropriate
24 by the Secretary.

1 “(2) The grantee shall ensure that, in addition
2 to the representatives under paragraph (1), the
3 working group has not less than 5 health professions
4 students representing various health profession fields
5 and levels of training.

6 “(c) ACTIVITIES.—The working group established
7 under subsection (a) shall convene at least twice each year
8 to complete the following activities:

9 “(1) Review public and private health workforce
10 diversity initiatives.

11 “(2) Identify successful health workforce diver-
12 sity programs and practices.

13 “(3) Examine challenges relating to the devel-
14 opment and implementation of health workforce di-
15 versity initiatives.

16 “(4) Draft a national strategic work plan for
17 health workforce diversity, including recommenda-
18 tions for public and private sector initiatives.

19 “(5) Develop a framework and methods for the
20 evaluation of current and future health workforce di-
21 versity initiatives.

22 “(6) Develop recommended standards for work-
23 force diversity that could be applicable to all health
24 professions programs and programs funded under
25 this Act.

1 “(7) Develop guidelines to train health profes-
2 sionals to care for a diverse population.

3 “(8) Develop a workforce data collection or
4 tracking system to identify where racial and ethnic
5 minority health professionals practice.

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

9 “(10) Help with monitoring and implementation
10 of standards for diversity, equity, and inclusion.

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

13 “(d) ANNUAL REPORT.—Not later than 1 year after
14 the establishment of the working group under subsection
15 (a), and annually thereafter, the working group shall pre-
16 pare and make available to the general public for com-
17 ment, an annual report on the activities of the working
18 group. Such report shall include the recommendations of
19 the working group for improving health workforce diver-
20 sity.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section
23 such sums as may be necessary for each of fiscal years
24 2021 through 2025.

1 **“SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH**
2 **WORKFORCE DIVERSITY.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Deputy Assistant Secretary for Minority Health, and
5 in collaboration with the Bureau of Health Workforce
6 within the Health Resources and Services Administration
7 and the National Institute on Minority Health and Health
8 Disparities, shall establish a technical clearinghouse on
9 health workforce diversity within the Office of Minority
10 Health and coordinate current and future clearinghouses
11 related to health workforce diversity.

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

15 “(1) Information on the importance of health
16 workforce diversity.

17 “(2) Statistical information relating to under-
18 represented minority representation in health and al-
19 lied health professions and occupations.

20 “(3) Model health workforce diversity practices
21 and programs, including integrated models of care.

22 “(4) Admissions policies that promote health
23 workforce diversity and are in compliance with Fed-
24 eral and State laws.

1 “(5) Retainment policies that promote comple-
2 tion of health profession degrees for underserved
3 populations.

4 “(6) Lists of scholarship, loan repayment, and
5 loan cancellation grants as well as fellowship infor-
6 mation for underserved populations for health pro-
7 fessions schools.

8 “(7) Foundation and other large organizational
9 initiatives relating to health workforce diversity.

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

15 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section
17 such sums as may be necessary for each of fiscal years
18 2021 through 2025.

19 **“SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO**
20 **WORKFORCE DIVERSITY, EQUITY, AND IN-**
21 **CLUSION.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Administrator of the Health Resources and Services
24 Administration and the Centers for Disease Control and

1 Prevention, shall award grants to eligible entities that
2 demonstrate a commitment to health workforce diversity.

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

5 “(1) be an educational institution or entity that
6 historically produces or trains meaningful numbers
7 of underrepresented minority health professionals,
8 including—

9 “(A) part B institutions, as defined in sec-
10 tion 322 of the Higher Education Act of 1965;

11 “(B) Hispanic-serving health professions
12 schools;

13 “(C) Hispanic-serving institutions, as de-
14 fined in section 502 of such Act;

15 “(D) Tribal colleges or universities, as de-
16 fined in section 316 of such Act;

17 “(E) Asian American and Native American
18 Pacific Islander-serving institutions, as defined
19 in section 371(c) of such Act;

20 “(F) institutions that have programs to re-
21 cruit and retain underrepresented minority
22 health professionals, in which a significant
23 number of the enrolled participants are under-
24 represented minorities;

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

4 “(H) institutions, including national and
5 regional community-based organizations with
6 demonstrated commitment to a diversified
7 workforce—

8 “(i) located in communities with pre-
9 dominantly underrepresented minority pop-
10 ulations;

11 “(ii) with whom partnerships have
12 been formed for the purpose of increasing
13 workforce diversity; and

14 “(iii) in which at least 20 percent of
15 the enrolled participants are underrep-
16 resented minorities; and

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

20 “(c) USE OF FUNDS.—Amounts received under a
21 grant under subsection (a) shall be used to expand existing
22 workforce diversity programs, implement new workforce
23 diversity programs, or evaluate existing or new workforce
24 diversity programs, including with respect to mental
25 health care professions. Such programs shall enhance di-

1 versity by considering minority status as part of an indi-
2 vidualized consideration of qualifications. Possible activi-
3 ties may include—

4 “(1) educational outreach programs relating to
5 opportunities in the health professions;

6 “(2) scholarship, fellowship, grant, loan repay-
7 ment, and loan cancellation programs;

8 “(3) postbaccalaureate programs;

9 “(4) academic enrichment programs, particu-
10 larly targeting those who would not be competitive
11 for health professions schools;

12 “(5) supporting workforce diversity in kinder-
13 garten through 12th grade and other health pipeline
14 programs;

15 “(6) mentoring programs;

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

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

21 “(9) leadership training.

22 “(d) REPORTS.—Not later than 1 year after receiving
23 a grant under this section, and annually for the term of
24 the grant, a grantee shall submit to the Secretary a report

1 that summarizes and evaluates all activities conducted
2 under the grant.

3 “(e) 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 2021 through 2025.

7 **“SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND**
8 **RESEARCHERS.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Director of the National Institutes of Health, the Di-
11 rector of the Centers for Disease Control and Prevention,
12 the Commissioner of Food and Drugs, the Director of the
13 Agency for Healthcare Research and Quality, and the Ad-
14 ministrator of the Health Resources and Services Admin-
15 istration, shall award grants that expand existing opportu-
16 nities for scientists and researchers and promote the inclu-
17 sion of underrepresented minorities in the health profes-
18 sions.

19 “(b) RESEARCH FUNDING.—The head of each agency
20 listed in subsection (a) shall establish or expand existing
21 programs to provide research funding to scientists and re-
22 searchers in training. Under such programs, the head of
23 each such entity shall give priority in allocating research
24 funding to support health research in traditionally under-
25 served communities, including underrepresented minority

1 communities, and research classified as community or
2 participatory.

3 “(c) DATA COLLECTION.—The head of each agency
4 listed in subsection (a) shall collect data on the number
5 (expressed as an absolute number and a percentage) of
6 underrepresented minority and nonminority applicants
7 who receive and are denied agency funding at every stage
8 of review. Such data shall be reported annually to the Sec-
9 retary and the appropriate committees of Congress.

10 “(d) STUDENT LOAN REIMBURSEMENT.—The Sec-
11 retary shall establish a student loan reimbursement pro-
12 gram to provide student loan reimbursement assistance to
13 researchers who focus on racial and ethnic disparities in
14 health. The Secretary shall promulgate regulations to de-
15 fine the scope and procedures for the program under this
16 subsection.

17 “(e) STUDENT LOAN CANCELLATION.—The Sec-
18 retary shall establish a student loan cancellation program
19 to provide student loan cancellation assistance to research-
20 ers who focus on racial and ethnic disparities in health.
21 Students participating in the program shall make a min-
22 imum 5-year commitment to work at an accredited health
23 profession school. The Secretary shall promulgate addi-
24 tional regulations to define the scope and procedures for
25 the program under this subsection.

1 “(f) 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 2021 through 2025.

5 **“SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH**
6 **PROFESSIONALS.**

7 “(a) IN GENERAL.—The Secretary, acting through
8 the Director of the Centers for Disease Control and Pre-
9 vention, the Assistant Secretary for Mental Health and
10 Substance Use, the Administrator of the Health Resources
11 and Services Administration, and the Administrator of the
12 Centers for Medicare & Medicaid Services, shall establish
13 a program to award grants to eligible individuals for ca-
14 reer support in nonresearch-related health and wellness
15 professions.

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

18 “(1) be a student in a health professions school,
19 a graduate of such a school who is working in a
20 health profession, an individual working in a health
21 or wellness profession (including mental and behav-
22 ioral health), or a faculty member of such a school;
23 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.—An individual shall use
5 amounts received under a grant under this section to—

6 “(1) support the individual’s health activities or
7 projects that involve underserved communities, in-
8 cluding racial and ethnic minority communities;

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

11 “(3) to pay, or as reimbursement for payments
12 of, student loans or training or credentialing costs
13 for individuals who are health professionals and are
14 focused on health issues affecting underserved com-
15 munities, including racial and ethnic minority com-
16 munities; and

17 “(4) to establish and promote leadership train-
18 ing programs to decrease health disparities and to
19 increase cultural competence with the goal of in-
20 creasing diversity in leadership positions.

21 “(d) DEFINITION.—In this section, the term ‘career
22 in nonresearch-related health and wellness professions’
23 means employment or intended employment in the field
24 of public health, health policy, health management, health
25 administration, medicine, nursing, pharmacy, psychology,

1 social work, psychiatry, other mental and behavioral
2 health, allied health, community health, social work, or
3 other fields determined appropriate by the Secretary,
4 other than in a position that involves research.

5 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
6 is authorized to be appropriated to carry out this section
7 such sums as may be necessary for each of fiscal years
8 2021 through 2025.

9 **“SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DI-**
10 **VERSITY ON QUALITY.**

11 “(a) IN GENERAL.—The Director of the Agency for
12 Healthcare Research and Quality, in collaboration with
13 the Deputy Assistant Secretary for Minority Health and
14 the Director of the National Institute on Minority Health
15 and Health Disparities, shall award grants to eligible enti-
16 ties to expand research on the link between health work-
17 force diversity and quality health care.

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

20 “(1) be a clinical, public health, or health serv-
21 ices research entity or other entity determined ap-
22 propriate by the Director; and

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

1 “(c) USE OF FUNDS.—Amounts received under a
2 grant awarded under subsection (a) shall be used to sup-
3 port research that investigates the effect of health work-
4 force diversity on—

5 “(1) language access;

6 “(2) cultural competence;

7 “(3) patient satisfaction;

8 “(4) timeliness of care;

9 “(5) safety of care;

10 “(6) effectiveness of care;

11 “(7) efficiency of care;

12 “(8) patient outcomes;

13 “(9) community engagement;

14 “(10) resource allocation;

15 “(11) organizational structure;

16 “(12) compliance of care; or

17 “(13) other topics determined appropriate by
18 the Director.

19 “(d) PRIORITY.—In awarding grants under sub-
20 section (a), the Director shall give individualized consider-
21 ation to all relevant aspects of the applicant’s background.
22 Consideration of prior research experience involving the
23 health of underserved communities shall be such a factor.

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

1 such sums as may be necessary for each of fiscal years
2 2021 through 2025.

3 **“SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.**

4 “(a) ESTABLISHMENT.—The Secretary, acting
5 through the Office of Minority Health, in collaboration
6 with the National Institute on Minority Health and Health
7 Disparities, the Office for Civil Rights, the Centers for
8 Disease Control and Prevention, the Centers for Medicare
9 & Medicaid Services, the Health Resources and Services
10 Administration, and other appropriate public and private
11 entities, shall establish and coordinate a health and health
12 care disparities education program to support, develop,
13 and implement educational initiatives and outreach strate-
14 gies that inform health care professionals and the public
15 about the existence of and methods to reduce racial and
16 ethnic disparities in health and health care.

17 “(b) ACTIVITIES.—The Secretary, through the edu-
18 cation program established under subsection (a), shall,
19 through the use of public awareness and outreach cam-
20 paigns targeting the general public and the medical com-
21 munity at large—

22 “(1) disseminate scientific evidence for the ex-
23 istence and extent of racial and ethnic disparities in
24 health care, including disparities that are not other-
25 wise attributable to known factors such as access to

1 care, patient preferences, or appropriateness of
2 intervention, as described in the 2002 Institute of
3 Medicine Report entitled ‘Unequal Treatment: Con-
4 fronting Racial and Ethnic Disparities in Health
5 Care’, as well as the impact of disparities related to
6 age, disability status, socioeconomic status, sex, gen-
7 der identity, and sexual orientation on racial and
8 ethnic minorities;

9 “(2) disseminate new research findings to
10 health care providers and patients to assist them in
11 understanding, reducing, and eliminating health and
12 health care disparities;

13 “(3) disseminate information about the impact
14 of linguistic and cultural barriers on health care
15 quality and the obligation of health providers who
16 receive Federal financial assistance to ensure that
17 individuals with limited English proficiency have ac-
18 cess to language access services;

19 “(4) disseminate information about the impor-
20 tance and legality of racial, ethnic, disability status,
21 socioeconomic status, sex, gender identity, and sex-
22 ual orientation, and primary language data collec-
23 tion, analysis, and reporting;

1 “(5) design and implement specific educational
2 initiatives to health care providers relating to health
3 and health care disparities;

4 “(6) assess the impact of the programs estab-
5 lished under this section in raising awareness of
6 health and health care disparities and providing in-
7 formation on available resources; and

8 “(7) design and implement specific educational
9 initiatives to educate the health care workforce relat-
10 ing to unconscious bias.

11 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
12 is authorized to be appropriated to carry out this section
13 such sums as may be necessary for each of fiscal years
14 2021 through 2025.”.

15 **SEC. 1203. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
16 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
17 **ASIAN AMERICAN AND NATIVE AMERICAN PA-**
18 **CIFIC ISLANDER-SERVING INSTITUTIONS,**
19 **TRIBAL COLLEGES, REGIONAL COMMUNITY-**
20 **BASED ORGANIZATIONS, AND NATIONAL MI-**
21 **NORITY MEDICAL ASSOCIATIONS.**

22 Part B of title VII of the Public Health Service Act
23 (42 U.S.C. 293 et seq.) is amended by adding at the end
24 the following:

1 **“SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORI-**
2 **CALLY BLACK COLLEGES AND UNIVERSITIES,**
3 **ASIAN AMERICAN AND NATIVE AMERICAN PA-**
4 **CIFIC ISLANDER-SERVING INSTITUTIONS,**
5 **AND TRIBAL COLLEGES.**

6 “(a) IN GENERAL.—The Secretary, acting through
7 the Administrator of the Health Resources and Services
8 Administration and in consultation with the Secretary of
9 Education, shall award grants to Hispanic-serving institu-
10 tions, Historically Black Colleges and Universities, Asian
11 American and Native American Pacific Islander-serving
12 institutions, Tribal Colleges or Universities, regional com-
13 munity-based organizations, and national minority med-
14 ical associations, for counseling, mentoring and providing
15 information on financial assistance to prepare underrep-
16 resented minority individuals to enroll in and graduate
17 from health professional schools and to increase services
18 for underrepresented minority students including—

19 “(1) mentoring with underrepresented health
20 professionals; and

21 “(2) providing financial assistance information
22 for continued education and applications to health
23 professional schools.

24 “(b) DEFINITIONS.—In this section:

25 “(1) ASIAN AMERICAN AND NATIVE AMERICAN
26 PACIFIC ISLANDER-SERVING INSTITUTION.—The

1 term ‘Asian American and Native American Pacific
2 Islander-serving institution’ has the meaning given
3 such term in section 320(b) of the Higher Education
4 Act of 1965.

5 “(2) HISPANIC-SERVING INSTITUTION.—The
6 term ‘Hispanic-serving institution’ means an entity
7 that—

8 “(A) is a school or program for which
9 there is a definition under 799B;

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

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

16 “(D) has been effective in recruiting and
17 retaining Hispanic faculty members;

18 “(E) has a significant number of graduates
19 who are providing health services to medically
20 underserved populations or to individuals in
21 health professional shortage areas; and

22 “(F) is a Hispanic Center of Excellence in
23 Health Professions Education designated under
24 section 736(d)(2) of the Public Health Service
25 Act (42 U.S.C. 293(d)(2)).

1 “(3) HISTORICALLY BLACK COLLEGES AND
2 UNIVERSITY.—The term ‘historically black college
3 and university’ has the meaning given the term ‘part
4 B institution’ as defined in section 322 of the High-
5 er Education Act of 1965.

6 “(4) TRIBAL COLLEGE OR UNIVERSITY.—The
7 term ‘Tribal College or University’ has the meaning
8 given such term in section 316(b) of the Higher
9 Education Act of 1965.

10 “(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In
11 carrying out the National Health Service Corps Loan Re-
12 payment Program established under subpart III of part
13 D of title III and the loan repayment program under sec-
14 tion 317F, the Secretary shall ensure, notwithstanding
15 such subpart or section, that loan repayments of not less
16 than \$50,000 per year per person are awarded for repay-
17 ment of loans incurred for enrollment or participation of
18 underrepresented minority individuals in health profes-
19 sional schools and other health programs described in this
20 section.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section
23 such sums as may be necessary for each of fiscal years
24 2021 through 2026.”.

1 **SEC. 1204. LOAN REPAYMENT PROGRAM OF CENTERS FOR**
2 **DISEASE CONTROL AND PREVENTION.**

3 Section 317F(c)(1) of the Public Health Service Act
4 (42 U.S.C. 247b–7(c)(1)) is amended—

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

6 (2) by inserting before the period at the end the
7 following: “, \$750,000 for fiscal year 2020, and such
8 sums as may be necessary for each of the fiscal
9 years 2021 through 2025”.

10 **SEC. 1205. STUDY AND REPORT ON STRATEGIES FOR IN-**
11 **CREASING DIVERSITY.**

12 (a) STUDY.—The Comptroller General of the United
13 States shall conduct a study on strategies for increasing
14 the diversity of the health professional workforce. Such
15 study shall include an analysis of strategies for increasing
16 the number of health professionals from rural, lower in-
17 come, and underrepresented minority communities, includ-
18 ing which strategies are most effective for achieving such
19 goal.

20 (b) REPORT.—Not later than 2 years after the date
21 of enactment of this Act, the Comptroller General shall
22 submit to Congress a report on the study conducted under
23 subsection (a), together with recommendations for such
24 legislation and administrative action as the Comptroller
25 General determines appropriate.

1 **SEC. 1206. AMENDMENTS TO THE PANDEMIC EBT ACT.**

2 Section 1101 of the Families First Coronavirus Re-
3 sponse Act (Public Law 116–127) is amended—

4 (1) in subsection (a)—

5 (A) by striking “fiscal year 2020” and in-
6 serting “fiscal years 2020 and 2021”;

7 (B) by striking “during which the school
8 would otherwise be in session”; and

9 (C) by inserting “until the school reopens”
10 after “assistance”;

11 (2) in subsection (b)—

12 (A) by inserting “and State agency plans
13 for child care covered children in accordance
14 with subsection (i)” after “with eligible chil-
15 dren”;

16 (B) by inserting “, a plan to enroll chil-
17 dren who become eligible children during a pub-
18 lic health emergency designation” before “, and
19 issuances”;

20 (C) by striking “in an amount not less
21 than the value of meals at the free rate over the
22 course of 5 school days” and inserting “in ac-
23 cordance with subsection (h)(1)”;

24 (D) by inserting “and for each child care
25 covered child in the household” before the pe-
26 riod at the end;

1 (3) in subsection (c), by inserting “or child care
2 center” after “school”;

3 (4) by amending subsection (e) to read as fol-
4 lows:

5 “(e) RELEASE OF INFORMATION.—Notwithstanding
6 any other provision of law, the Secretary of Agriculture
7 may authorize—

8 “(1) State educational agencies and school food
9 authorities administering a school lunch program
10 under the Richard B. Russell National School Lunch
11 Act (42 U.S.C. 1751 et seq.) to release to appro-
12 priate officials administering the supplemental nutri-
13 tion assistance program such information as may be
14 necessary to carry out this section with respect to el-
15 igible children; and

16 “(2) State agencies administering a child and
17 adult care food program under section 17 of the
18 Richard B. Russell National School Lunch Act (42
19 U.S.C. 1766) to release to appropriate officials ad-
20 ministering the supplemental nutrition assistance
21 program such information as may be necessary to
22 carry out this section with respect to child care cov-
23 ered children.”;

24 (5) by amending subsection (g) to read as fol-
25 lows:

1 “(g) AVAILABILITY OF COMMODITIES.—

2 “(1) IN GENERAL.—Subject to paragraph (2),
3 during fiscal year 2020, the Secretary of Agriculture
4 may purchase commodities for emergency distribu-
5 tion in any area of the United States during a public
6 health emergency designation.

7 “(2) PURCHASES.—Funds made available to
8 carry out this subsection on or after the date of the
9 enactment of the Child Nutrition and Related Pro-
10 grams Recovery Act may only be used to purchase
11 commodities for emergency distribution—

12 “(A) under commodity distribution pro-
13 grams and child nutrition programs that were
14 established and administered by the Food and
15 Nutrition Service on or before the day before
16 the date of the enactment of the Families First
17 Coronavirus Response Act (Public Law 116–
18 127);

19 “(B) to Tribal organizations (as defined in
20 section 3 of the Food and Nutrition Act of
21 2008 (7 U.S.C. 2012)), that are not admin-
22 istering the food distribution program estab-
23 lished under section 4(b) of the Food and Nu-
24 trition Act of 2008 (7 U.S.C. 2013(b)); or

1 “(C) to emergency feeding organizations
2 that are eligible recipient agencies (as such
3 terms are defined in section 201A of the Emer-
4 gency Food Assistance Act of 1983 (7 U.S.C.
5 7501)).”;

6 (6) by redesignating subsections (h) and (i) as
7 subsections (l) and (m);

8 (7) by inserting after subsection (g) the fol-
9 lowing:

10 “(h) AMOUNT OF BENEFITS.—

11 “(1) IN GENERAL.—A household shall receive
12 benefits under this section in an amount equal to 1
13 breakfast and 1 lunch at the free rate for each eligi-
14 ble child or child care covered child in such house-
15 hold for each day.

16 “(2) TREATMENT OF NEWLY ELIGIBLE CHIL-
17 DREN.—In the case of a child who becomes an eligi-
18 ble child during a public health emergency designa-
19 tion, the Secretary and State agency shall—

20 “(A) if such child becomes an eligible child
21 during school year 2019–2020, treat such child
22 as if such child was an eligible child as of the
23 date the school in which the child is enrolled
24 closed; and

1 “(B) if such child becomes an eligible child
2 after school year 2019–2020, treat such child
3 as an eligible child as of the first day of the
4 month in which such child becomes so eligible.

5 “(i) CHILD CARE COVERED CHILD ASSISTANCE.—

6 “(1) IN GENERAL.—During fiscal years 2020
7 and 2021, in any case in which a child care center
8 is closed for at least 5 consecutive days during a
9 public health emergency designation, each household
10 containing at least 1 member who is a child care
11 covered child attending the child care center shall be
12 eligible until the schools in the State in which such
13 child care center is located reopen, as determined by
14 the Secretary, to receive assistance pursuant to—

15 “(A) a State agency plan approved under
16 subsection (b) that includes—

17 “(i) an application by the State agen-
18 cy seeking to participate in the program
19 under this subsection; and

20 “(ii) a State agency plan for tem-
21 porary emergency standards of eligibility
22 and levels of benefits under the Food and
23 Nutrition Act of 2008 (7 U.S.C. 2011 et
24 seq.) for households with child care covered
25 children; or

1 “(B) an addendum application described in
2 paragraph (2).

3 “(2) ADDENDUM APPLICATION.—In the case of
4 a State agency that submits a plan to the Secretary
5 of Agriculture under subsection (b) that does not in-
6 clude an application or plan described in clauses (i)
7 and (ii) of paragraph (1)(A), such State agency may
8 apply to participate in the program under this sub-
9 section by submitting to the Secretary of Agriculture
10 an addendum application for approval that includes
11 a State agency plan described in such clause (ii).

12 “(3) REQUIREMENTS FOR PARTICIPATION.—A
13 State agency may not participate in the program
14 under this subsection if—

15 “(A) the State agency plan submitted by
16 such State agency under subsection (b) with re-
17 spect to eligible children is not approved by the
18 Secretary under such subsection; or

19 “(B) the State agency plan submitted by
20 such State agency under subsection (b) or this
21 subsection with respect to child care covered
22 children is not approved by the Secretary under
23 either such subsection.

24 “(4) AUTOMATIC ENROLLMENT.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the Secretary shall deem a child who
3 is less than 6 years of age to be a child care
4 covered child eligible to receive assistance under
5 this subsection if—

6 “(i) the household with such child at-
7 tests that such child is a child care covered
8 child;

9 “(ii) such child resides in a household
10 that includes an eligible child;

11 “(iii) such child receives cash assist-
12 ance benefits under the temporary assist-
13 ance for needy families program under
14 part A of title IV of the Social Security
15 Act (42 U.S.C. 601 et seq.);

16 “(iv) such child receives assistance
17 under the Child Care and Development
18 Block Grant Act of 1990 (42 U.S.C. 9857
19 et seq.);

20 “(v) such child is—

21 “(I) enrolled as a participant in a
22 Head Start program authorized under
23 the Head Start Act (42 U.S.C. 9831
24 et seq.);

1 “(II) a foster child whose care
2 and placement is the responsibility of
3 an agency that administers a State
4 plan under part B or E of title IV of
5 the Social Security Act (42 U.S.C.
6 621 et seq.);

7 “(III) a foster child who a court
8 has placed with a caretaker house-
9 hold; or

10 “(IV) a homeless child or youth
11 (as defined in section 725(2) of the
12 McKinney-Vento Homeless Assistance
13 Act (42 U.S.C. 11434a(2)));

14 “(vi) such child participates in the
15 special supplemental nutrition program for
16 women, infants, and children under section
17 17 of the Child Nutrition Act of 1966 (42
18 U.S.C. 1786);

19 “(vii) through the use of information
20 obtained by the State agency for the pur-
21 pose of participating in the supplemental
22 nutrition assistance program under the
23 Food and Nutrition Act of 2008 (7 U.S.C.
24 2011 et seq.), the State agency elects to
25 treat as a child care covered child each

1 child less than 6 years of age who is a
2 member of a household that receives sup-
3 plemental nutrition assistance program
4 benefits under such Act; or

5 “(viii) the State in which such child
6 resides determines that such child is a
7 child care covered child, using State data
8 approved by the Secretary.

9 “(B) ACCEPTANCE OF ANY FORM OF
10 AUTOMATIC ENROLLMENT.—

11 “(i) ONE CATEGORY.—For purposes
12 of deeming a child to be a child care cov-
13 ered child under subparagraph (A), a State
14 agency may not be required to show that
15 a child meets more than one requirement
16 specified in clauses (i) through (viii) of
17 such subparagraph.

18 “(ii) DEEMING REQUIREMENT.—If a
19 State agency submits to the Secretary in-
20 formation that a child meets any one of
21 the requirements specified in clauses (i)
22 through (viii) of subparagraph (A), the
23 Secretary shall deem such child a child
24 care covered child under such subpara-
25 graph.

1 “(j) EXCLUSIONS.—The provisions of section 16 of
2 the Food and Nutrition Act of 2008 (7 U.S.C. 2025) re-
3 lating to quality control shall not apply with respect to
4 assistance provided under this section.

5 “(k) FEASIBILITY ANALYSIS.—

6 “(1) IN GENERAL.—Not later than 30 days
7 after the date of the enactment of the Child Nutri-
8 tion and Related Programs Recovery Act, the Sec-
9 retary shall submit to the Education and Labor
10 Committee and the Agriculture Committee of the
11 House of Representatives and the Committee on Ag-
12 riculture, Nutrition, and Forestry of the Senate a
13 report on—

14 “(A) the feasibility of implementing the
15 program for eligible children under this section
16 using an EBT system in Puerto Rico, the Com-
17 monwealth of the Northern Mariana Islands,
18 and American Samoa similar to the manner in
19 which the supplemental nutrition assistance
20 program under the Food and Nutrition Act of
21 2008 is operated in the States, including an
22 analysis of—

23 “(i) the current nutrition assistance
24 program issuance infrastructure;

25 “(ii) the availability of—

1 “(I) an EBT system, including
2 the ability for authorized retailers to
3 accept EBT cards; and

4 “(II) EBT cards;

5 “(iii) the ability to limit purchases
6 using nutrition assistance program benefits
7 to food for home consumption; and

8 “(iv) the availability of reliable data
9 necessary for the implementation of such
10 program under this section for eligible chil-
11 dren and child care covered children, in-
12 cluding the names of such children and the
13 mailing addresses of their households; and

14 “(B) the feasibility of implementing the
15 program for child care covered children under
16 subsection (i) in Puerto Rico, the Common-
17 wealth of the Northern Mariana Islands, and
18 American Samoa, including with respect to such
19 program each analysis specified in clauses (i)
20 through (iv) of subparagraph (A).

21 “(2) CONTINGENT AVAILABILITY OF PARTICIPA-
22 TION.—Beginning 30 days after the date of the en-
23 actment of the Child Nutrition and Related Pro-
24 grams Recovery Act, Puerto Rico, the Common-

1 wealth of the Northern Mariana Islands, and Amer-
2 ican Samoa may each—

3 “(A) submit a plan under subsection (b),
4 unless the Secretary makes a finding, based on
5 the analysis provided under paragraph (1)(A),
6 that the implementation of the program for eli-
7 gible children under this section is not feasible
8 in such territories; and

9 “(B) submit a plan under subsection (i),
10 unless the Secretary makes a finding, based on
11 the analysis provided under paragraph (1)(B),
12 that the implementation of the program for
13 child care covered children under subsection (i)
14 is not feasible in such territories.

15 “(3) TREATMENT OF PLANS SUBMITTED BY
16 TERRITORIES.—Notwithstanding any other provision
17 of law, with respect to a plan submitted pursuant to
18 this subsection by Puerto Rico, the Commonwealth
19 of the Northern Mariana Islands, or American
20 Samoa under subsection (b) or subsection (i), the
21 Secretary shall treat such plan in the same manner
22 as a plan submitted by a State agency under such
23 subsection, including with respect to the terms of
24 funding provided under subsection (m).”;

1 (8) in subsection (1), as redesigned by para-
2 graph (7)—

3 (A) by redesignating paragraph (1) as
4 paragraph (3);

5 (B) by redesignating paragraphs (2) and
6 (3) as paragraphs (5) and (6), respectively;

7 (C) by inserting before paragraph (3) (as
8 so redesignated) the following:

9 “(1) The term ‘child care center’ means an or-
10 ganization described in subparagraph (A) or (B) of
11 section 17(a)(2) of the Richard B. Russell National
12 School Lunch Act (42 U.S.C. 1766(a)(2)) and a
13 family or group day care home.

14 “(2) The term ‘child care covered child’ means
15 a child served under section 17 of the Richard B.
16 Russell National School Lunch Act (42 U.S.C.
17 1766) who, if not for the closure of the child care
18 center attended by the child during a public health
19 emergency designation and due to concerns about a
20 COVID–19 outbreak, would receive meals under
21 such section at the child care center.”; and

22 (D) by inserting after paragraph (3) (as so
23 redesignated) the following:

24 “(4) The term ‘free rate’ means—

1 “(A) with respect to a breakfast, the rate
2 of a free breakfast under the school breakfast
3 program under section 4 of the Child Nutrition
4 Act of 1966 (42 U.S.C. 1773); and

5 “(B) with respect to a lunch, the rate of
6 a free lunch under the school lunch program
7 under the Richard B. Russell National School
8 Lunch Act (42 U.S.C. 1771 et seq.).”; and

9 (9) in subsection (m), as redesignated by para-
10 graph (7), by inserting “(including all administrative
11 expenses)” after “this section”.

12 **TITLE XIII—PUBLIC HEALTH** 13 **ASSISTANCE TO TRIBES**

14 **SEC. 1301. APPROPRIATIONS FOR THE INDIAN HEALTH** 15 **SERVICE.**

16 HEROES Act Division A, Title V—Department of
17 Health & Human Services—Indian Health Service—The
18 \$2.1 billion in COVID–19 response funding for the Indian
19 Health Service.

20 **SEC. 1302. IMPROVING STATE, LOCAL, AND TRIBAL PUBLIC** 21 **HEALTH SECURITY.**

22 Section 319C–1 of the Public Health Service Act (42
23 U.S.C. 247d–3a) is amended—

24 (1) in the section heading, by striking “**AND**
25 **LOCAL**” and inserting “**, LOCAL, AND TRIBAL**”;

1 (2) in subsection (b)—

2 (A) in paragraph (1)—

3 (i) in subparagraph (B), by striking
4 “or” at the end;

5 (ii) in subparagraph (C), by striking
6 “and” at the end and inserting “or”; and

7 (iii) by adding at the end the fol-
8 lowing:

9 “(D) be an Indian Tribe, Tribal organiza-
10 tion, or a consortium of Indian Tribes or Tribal
11 organizations; and”; and

12 (B) in paragraph (2)—

13 (i) in the matter preceding subpara-
14 graph (A), by inserting “, as applicable”
15 after “including”;

16 (ii) in subparagraph (A)(viii)—

17 (I) by inserting “and Tribal”
18 after “with State”;

19 (II) by striking “(as defined in
20 section 8101 of the Elementary and
21 Secondary Education Act of 1965)”
22 and inserting “and Tribal educational
23 agencies (as defined in sections 8101
24 and 6132, respectively, of the Elemen-

1 tary and Secondary Education Act of
2 1965)”; and

3 (III) by inserting “and Tribal”
4 after “and State”;

5 (iii) in subparagraph (G), by striking
6 “and tribal” and inserting “Tribal, and
7 urban Indian organization”; and

8 (iv) in subparagraph (H), by inserting
9 “, Indian Tribes, and urban Indian organi-
10 zations” after “public health”;

11 (3) in subsection (e), by inserting “Indian
12 Tribes, Tribal organizations, urban Indian organiza-
13 tions,” after “local emergency plans,”;

14 (4) in subsection (g)(1), by striking “tribal offi-
15 cials” and inserting “Tribal officials”;

16 (5) in subsection (h)—

17 (A) in paragraph (1)(A)—

18 (i) by striking “through 2023” and
19 inserting “and 2020”; and

20 (ii) by inserting before the period “;
21 and \$690,000,000 for each of fiscal years
22 2021 through 2023 for awards pursuant to
23 paragraph (3) (subject to the authority of
24 the Secretary to make awards pursuant to
25 paragraphs (4) and (5)) and paragraph

1 (8), of which not less than \$5,000,000
2 shall be reserved each fiscal year for
3 awards under paragraph (8)”;

4 (B) in subsection (h)(2)(B), by striking
5 “tribal public” and inserting “Tribal public”;

6 (C) in the heading of paragraph (3), by in-
7 serting “FOR STATES” after “AMOUNT”; and

8 (D) by adding at the end the following:

9 “(8) TRIBAL ELIGIBLE ENTITIES.—

10 “(A) DETERMINATION OF FUNDING
11 AMOUNT.—

12 “(i) IN GENERAL.—The Secretary
13 shall award at least 10 cooperative agree-
14 ments under this section, in amounts not
15 less than the minimum amount determined
16 under clause (ii), to eligible entities de-
17 scribed in subsection (b)(1)(D) that sub-
18 mits to the Secretary an application that
19 meets the criteria of the Secretary for the
20 receipt of such an award and that meets
21 other reasonable implementation conditions
22 established by the Secretary, in consulta-
23 tion with Indian Tribes, for such awards.
24 If the Secretary receives more than 10 ap-
25 plications under this section from eligible

1 entities described in subsection (b)(1)(D)
2 that meet the criteria and conditions de-
3 scribed in the previous sentence, the Sec-
4 retary, in consultation with Indian Tribes,
5 may make additional awards under this
6 section to such entities.

7 “(ii) MINIMUM AMOUNT.—In deter-
8 mining the minimum amount of an award
9 pursuant to clause (i), the Secretary, in
10 consultation with Indian Tribes, shall first
11 determine an amount the Secretary con-
12 siders appropriate for the eligible entity.

13 “(B) AVAILABLE UNTIL EXPENDED.—
14 Amounts provided to a Tribal eligible entity
15 under a cooperative agreement under this sec-
16 tion for a fiscal year and remaining unobligated
17 at the end of such year shall remain available
18 to such entity during the entirety of the per-
19 formance period, for the purposes for which
20 said funds were provided.

21 “(C) NO MATCHING REQUIREMENT.—Sub-
22 paragraphs (B), (C), and (D) of paragraph (1)
23 shall not apply with respect to cooperative
24 agreements awarded under this section to eligi-

1 ble entities described in subsection (b)(1)(D).”;

2 and

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

4 “(1) SPECIAL RULES RELATED TO TRIBAL ELIGIBLE
5 ENTITIES.—

6 “(1) MODIFICATIONS.—After consultation with
7 Indian Tribes, the Secretary may make necessary
8 and appropriate modifications to the program under
9 this section to facilitate the use of the cooperative
10 agreement program by eligible entities described in
11 subsection (b)(1)(D).

12 “(2) WAIVERS.—

13 “(A) IN GENERAL.—Except as provided in
14 subparagraph (B), the Secretary may waive or
15 specify alternative requirements for any provi-
16 sion of this section (including regulations) that
17 the Secretary administers in connection with
18 this section if the Secretary finds that the waiv-
19 er or alternative requirement is necessary for
20 the effective delivery and administration of this
21 program with respect to eligible entities de-
22 scribed in subsection (b)(1)(D).

23 “(B) EXCEPTION.—The Secretary may not
24 waive or specify alternative requirements under

1 subparagraph (A) relating to labor standards or
2 the environment.

3 “(3) CONSULTATION.—The Secretary shall con-
4 sult with Indian Tribes and Tribal organizations on
5 the design of this program with respect to such
6 Tribes and organizations to ensure the effectiveness
7 of the program in enhancing the security of Indian
8 Tribes with respect to public health emergencies.

9 “(4) REPORTING.—

10 “(A) IN GENERAL.—Not later than 2 years
11 after the date of enactment of this subsection,
12 and as an addendum to the biennial evaluations
13 required under subsection (k), the Secretary, in
14 coordination with the Director of the Indian
15 Health Service, shall—

16 “(i) conduct a review of the implemen-
17 tation of this section with respect to eligi-
18 ble entities described in subsection
19 (b)(1)(D), including any factors that may
20 have limited its success; and

21 “(ii) submit a report describing the
22 results of the review described in clause (i)
23 to—

24 “(I) the Committee on Indian Af-
25 fairs, the Committee on Health, Edu-

1 cation, Labor, and Pensions, and the
 2 Committee on Appropriations of the
 3 Senate; and

4 “(II) the Subcommittee for In-
 5 digenous Peoples of the United States
 6 of the Committee on Natural Re-
 7 sources, the Committee on Energy
 8 and Commerce, and the Committee on
 9 Appropriations of the House of Rep-
 10 resentatives.

11 “(B) ANALYSIS OF TRIBAL PUBLIC
 12 HEALTH EMERGENCY INFRASTRUCTURE LIM-
 13 TATION.—The Secretary shall include in the
 14 initial report submitted under subparagraph (A)
 15 a description of any public health emergency in-
 16 frastructure limitation encountered by eligible
 17 entities described in subsection (b)(1)(D).”.

18 **SEC. 1303. PROVISION OF ITEMS TO INDIAN PROGRAMS**
 19 **AND FACILITIES.**

20 (a) STRATEGIC NATIONAL STOCKPILE.—Section
 21 319F–2(a)(3)(G) of the Public Health Service Act (42
 22 U.S.C. 247d–6b(a)(3)(G)) is amended by inserting “, and,
 23 in the case that the Secretary deploys the stockpile under
 24 this subparagraph, ensure, in coordination with the appli-
 25 cable States and programs and facilities, that appropriate

1 drugs, vaccines and other biological products, medical de-
2 vices, and other supplies are deployed by the Secretary di-
3 rectly to health programs or facilities operated by the In-
4 dian Health Service, an Indian Tribe, a Tribal organiza-
5 tion (as those terms are defined in section 4 of the Indian
6 Self-Determination and Education Assistance Act (25
7 U.S.C. 5304)), or an inter-Tribal consortium (as defined
8 in section 501 of the Indian Self-Determination and Edu-
9 cation Assistance Act (25 U.S.C. 5381)) or through an
10 urban Indian organization (as defined in section 4 of the
11 Indian Health Care Improvement Act), while avoiding du-
12 plicative distributions to such programs or facilities” be-
13 fore the semicolon.

14 (b) DISTRIBUTION OF QUALIFIED PANDEMIC OR EPI-
15 DEMIC PRODUCTS TO IHS FACILITIES.—Title III of the
16 Public Health Service Act (42 U.S.C. 241 et seq.) is
17 amended by inserting after section 319F–4 the following:

18 **“SEC. 319F–5. DISTRIBUTION OF QUALIFIED PANDEMIC OR**
19 **EPIDEMIC PRODUCTS TO INDIAN PROGRAMS**
20 **AND FACILITIES.**

21 “In the case that the Secretary distributes qualified
22 pandemic or epidemic products (as defined in section
23 319F–3(i)(7)) to States or other entities, the Secretary
24 shall ensure, in coordination with the applicable States
25 and programs and facilities, that, as appropriate, such

1 products are distributed directly to health programs or fa-
 2 cilities operated by the Indian Health Service, an Indian
 3 Tribe, a Tribal organization (as those terms are defined
 4 in section 4 of the Indian Self-Determination and Edu-
 5 cation Assistance Act (25 U.S.C. 5304)), or an inter-Trib-
 6 al consortium (as defined in section 501 of the Indian
 7 Self-Determination and Education Assistance Act (25
 8 U.S.C. 5381)) or through an urban Indian organization
 9 (as defined in section 4 of the Indian Health Care Im-
 10 provement Act), while avoiding duplicative distributions to
 11 such programs or facilities.”.

12 **SEC. 1304. HEALTH CARE ACCESS FOR URBAN NATIVE VET-**
 13 **ERANS.**

14 Section 405 of the Indian Health Care Improvement
 15 Act (25 U.S.C. 1645) is amended—

16 (1) in subsection (a)(1), by inserting “urban In-
 17 dian organizations,” before “and tribal organiza-
 18 tions”; and

19 (2) in subsection (c)—

20 (A) by inserting “urban Indian organiza-
 21 tion,” before “or tribal organization”; and

22 (B) by inserting “an urban Indian organi-
 23 zation,” before “or a tribal organization”.

1 **SEC. 1305. PROPER AND REIMBURSED CARE FOR NATIVE**
2 **VETERANS.**

3 Section 405(c) of the Indian Health Care Improve-
4 ment Act (25 U.S.C. 1645(c)) is amended by inserting be-
5 fore the period at the end the following: “, regardless of
6 whether such services are provided directly by the Service,
7 an Indian tribe, or tribal organization, through contract
8 health services, or through a contract for travel described
9 in section 213(b)”.

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