I

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

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Ending Health Disparities During COVID–19 Act of 2020'' or the ''EHDC Act of 2020''.

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Subtitle A—Collection and Reporting

SEC. 101. EQUITABLE DATA COLLECTION AND DISCLOSURE ON COVID–19 ACT.

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

(1) The World Health Organization (WHO) declared COVID–19 a ''Public Health Emergency of International Concern'' on January 30, 2020. By late March 2020, there have been over 470,000 confirmed cases of, and 20,000 deaths associated with, COVID–19 worldwide.

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

(3) Early reporting on racial inequities in COVID–19 testing and treatment have renewed calls for the Centers for Disease Control and Prevention and other relevant subagencies within the Department of Health and Human Services to publicly release racial and demographic information to better inform the pandemic response, specifically in communities of color and in Limited English Proficient (LEP) communities.

(4) The burden of morbidity and mortality in the United States has historically fallen disproportionately on marginalized communities (those who suffer the most from great public health needs and are the most medically underserved).

(5) Historically, structures and systems, such as racism, ableism and class oppression, have rendered affected individuals more vulnerable to inequities and have prevented people from achieving their optimal health even when there is not a crisis of pandemic proportions.

(6) Significant differences in access to health care, specifically to primary health care providers, health care information, and greater perceived discrimination in health care place communities of color, individuals with disabilities, and LEP individuals at greater risk of receiving delayed, and perhaps poorer, health care.

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

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

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

(9) Such communities are made even more vulnerable to the uncertainty of the preparation, response, and events surrounding the pandemic public health crisis, COVID–19. For instance, in the recent past, multiple epidemiologic studies and reviews have reported higher rates of hospitalization due to the 2009 H1N1 pandemic among the poor, individuals with disabilities and preexisting conditions, those living in impoverished neighborhoods, and individuals of color and ethnic backgrounds in the United States. These findings highlight the urgency to adapt the COVID–19 response to monitor and act on these inequities via data collection and research by race and ethnicity.

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

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

(11) Language barriers are highly correlated with medication noncompliance and inconsistent engagement with health systems. Without language accessibility data and research around COVID–19, these communities are less likely to receive critical testing and preventive health services. Yet, to date, the Centers for Disease Control and Prevention do not disseminate COVID–19 messaging in critical languages, including Mandarin Chinese, Spanish, and Korean within the same timeframe as information in English despite requirements to ensure limited English proficient populations are not discriminated against under title VI of the Civil Rights Act of 1964 and subsequent laws and Federal policies.

(12) Further, it is critical to disaggregate data further by ancestry to address disparities among Asian American, Native Hawaiian, and Pacific Islander groups. According to the National Equity Atlas, while 13 percent of the Asian population overall lived in poverty in 2015, 39 percent of Burmese people, 29 percent of Hmong people, and 21 percent of Pacific Islanders lived in poverty.

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

(14) Without clear understanding of how COVID–19 impacts marginalized racial and ethnic communities, there will be exacerbated risk of endangering the most historically vulnerable of our Nation.

(15) The consequences of misunderstanding the racial and ethnic impact of COVID–19 expound beyond communities of color such that it would impact all.

(16) Race and ethnicity are valuable research and practice variables when used and interpreted appropriately. Health data collected on patients by

race and ethnicity will boost and more efficiently direct critical resources and inform risk communication development in languages and at appropriate health literacy levels, which resonate with historically vulnerable communities of color.

(17) To date, there is no public standardized and comprehensive race and ethnicity data repository of COVID–19 testing, hospitalizations, or mortality. The inconsistency of data collection by Federal, State, and local health authorities, and the inability to access data by public research institutions and academic organizations, poses a threat to analysis and synthesis of the pandemic impact on communities of color. However, research and medical experts of Historically Black Colleges and Universities, academic health care institutions which are historically and geographically embedded in minoritized and marginalized communities, generally also possess rapport with the communities they serve. They are well-positioned, as trusted thought leaders and health care service providers, to collect data and conduct research toward creating holistic solutions to remedy the inequitable impact of this and future public health crises.

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

(19) The dearth of racially and ethnically disaggregated data reflecting the health of communities of color underlies the challenges of a fully informed public health response.

(20) Without collecting race and ethnicity data associated with COVID–19 testing, hospitalizations, morbidities, and mortalities, as well as publicly disclosing it, communities of color will remain at greater risk of disease and death.

(b) EMERGENCY FUNDING FOR FEDERAL DATA COLLECTION ON THE RACIAL, ETHNIC, AND OTHER DEMOGRAPHIC DISPARITIES OF COVID–19.—To conduct or support data collection on the racial, ethnic, and other demographic implications of COVID–19 in the United States and its territories, including support to assist in the capacity building for State and local public health departments to collect and transmit racial, ethnic, and other demographic data to the relevant Department of Health and

Human Services agencies, there is authorized to be appropriated—

(1) to the Centers for Disease Control and Prevention, $12,000,000;

(2) to State, territorial, and Tribal public health agencies, distributed proportionally based on the total population of their residents who are enrolled in Medicaid or who have no health insurance, $15,000,000;

(3) to the Indian Health Service, Indian Tribes and Tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act), and urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act), $3,000,000;

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

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

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

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

(c) COVID–19 DATA COLLECTION AND DISCLOSURE.—

(1) DATA COLLECTION.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention and the Administrator of the Centers for Medicare & Medicaid Services, shall make publicly available on the website of the Centers for Disease Control and Prevention data collected across all surveillance systems relating to COVID–19, disaggregated by race, ethnicity, sex, age, primary language, socioeconomic status, disability status, and county, including the following:

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

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

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

(2) APPLICATION OF STANDARDS.—To the extent practicable, data collection under this sub-

section shall follow standards developed by the Department of Health and Human Services Office of Minority Health and be collected, analyzed, and reported in accordance with the standards promulgated by the Assistant Secretary for Planning and Evaluation under title XXXI of the Public Health Service Act (42 U.S.C. 300kk et seq.).

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

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

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

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

(5) CONSULTATION WITH TRIBES.—The Indian Health Service shall consult with Indian Tribes and confer with urban Indian organizations on data collection and reporting.

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

(7) REPORT.—Not later than 60 days after the date on which the Secretary certifies that the public health emergency related to COVID–19 has ended, the Department of Health and Human Services shall compile and submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a preliminary report—

(A) describing the testing, hospitalization, mortality rates, and preferred language of patients associated with COVID–19 by race and ethnicity; and

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

(d) COMMISSION ON ENSURING HEALTH EQUITY DURING THE COVID–19 PUBLIC HEALTH EMERGENCY.—

(1) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Secretary shall establish a commission, to be known as the ''Commission on Ensuring Health Equity During the COVID–19 Public Health Emergency'' (referred to in this subsection as the ''Commission'') to provide clear and robust guidance on how to improve the collection, analysis, and use of demographic data in responding to future waves of the coronavirus.

(2) MEMBERSHIP AND CHAIRPERSON.—

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

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

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

(iii) the Commissioner of Food and Drugs;

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

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

(vi) the Director of the Indian Health Service;

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

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

(ix) the Surgeon General;

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

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

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

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

(xiv) at least 4 State, local, territorial, and Tribal public health officials representing departments of public health, who shall represent jurisdictions from different regions of the United States with

relatively high concentrations of historically marginalized populations, to be appointed by the Secretary; and

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

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

(3) DUTIES.—The Commission shall—

(A) examine barriers to collecting, analyzing, and using demographic data;

(B) determine how to best use such data to promote health equity across the United States and reduce racial, Tribal, and other demographic disparities in COVID–19 prevalence and outcomes;

(C) gather available data related to COVID–19 treatment of individuals with disabilities, including denial of treatment for pre-existing conditions, removal or denial of disability related equipment (including ventilators

and CPAP), and data on completion of DNR orders, and identify barriers to obtaining accurate and timely data related to COVID–19 treatment of such individuals;

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

(E) recommend policy changes that the data indicates are necessary to reduce disparities.

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

(A) how to enhance State, local, territorial, and Tribal capacity to conduct public health research on COVID–19, with a focus on expanded

capacity to analyze data on disparities correlated with race, ethnicity, income, sex, age, disability status, specific geographic areas, and other relevant demographic characteristics, and an analysis of what demographic data is currently being collected about COVID–19, the accuracy of that data and any gaps, how this data is currently being used to inform efforts to combat COVID–19, and what resources are needed to supplement existing public health data collection;

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

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

(D) to the extent possible, a preliminary analysis of racial and other demographic disparities in COVID–19 mortality, including an analysis of comorbidities and case fatality rates;

(E) to the extent possible, a preliminary analysis of sex, gender, sexual orientation, and gender identity disparities in COVID–19 treatment and mortality;

(F) an analysis of COVID–19 treatment of individuals with disabilities, including equity of access to treatment and equipment and intersections of disability status with other demographic factors, including race, and recommendations for how to improve transparency and equity of treatment for such individuals during the COVID–19 public health emergency and future emergencies;

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

(H) to the extent possible, a preliminary analysis of Federal Government policies that disparately exacerbate the COVID–19 impact, and recommendations to improve racial and other demographic disparities in health outcomes.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this subsection.

SEC. 102. COVID–19 REPORTING PORTAL.

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

(b) ELIGIBLE HEALTH CARE ENTITIES.—In this section, the term ''eligible health care entity'' means a licensed acute care hospital, hospital system, or long-term care facility with confirmed cases of COVID–19.

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

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

(1) PERSONAL PROTECTIVE EQUIPMENT.—Total personal protective equipment inventory, including, in units, the numbers of N95 masks and

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

(2) MEDICAL SUPPLY.—

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

(B) Total diagnostic and serological test inventory, including, in units, the number of test platforms, tests, test kits, reagents, transport media, swabs, and other materials or supplies determined necessary by the Secretary.

(3) CAPACITY.—

(A) Case count measurements, including confirmed positive cases and persons under investigation.

(B) Total number of staffed beds, including medical surgical beds, intensive care beds, and critical care beds.

(C) Available beds, including medical surgical beds, intensive care beds, and critical care beds.

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

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

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

(G) Total number of hospital personnel currently not working due to self-isolation following a known or presumed COVID–19 exposure.

(e) ACCESS TO INFORMATION RELATED TO INVENTORY AND CAPACITY.—The Secretary shall ensure that relevant agencies and officials, including the Centers for Disease Control and Prevention, the Assistant Secretary for Preparedness and Response, and the Federal Emergency Management Agency, have access to information related to inventory and capacity submitted under this section.

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

SEC. 103. REGULAR CDC REPORTING ON DEMOGRAPHIC DATA.

Not later than 14 days after the date of enactment of this Act, the Secretary of Health and Human Services, in coordination with the Director of the Centers for Disease Control and Prevention, shall amend the reporting under the heading ''Department of Health and Human Services—Office of the Secretary—Public Health and Social Service Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139; 134 Stat. 620, 626) on the demographic characteristics, including race, ethnicity (including breakdowns of major ethnic groups and Tribal affiliations within minority populations), age, sex, gender, geographic region, primary written and spoken language, disability status, sexual orientation, socioeconomic status, occupation, and other relevant factors of individuals tested for or diagnosed with COVID–19, to include—

(1) providing technical assistance to State, local, Tribal, and territorial health departments to improve the collection and reporting of such demographic data;

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

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

(3) making a copy of such report available publicly on the website of the Centers for Disease Control and Prevention.

SEC. 104. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

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

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

"TITLE XXXIV—STRENGTHENING DATA COLLECTION, IMPROVING DATA ANALYSIS, AND EXPANDING DATA REPORTING

"SEC. 3400. HEALTH DISPARITY DATA.

"(a) REQUIREMENTS.—

"(1) IN GENERAL.—Each health-related program shall—

"(A) require the collection, by the agency or program involved, of data on the race, eth-

nicity, sex, primary language, sexual orientation, disability status, gender identity, age, and socioeconomic status of each applicant for and recipient of health-related assistance under such program, including—

"(i) using, at a minimum, standards for data collection on race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status as each are developed under section 3101;

"(ii) collecting data for additional population groups if such groups can be aggregated into the race and ethnicity categories outlined by standards developed under section 3101;

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

"(iv) where practicable, collecting such data through self-reporting;

"(B) with respect to the collection of the data described in subparagraph (A), for applicants and recipients who are minors, require communication assistance in speech or writing, and for applicants and recipients who are otherwise legally incapacitated, require that—

"(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

"(ii) the primary language of the parent or legal guardian of such an applicant or recipient be collected;

"(C) systematically analyze such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities, as well as disparities along the lines of primary language, sex, disability status, sexual orientation, gender identity, age, and socioeconomic status in health and health care, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, each agency listed in section 3101(c)(1), the Committee 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-

vider, Federal official, or other entity to compel the disclosure of any data collected under this title. The disclosure of any such data by an individual pursuant to this title shall be strictly voluntary.

''(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) are protected—

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

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

''(c) NATIONAL PLAN OF THE DATA COUNCIL.—The Secretary shall develop and implement a national plan to ensure the collection of data in a culturally and linguistically appropriate manner, to improve the collection, analysis, and reporting of racial, ethnic, sex, primary lan-

guage, sexual orientation, disability status, gender identity, age, and socioeconomic status data at the Federal, State, territorial, Tribal, and local levels, including data to be collected under subsection (a), and to ensure that data collection activities carried out under this section are in compliance with standards developed under section 3101. The Data Council of the Department of Health and Human Services, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, Office on Women's Health, and other appropriate public and private entities, shall make recommendations to the Secretary concerning the development, implementation, and revision of the national plan. Such plan shall include recommendations on how to—

''(1) implement subsection (a) while minimizing the cost and administrative burdens of data collection and reporting;

''(2) expand knowledge among Federal agencies, States, territories, Indian Tribes, counties, municipalities, health providers, health plans, and the general public that data collection, analysis, and reporting by race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status is legal and

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

''(3) ensure that future patient record systems follow Federal standards promulgated under the Health Information Technology for Economic and Clinical Health Act for the collection and meaningful use of electronic health data on race, ethnicity, sex, primary language, sexual orientation, gender identity, age, socioeconomic status, and disability status;

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

''(5) provide researchers with greater access to racial, ethnic, primary language, sex, sexual orientation, gender identity, age, socioeconomic status data, and disability status data, subject to all applicable privacy and confidentiality requirements, including HIPAA privacy and security law as defined in section 3009; and

''(6) safeguard and prevent the misuse of data collected under subsection (a).

''(d) COMPLIANCE WITH STANDARDS.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes) in accordance with standards developed under section 3101.

''(e) ANALYSIS OF HEALTH DISPARITY DATA.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in coordination with the Assistant Secretary for Planning and Evaluation, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Center for Health Statistics, and the Director of the National Institutes of Health, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting Federal standards for health disparity data collection and for analysis of racial, ethnic, and other disparities in health and health care in programs conducted or supported by such agencies by—

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

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

''(3) developing new quality measures relating to racial and ethnic disparities and their overlap

with other disparity factors in health and health care;

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

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

''(f) DEFINITIONS.—In this section—

''(1) the term 'health-related program' means a program that is operated by the Secretary, or that receives funding or reimbursement, in whole or in part, either directly or indirectly from the Secretary—

''(A) for activities under the Social Security Act for health care services; or

''(B) for providing Federal financial assistance for health care, biomedical research, or health services research or for otherwise improving the health of the public;

''(2) the term 'primary language data' includes spoken and written primary language data; and

''(3) the term 'primary language data collection activities' includes identifying, collecting, storing, tracking, and analyzing primary language data and information on the methods used to meet the lan-

guage access needs of individuals with limited English proficiency.

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

''SEC. 3401. ESTABLISHING GRANTS FOR DATA COLLECTION IMPROVEMENT ACTIVITIES.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in consultation with the Deputy Assistant Secretary for Minority Health, the Director of the National Institutes of Health, the Assistant Secretary for Planning and Evaluation, and the Director of the National Center for Health Statistics, shall establish a technical assistance program under which the Secretary provides grants to eligible entities to assist such entities in complying with section 3431.

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

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

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

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

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

''(c) ELIGIBLE ENTITY.—To be eligible for grants under this section, an entity shall be a State, territory, Indian Tribe, municipality, county, health provider, health care organization, or health plan making a demonstrated effort to bring data collections into compliance with section 3431.

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

"SEC. 3402. OVERSAMPLING OF UNDERREPRESENTED GROUPS IN FEDERAL HEALTH SURVEYS.

''(a) NATIONAL STRATEGY.—

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

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

''(A) consult with representatives of community groups, nonprofit organizations, nongovernmental organizations, and government

agencies working with underrepresented populations;

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

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

"(b) PROGRESS REPORT.—Not later than 2 years after the date of the enactment of this section, the Secretary shall submit to the Congress a progress report, which shall include the national strategy described in subsection (a)(1).

"(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2025.".

SEC. 105. ELIMINATION OF PREREQUISITE OF DIRECT APPROPRIATIONS FOR DATA COLLECTION AND ANALYSIS.

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

(1) by striking subsection (h); and

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

SEC. 106. COLLECTION OF DATA FOR THE MEDICARE PROGRAM.

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

''COLLECTION OF DATA FOR THE MEDICARE PROGRAM

''SEC. 1150C.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—The Commissioner of Social Security, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall collect data on the race, ethnicity, sex, primary language, sexual orientation, gender identity, socioeconomic status, and disability status of all applicants for Social Security benefits under title II or Medicare benefits under title XVIII.

''(2) DATA COLLECTION STANDARDS.—In collecting data under paragraph (1), the Commissioner

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

''(3) DATA FOR ADDITIONAL POPULATION GROUPS.—Where practicable, the information collected by the Commissioner of Social Security under paragraph (1) shall include data for additional population groups if such groups can be aggregated into the race and ethnicity categories outlined by the data collection standards described in paragraph (2).

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

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

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

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

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

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

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

"(B) incorporate such data in other analysis and reporting on health disparities as appropriate;

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

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

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

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

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

individually identifiable health information and other protections); and

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

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

"(c) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide technical assistance to enable any entity to comply with the requirements of this section or with regulations implementing this section.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $500 million for 2020 and $100 million for each fiscal year thereafter.".

SEC. 107. REVISION OF HIPAA CLAIMS STANDARDS.

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

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

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

(2) in consultation with the Office of the National Coordinator for Health Information Technology, the designation of the appropriate racial, ethnic, primary language, disability, sex, and other code sets as required for claims and enrollment data.

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

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

than 2 years after the final promulgation of such standards.

SEC. 108. DISPARITIES DATA COLLECTED BY THE FEDERAL GOVERNMENT.

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

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

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

tor of the Agency for Healthcare Research and Quality, the Director of the National Center for Health Statistics, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Institute on Minority Health and Health Disparities, and the Deputy Assistant Secretary for Minority Health, shall—

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

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

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

SEC. 109. STANDARDS FOR MEASURING SEXUAL ORIENTATION, GENDER IDENTITY, AND SOCIOECONOMIC STATUS IN COLLECTION OF HEALTH DATA.

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

(1) in paragraph (1)(A), by inserting ''sexual orientation, gender identity, socioeconomic status,'' before ''and disability status'';

(2) in paragraph (1)(C), by inserting ''sexual orientation, gender identity, socioeconomic status,'' before ''and disability status''; and

(3) in paragraph (2)(B), by inserting ''sexual orientation, gender identity, socioeconomic status,'' before ''and disability status''.

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

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

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

''(a) DEFINITIONS.—In this section:

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

''(2) NONPROFIT, NONGOVERNMENTAL ORGANIZATION.—The term 'nonprofit, nongovernmental organization' means a group of NHOPI with a dem-

onstrated history of addressing NHOPI issues, including a NHOPI coalition.

''(3) DESIGNATED ORGANIZATION.—The term 'designated organization' means an entity established to represent NHOPI populations and which has statutory responsibilities to provide, or has community support for providing, health care.

''(4) GOVERNMENT REPRESENTATIVES OF NHOPI POPULATIONS.—The term 'government representatives of NHOPI populations' means representatives from Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

''(5) NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS (NHOPI).—The term 'Native Hawaiians and Other Pacific Islanders' or 'NHOPI' means people having origins in any of the original peoples of American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Hawaii, the Republic of the Marshall Islands, the Republic of Palau, or any other Pacific Island.

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

''(b) NATIONAL STRATEGY.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the National Center for Health Statistics (referred to in this section as 'NCHS') of the Centers for Disease Control and Prevention, and other agencies within the Department of Health and Human Services as the Secretary determines appropriate, shall develop and implement an ongoing and sustainable national strategy for identifying and evaluating the health status and health care needs of NHOPI populations living in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands.

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

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

"(A) shall consult with representatives of community groups, designated organizations, and nonprofit, nongovernmental organizations and with government representatives of NHOPI populations; and

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

"(c) PRELIMINARY HEALTH SURVEY.—

"(1) IN GENERAL.—The Secretary, acting through the Director of NCHS, shall conduct a preliminary health survey in order to identify the major areas and regions in the continental United States, Hawaii, American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, the Republic of Palau, and the Republic of the Marshall Islands in which NHOPI people reside.

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

"(A) useful in determining health status and health care needs; or

''(B) required for developing or implementing a national strategy.

''(3) METHODOLOGY.—Methodology for the health survey described in paragraph (1), including plans for designing questions, implementation, sampling, and analysis, shall be developed in consultation with community groups, designated organizations, nonprofit, nongovernmental organizations, and government representatives of NHOPI populations, as determined by the Secretary.

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

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

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

''(1) IN GENERAL.—The Secretary shall enter into an agreement with the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine to conduct a study, with input

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

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

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

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

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

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

scription of the results of the study conducted under paragraph (1), including the conclusions and recommendations of the Health and Medicine Division for each of the items described in subparagraphs (A) through (D) of such paragraph.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2025.''.

Subtitle B—Improvements and Modernization

SEC. 121. FEDERAL MODERNIZATION FOR HEALTH INEQUITIES DATA.

(a) IN GENERAL.—The Secretary of Health and Human Services shall work with covered agencies to support the modernization of data collection methods and infrastructure at such agencies for the purpose of increasing data collection related to health inequities, such as racial, ethnic (including breakdowns of major ethnic groups and Tribal affiliations within minority populations), socioeconomic, sex, gender, age, geographic region, primary written and spoken language, sexual orientation, occupation, and disability status disparities.

(b) COVERED AGENCY DEFINED.—In this section, the term ''covered agency'' means each of the following Federal agencies:

(1) The Agency for Healthcare Research and Quality.

(2) The Centers for Disease Control and Prevention.

(3) The Centers for Medicare & Medicaid Services.

(4) The Food and Drug Administration.

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

(6) The National Institutes of Health.

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

SEC. 122. MODERNIZATION OF STATE AND LOCAL HEALTH INEQUITIES DATA.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State, local, Tribal, and territorial health departments in

order to support the modernization of data collection methods and infrastructure for the purposes of increasing data related to health inequities, such as racial, ethnic (including breakdowns of major ethnic groups and Tribal affiliations within minority populations), socioeconomic, sex, gender, age, geographic region, primary written and spoken language, sexual orientation, occupation, and disability status disparities. The Secretary shall—

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

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

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

(1) nationwide best practices for ensuring States and localities collect and transmit health inequities data;

(2) nationwide trends which hinder the collection and transmission of health inequities data;

(3) Federal best practices for working with States and localities to ensure culturally competent, accurate, and increased data collection and transmission; and

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

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

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

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

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

SEC. 123. ADDITIONAL REPORTING TO CONGRESS ON THE RACE AND ETHNICITY RATES OF COVID–19 TESTING, HOSPITALIZATIONS, AND MORTALITIES.

(a) IN GENERAL.—Not later than August 1, 2020, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall submit to the Committee on Appropriations and the Committee on Energy and Commerce of the House of Representatives and the Committee on Appropriations and the Committee on Health, Education, Labor, and Pensions of the Senate an initial report—

(1) describing the testing, positive diagnoses, hospitalization, intensive care admissions, and mortality rates associated with COVID–19, disaggregated by race, ethnicity (including breakdowns of major ethnic groups and Tribal affiliations within minority populations), age, sex, gender, geographic region, primary written and spoken language, disability status, sexual orientation, socioeconomic status, occupation, and other relevant factors as determined by the Secretary;

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

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

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

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

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

(c) COORDINATION.—In preparing the report submitted under this section, the Secretary shall take into account and otherwise coordinate such report with reporting required under section 103 and under the heading ''Department of Health and Human Services—Office of the Secretary—Public Health and Social Service Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139; 134 Stat. 620, 626).

TITLE II—EQUITABLE TESTING AND TRACING

Subtitle A—Free Testing for Patients

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

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

amended by striking ''beginning on or after'' and inserting ''beginning before, on, or after''.

Subtitle B—National Testing Strategy

SEC. 211. COVID–19 TESTING STRATEGY.

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

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

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

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

(C) to provide for ongoing surveillance sufficient to support contact tracing, case identification, quarantine, and isolation to prevent future outbreaks of COVID–19;

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

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

(B) sufficient availability of all necessary 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–

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

(3) specific plans to ensure adequate testing in rural areas, frontier areas, health professional shortage areas, and medically underserved areas (as defined in section 330I(a) of the Public Health Service Act (42 U.S.C. 254c–14(a))), and for underserved populations, Native Americans (including Indian Tribes, Tribal organizations, and urban Indian organizations), and populations at increased risk related to COVID–19;

(4) specific plans to ensure accessibility of testing to people with disabilities, older individuals, individuals with limited English proficiency, and individuals with underlying health conditions or weakened immune systems; and

(5) specific plans for broadly developing and implementing testing for potential immunity in the United States, as appropriate, in a manner sufficient—

(A) to monitor and contribute to the control of SARS–CoV–2 in the United States;

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

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

(C) to reduce disparities (including disparities related to race, ethnicity, sex, age, disability status, socioeconomic status, primary written and spoken language, occupation, and geographic location) in the prevalence of, incidence of, and health outcomes with respect to, COVID–19.

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

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

(2) in collaboration with other agencies and departments, as appropriate; and

(3) taking into consideration the State plans for COVID–19 testing prepared as required under the heading ''Department of Health and Human Services—Office of the Secretary—Public Health and Social Service Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139; 134 Stat. 620, 624).

(c) UPDATES.—

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

(2) RELATION TO OTHER LAW.—Paragraph (1) applies in lieu of the requirement (for updates every 90 days until funds are expended) in the second to last proviso under the heading ''Department of Health and Human Services—Office of the Secretary—Public Health and Social Service Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139; 134 Stat. 620, 627).

(d) APPROPRIATE CONGRESSIONAL COMMITTEES.—In this section, the term ''appropriate congressional committees'' means—

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

(2) the Committee on Appropriations and the Committee on Health, Education, Labor, and Pensions of the Senate.

SEC. 212. CORONAVIRUS IMMIGRANT FAMILIES PROTECTION.

(a) DEFINITIONS.—In this section:

(1) CORONAVIRUS PUBLIC HEALTH EMERGENCY.—The term ''coronavirus public health emergency'' means—

(A) an emergency involving Federal primary responsibility determined to exist by the President under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5191(b)) with respect to COVID–19 or any other coronavirus with pandemic potential;

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

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

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

Service Act (42 U.S.C. 247(d)) with respect to COVID–19 or any other coronavirus with pandemic potential.

(2) CORONAVIRUS RESPONSE LAW.—The term ''coronavirus response law'' means—

(A) the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Public Law 116–123);

(B) the Families First Coronavirus Response Act (Public Law 116–127);

(C) the Coronavirus Aid, Relief, and Economic Security Act (Public Law 116–136); and

(D) any subsequent law enacted as a response to a coronavirus public health emergency.

(3) COVID–19.—The term ''COVID–19'' means the Coronavirus Disease 2019.

(4) ENFORCEMENT ACTION.—The term ''enforcement action'' means an apprehension, an arrest, a search, an interview, a request for identification, or surveillance for the purposes of immigration enforcement.

(5) SENSITIVE LOCATION.—The term ''sensitive location'' means all physical space located within 1,000 feet of—

(A) a medical treatment or health care facility, including a hospital, an office of a health care practitioner, an accredited health clinic, an alcohol or drug treatment center, an emergent or urgent care facility, and a community health center;

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

(C) an organization that provides—

(i) disaster or emergency social services and assistance;

(ii) services for individuals experiencing homelessness, including food banks and shelters; or

(iii) assistance for children, pregnant women, victims of crime or abuse, or individuals with significant mental or physical disabilities;

(D) a public assistance office, including any Federal, State, or municipal location at which individuals may apply for or receive unemployment compensation or report violations of labor and employment laws;

(E) a Federal, State, or local courthouse, including the office of the legal counsel or representative of an individual;

(F) a domestic violence shelter, rape crisis center, supervised visitation center, family justice center, or victim services provider;

(G) an office of the Social Security Administration;

(H) a childcare facility or a school, including a preschool, primary school, secondary school, post-secondary school up to and including a college or university, and any other institution of learning such as a vocational or trade school;

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

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

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

(L) any other location specified by the Secretary of Homeland Security.

(b) SUSPENSION OF ADVERSE IMMIGRATION ACTIONS THAT DETER IMMIGRANT COMMUNITIES FROM SEEKING HEALTH SERVICES IN A PUBLIC HEALTH EMERGENCY.—

(1) IN GENERAL.—Beginning on the date on which a coronavirus public health emergency is declared and ending on the date that is 60 days after the date on which the coronavirus public health emergency expires—

(A) the Secretary of Homeland Security, the Secretary of State, and the Attorney General shall not—

(i) implement the final rule of the Department of Homeland Security entitled ''Inadmissibility on Public Charge Grounds'' (84 Fed. Reg. 41292 (August 14, 2019));

(ii) implement the interim final rule of the Department of State entitled ''Visas: Ineligibility Based on Public Charge Grounds'' (84 Fed. Reg. 54996 (October 11, 2019));

(iii) implement the proposed rule of the Department of Justice entitled ''Inadmissibility on Public Charge Grounds'' published in the Fall 2018 Uniform Regulatory Agenda;

(iv) conduct any enforcement action against an individual at, or in transit to or from, a sensitive location unless the enforcement action is conducted pursuant to a valid judicial warrant;

(v) detain or remove—

(I) a survivor of domestic violence, sexual assault, or human trafficking, or any other individual, who has a pending application under section 101(a)(15)(T), 101(a)(15)(U), 106, 240A(b)(2) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(T), 1101(a)(15)(U), 1105a, 1229b(b)(2)) or section 244(a)(3) of that Act (as in effect on March 31, 1997); or

(II) a VAWA self-petitioner described in section 101(a)(51) of that

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

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

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

(vi) require an individual subject to supervision by U.S. Immigration and Customs Enforcement to report in person.

(B) The Attorney General shall conduct fully telephonic bond hearings and allow supporting documents to be faxed and emailed to the appropriate clerk.

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

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

amounts made available under a coronavirus response law.

(c) ACCESS TO COVID–19 TESTING AND TREATMENT FOR ALL COMMUNITIES.—

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

''For purposes of subparagraph (A), care and services described in such subparagraph include any in vitro diagnostic product described in section 1905(a)(3)(B) that is administered during any portion of the emergency period described in such section beginning on or after the date of the enactment of this sentence (and the administration of such product), any COVID–19 vaccine that is administered during any such portion (and the administration of such vaccine), any item or service that is furnished during any such portion for the treatment of COVID–19 or a condition that may complicate the treatment of COVID–19, and any services described in section 1916(a)(2)(G).''.

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

inserting ''means any concern that the individual may have contracted COVID–19 or another.''.

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

(A) the value of assistance or services provided to any person under a program with respect to which a coronavirus response law establishes or expands eligibility or benefits shall not be considered income or resources; and

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

(ii) a participating State or political subdivision of a State shall not decrease any assistance otherwise provided to an individual because of the receipt of benefits under the Social Security Act (42 U.S.C. 301 et seq.); and

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

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

(4) NONDISCRIMINATION.—No person shall be, on the basis of actual or perceived immigration status, excluded from participation in, denied the benefits of, or subject to discrimination under, any program or activity funded in whole or in part by amounts made available under a coronavirus response law.

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

(1) GRANTS AND COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—The Director of the Centers for Disease Control and Prevention (referred to in this subsection as the ''Director'') shall provide grants to, or enter into cooperative agreements with, community-based organizations for the purpose of supporting culturally and linguistically appropriate preparedness, response, and recovery activities, such as the de-

velopment of educational programs and materials to promote screening, testing, treatment, and public health practices.

(B) DEFINITION OF COMMUNITY-BASED ORGANIZATION.—In this paragraph, the term ''community-based organization'' means an entity that has established relationships with hard-to-reach populations, including racial and ethnic minorities, individuals with limited English proficiency, and individuals with disabilities.

(2) TRANSLATION.—

(A) IN GENERAL.—The Director shall provide for the translation of materials on awareness, screening, testing, and treatment for COVID–19 into the languages described in the language access plan of the Federal Emergency Management Agency dated October 1, 2016, as the languages most frequently encountered.

(B) PUBLIC AVAILABILITY.—Not later than 7 days after the date on which the materials described in subparagraph (A) are made available to the public in English, the Director shall ensure that the translations required by

that subparagraph are made available to the public.

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

(4) INTERAGENCY COORDINATION.—With respect to individuals with limited English proficiency, the Director shall facilitate interagency coordination among agencies activated through the National Response Framework based on the language access standards established under the language access plans of the Federal Emergency Management Agency and the Department of Health and Human Services.

(5) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—There is authorized to be appropriated to carry out this subsection $100,000,000 for fiscal year 2020, to be available until expended.

(B) GRANTS AND COOPERATIVE AGREEMENTS.—Of the amount authorized to be appropriated under subparagraph (A), not less than $50,000,000 shall be made available to carry out paragraph (1).

(e) ACCESS TO SUPPORT MEASURES FOR VULNERABLE COMMUNITIES.—

(1) DISASTER SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM BENEFITS.—The Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.) is amended—

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

(B) in section 301 (42 U.S.C. 5141), by inserting ''or an emergency due to a pandemic'' after ''major disaster'' each place the term appears;

(C) in section 412 (42 U.S.C. 5179)—

(i) by inserting ''or an emergency due to a pandemic'' after ''major disaster'' each place the term appears;

(ii) in subsection (a), by inserting ''without regard to regular allotments'' before ''and to make surplus''; and

(iii) by adding at the end the following:

''(d) ASSISTANCE DURING A PANDEMIC.—In the case of an emergency due to a pandemic, for purposes of providing benefits under this section, the Secretary of Agriculture shall remove or delay the requirement of an in-

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section, only if such sums are designated by Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901(b)(2)(A)(i)).''; and

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

(i) in paragraph (7), by striking ''and'' at the end;

(ii) in paragraph (8)(B), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following:

''(9) provide assistance in accordance with section 412.''.

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

Code of 1986, as added by section 2201 of the Coronavirus Aid, Relief, and Economic Security Act (Public Law 116–136), is amended by inserting before the period at the end ''or a taxpayer identification number''.

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

(A) IN GENERAL.—Notwithstanding any other provision of law, including the Immigration and Nationality Act (8 U.S.C. 1101 et seq.), the Secretary of Homeland Security shall automatically extend the immigration status and employment authorization, as applicable, of an alien described in subparagraph (B) for the same period for which the status and employment authorization was initially granted.

(B) ALIEN DESCRIBED.—An alien described in this subparagraph is an alien (as defined in section 101(a) of the Immigration and Nationality Act (8 U.S.C. 1101(a))) whose immigration status, including permanent, temporary, and deferred status, or whose employment authorization—

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

(ii) will expire not later than—

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

(II) 90 days after the date on which the national emergency declared by the President under the National Emergencies Act (50 U.S.C. 1601 et seq.) with respect to the Coronavirus Disease 2019 (COVID–19) is rescinded.

(4) LANGUAGE ACCESS.—Any agency receiving funding under a coronavirus response law shall ensure that all programs and opportunities made available to the general public provide translated materials describing the programs and opportunities into the languages described in the language access plan of the Federal Emergency Management Agency dated October 1, 2016, as the languages most frequently encountered.

SEC. 213. ICE DETENTION.

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

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

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

(1) all individuals in the custody of U.S. Immigration and Customs Enforcement—

(A) have access to telephonic or video communication at no cost to the detained individual;

(B) have access to free, unmonitored telephone calls, at any time, to contact attorneys or legal service providers in a sufficiently private space to protect confidentiality;

(C) are permitted to receive legal correspondence by fax or email rather than postal mail; and

(D) are provided sufficient soap, hand sanitizer, and other hygiene products; and

(2) nonprofit organizations providing legal orientation programming or know-your-rights programming to individuals in the custody of U.S. Immigration and Customs Enforcement are permitted broad and flexible access to such individuals—

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

(B) to schedule and provide individual orientations using free telephone calls or remote videoconferencing.

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

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

(2) ends 90 days after the date on which such 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) applicants proposing to conduct activities funded under this section in hot spots and medically underserved communities; and

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

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

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

(f) DEFINITIONS.—In this section:

(1) The term ''eligible entity'' means—

(A) a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)));

(B) a school-based health clinic;

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

(D) an academic medical center;

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

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

(G) a high school (as defined in section 8101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801));

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

(I) any other type of entity that is determined by the Secretary to be an eligible entity for purposes of this section.

(2) The term ''emergency period'' has the meaning given to that term in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)).

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

(4) The term ''medically underserved community'' has the meaning given to that term in section 799B of the Public Health Service Act (42 U.S.C. 295p).

(5) The term ''Secretary'' means the Secretary of Health and Human Services.

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

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

(2) such sums as may be necessary for each of fiscal year 2021 and any subsequent fiscal year during which the emergency period continues.

SEC. 222. NATIONAL SYSTEM FOR COVID–19 TESTING, CONTACT TRACING, SURVEILLANCE, CONTAINMENT, AND MITIGATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, and in coordination with State, local, Tribal, and territorial health departments, shall establish and implement a nationwide evidence-based system for—

(1) testing, contact tracing, surveillance, containment, and mitigation with respect to COVID–19;

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

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

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

(1) coordinate State, local, Tribal, and territorial activities related to testing, contact tracing, surveillance, containment, and mitigation with respect to COVID–19, as appropriate; and

(2) provide technical assistance for such activities, as appropriate.

(c) CONSIDERATION.—In establishing and implementing the national system under this section, the Secretary shall take into consideration—

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

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

(2) the testing strategy submitted under section 211.

(d) REPORTING.—The Secretary shall—

(1) not later than December 31, 2020, submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions a preliminary report on the effectiveness of the activities carried out pursuant to this subtitle; and

(2) not later than December 21, 2021, submit to such committees a final report on such effectiveness.

SEC. 223. GRANTS.

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

(1) diagnostic and surveillance testing and reporting;

(2) community-based contact tracing efforts; and

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

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

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

(2) local health departments receive funding from State health departments or directly from the Centers for Disease Control and Prevention to contribute to such systems, as appropriate.

(c) ALLOCATIONS.—

(1) FORMULA.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall allocate amounts made available pursuant to subsection (a) in accordance with a formula to be established by the Secretary that provides a minimum level of funding to each State, local, Tribal, and territorial health department that

seeks a grant under this section and allocates additional funding based on the following prioritization:

(A) The Secretary shall give highest priority to applicants proposing to serve populations in one or more geographic regions with a high burden of COVID–19 based on data provided by the Centers for Disease Control and Prevention, or other sources as determined by the Secretary.

(B) The Secretary shall give second highest priority to applicants preparing for, or currently working to mitigate, a COVID–19 surge in a geographic region that does not yet have a high number of reported cases of COVID–19 based on data provided by the Centers for Disease Control and Prevention, or other sources as determined by the Secretary.

(C) The Secretary shall give third highest priority to applicants proposing to serve high numbers of low-income and uninsured populations, including 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 minorities, or geographically diverse areas, as determined by the Secretary.

(2) NOTIFICATION.—Not later than the date that is one week before first awarding grants under this section, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a notification detailing the formula established under paragraph (1) for allocating amounts made available pursuant to subsection (a).

(d) USE OF FUNDS.—A State, local, Tribal, and territorial health department receiving a grant under this section shall, to the extent possible, use the grant funds for the following activities, or other activities deemed appropriate by the Director of the Centers for Disease Control and Prevention:

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

(A) leverages or modernizes existing testing infrastructure and capacity;

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

(C) is coordinated with the State plan for COVID–19 testing prepared as required under the heading ''Department of Health and Human Services—Office of the Secretary—Public Health and Social Service Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139; 134 Stat. 620, 624);

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

(E) is informed by guidelines established by the Centers for Disease Control and Prevention for which populations should be tested;

(F) identifies how diagnostic and serological tests in such system shall be validated prior to use;

(G) identifies how diagnostic and serological tests and testing supplies will be distributed to implement such system;

(H) identifies specific strategies for ensuring testing capabilities and accessibility 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 profes-

sional 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;

(I) identifies how testing may be used, and results may be reported, in both health care settings (such as hospitals, laboratories for moderate or high-complexity testing, pharmacies, mobile testing units, and community health centers) and non-health care settings (such as workplaces, schools, childcare centers, or drive-throughs);

(J) allows for testing in sentinel surveillance programs, as appropriate; and

(K) supports the procurement and distribution of diagnostic and serological tests and testing supplies to meet the goals of the system.

(2) CONTACT TRACING.—To implement a coordinated contact tracing system that—

(A) leverages or modernizes existing contact tracing systems and capabilities, including community health workers, health departments, and Federally qualified health centers;

(B) is able to investigate cases of COVID–19, and help to identify other potential cases of COVID–19, through tracing contacts of individuals with positive diagnoses;

(C) establishes culturally competent and multilingual strategies for contact tracing, which may include consultation with and support for cultural or civic organizations with established ties to the community;

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

(E) enables State, local, Tribal, and territorial health departments to work with a nongovernmental, community partner or partners and State and local workforce development systems (as defined in section 3(67) of Workforce Innovation and Opportunity Act (29 U.S.C. 3102(67))) receiving grants under section 224(b) of this Act to hire and compensate a locally sourced contact tracing workforce, if necessary, to supplement the public health workforce, to—

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

cality, territorial, or Tribal health department to identify all cases of COVID–19 currently in the jurisdiction and those anticipated to emerge over the next 18 months in such jurisdiction;

(ii) outline qualifications necessary for contact tracers;

(iii) train the existing and newly hired public health workforce on best practices related to tracing close contacts of individuals diagnosed with COVID–19, including the protection of individual privacy and cybersecurity protection; and

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

(F) identifies the level of contact tracing needed within the State, locality, territory, or Tribal area to contain and mitigate the transmission of COVID–19;

(G) establishes statewide mechanisms to integrate regular evaluation to the Centers for Disease Control and Prevention regarding contact tracing efforts, makes such evaluation publicly 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

(E) identifies specific strategies for ensuring disease surveillance 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.

(4) CONTAINMENT AND MITIGATION.—To implement a coordinated containment and mitigation system that—

(A) leverages or modernizes existing containment and mitigation strategies within the respective State, local, Tribal, or territorial governments and national containment and mitigation strategies;

(B) may provide for, connect to, and leverage existing social services and support for individuals who have been infected with or exposed to COVID–19 and who are isolated or quarantined in their homes, such as through—

(i) food assistance programs;

(ii) guidance for household infection control;

(iii) information and assistance with childcare services; and

(iv) information and assistance pertaining to support available under the CARES Act (Public Law 116–136) and this Act;

(C) provides guidance on the establishment of safe, high-quality, facilities for the voluntary isolation of individuals infected with, or quarantine of the contacts of individuals exposed to COVID–19, where hospitalization is not required, which facilities should—

(i) be prohibited from making inquiries relating to the citizenship status of an individual isolated or quarantined; and

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

(I) have previously established relationships in localities;

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

(III) are fully integrated into State, local, Tribal, or territorial containment and mitigation efforts; and

(D) identifies specific strategies for ensuring containment and mitigation 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.

(e) REPORTING.—The Secretary shall facilitate mechanisms for timely, standardized reporting by grantees under this section regarding implementation of the systems established under this section and coordinated processes with the reporting as required and under the heading ''Department of Health and Human Services—Office of the Secretary—Public Health and Social Service Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139, 134 Stat. 620), including—

(1) a summary of county or local health department level information from the States receiving

funding, and information from directly funded localities, territories, and Tribal entities, about the activities that will be undertaken using funding awarded under this section, including subgrants;

(2) any anticipated shortages of required materials for testing for COVID–19 under subsection (a); and

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

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

(1) not later than 7 days after first awarding grants under this section, post in a searchable, electronic format a list of all awards made by the Secretary under this section, including the recipients and amounts of such awards; and

(2) update such list not less than every 7 days until all funds made available to carry out this section are expended.

SEC. 224. GRANTS TO STATE AND TRIBAL WORKFORCE AGENCIES.

(a) DEFINITIONS.—In this section:

(1) IN GENERAL.—Except as otherwise provided, the terms in this section have the meanings

given the terms in section 3 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3102).

(2) APPRENTICESHIP; APPRENTICESHIP PROGRAM.—The term ''apprenticeship'' or ''apprenticeship program'' means an apprenticeship program registered under the Act of August 16, 1937 (commonly known as the ''National Apprenticeship Act'') (50 Stat. 664, chapter 663; 29 U.S.C. 50 et seq.), including any requirement, standard, or rule promulgated under such Act, as such requirement, standard, or rule was in effect on December 30, 2019.

(3) CONTACT TRACING AND RELATED POSITIONS.—The term ''contact tracing and related positions'' means employment related to contact tracing, surveillance, containment, and mitigation activities as described in paragraphs (2), (3), and (4) of section 223(d).

(4) ELIGIBLE ENTITY.—The term ''eligible entity'' means—

(A) a State or territory, including the District of Columbia and Puerto Rico;

(B) an Indian Tribe, Tribal organization, Alaska Native entity, Indian-controlled organizations serving Indians, or Native Hawaiian organizations;

(C) an outlying area; or

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

(5) ELIGIBLE INDIVIDUAL.—Notwithstanding section 170(b)(2) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3225(b)(2)), the term ''eligible individual'' means an individual seeking or securing employment in contact tracing and related positions and served by an eligible entity or community-based organization receiving funding under this section.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Labor.

(b) GRANTS.—

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

rying out activities under subsections (f) and (d), respectively, for the following purposes:

(A) To support the recruitment, placement, and training, as applicable, of eligible individuals seeking employment in contact tracing and related positions in accordance with the national system for COVID–19 testing, contact tracing, surveillance, containment, and mitigation established under section 222.

(B) To assist with the employment transition to new employment or education and training of individuals employed under this section in preparation for and upon termination of such employment.

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

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

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

(c) GRANT APPLICATION.—An eligible entity applying for a grant under this section shall submit an application to the Secretary, at such time and in such form and

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

(1) how the eligible entity will support the recruitment, placement, and training, as applicable, of eligible individuals seeking employment in contact tracing and related positions by partnering with—

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

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

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

(A) the State plans referred to in the heading ''Public Health and Social Services Emergency Fund'' in title I of division B of the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139);

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

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

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

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

(A) plans for the recruitment of eligible individuals to serve as contact tracers and related positions, including dislocated workers, individuals with barriers to employment, veterans, new entrants in the workforce, or underemployed or furloughed workers, who are from or reside in or near the local area in which they will serve, and who, to the extent practicable—

(i) have experience or a background in industry-sectors and occupations such as public health, social services, customer service, case management, or occupations that require related qualifications, skills, or competencies, such as strong interpersonal and communication skills, needed for contact tracing and related positions, as described in section 223(d)(2)(E)(ii); or

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

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

(B) how such strategies will take into account the diversity of such community, including racial, ethnic, socioeconomic, linguistic, or geographic diversity;

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

(5) for eligible entities described in subparagraphs (A) through (C) of subsection (a)(4), a description of how the eligible entity will ensure the equitable distribution of funds with respect to—

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

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

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

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

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

would serve the equitable distribution of funds as described in paragraph (5).

(d) SUBGRANT AUTHORIZATION AND APPLICATION PROCESS.—

(1) IN GENERAL.—An eligible entity may award a subgrant to one or more community-based organizations for the purposes of partnering with a State or local board to conduct outreach and education activities to inform potentially eligible individuals about employment opportunities in contact tracing and related positions.

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

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

(B) a demonstration of the community-based organization's expertise in providing employment or public health information to the local areas in which such organization plans to serve; and

(C) a description of the expertise of the community-based organization in utilizing culturally competent and multilingual strategies in the provision of services.

(e) GRANT DISTRIBUTION.—

(1) FEDERAL DISTRIBUTION.—

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

(i) Subject to clause (ii), the Secretary shall distribute funds among eligible entities in accordance with a formula to be established by the Secretary that provides a minimum level of funding to each eligible entity that seeks a grant under this section and allocates additional funding as follows:

(I) The formula shall give first priority based on the number and proportion of contact tracing and related positions that the State plans to recruit, place, and train individuals as a part of the State strategy described in subsection (c)(2)(A).

(II) Subject to subclause (I), the formula shall give priority in accordance with section 223(c).

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

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

(2) ELIGIBLE ENTITY USE OF FUNDS.—An eligible entity described in subparagraphs (A) through (C) of subsection (a)(4)—

(A) shall, not later than 30 days after the date on which the entity receives grant funds under this section, provide not less than 70 percent of grant funds to local boards for the purpose of carrying out activities in subsection (f);

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

reach, to potential eligible individuals, as described in subsection (d);

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

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

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

(A) not less than 60 percent of the funds for recruitment and training for COVID–19 testing, contact tracing, surveillance, containment, and mitigation established under section 222;

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

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

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

(1) Establishing or expanding partnerships with—

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

(B) community-based health providers, including community health centers and rural health clinics;

(C) labor organizations or joint labor management organizations;

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

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

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

(2) Providing training for contact tracing and related positions in coordination with State, local, Tribal, or territorial health departments that is consistent with the State or territorial testing and contact tracing strategy, and ensuring that eligible individuals receive compensation while participating in such training.

(3) Providing eligible individuals with—

(A) adequate and safe equipment, environments, and facilities for training and supervision, as applicable;

(B) information regarding the wages and benefits related to contact tracing and related positions, as compared to State, local, and national averages;

(C) supplies and equipment needed by the eligible individuals to support placement of an individual in contact tracing and related positions, as applicable;

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

(i) in coordination with the entity employing the eligible individual in a contact tracing and related positions; and

(ii) which shall include providing a case manager to work with each eligible individual to develop the plan, which may include—

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

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

(E) services for the period during which the eligible individual is employed in a contact tracing and related position to ensure job retention, which may include—

(i) supportive services throughout the term of employment;

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

collaboration with the employers of such individuals;

(iii) mentorship services and job retention support for eligible individuals; or

(iv) targeted training for managers and workers working with eligible individuals (such as mentors), and human resource representatives.

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

(A) any additional training and employment activities as described in section 170(d)(4) of the Workforce Innovation and Opportunity Act (29 U.S.C. 3225(d)(4));

(B) developing the appropriate combination of services to enable the eligible individual to achieve the employment and career goals identified under paragraph (3)(D)(ii)(I); and

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

contact tracing and related positions, as appropriate.

(5) Any other activities as described in subsections (a)(3) and (b) of section 134 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3174).

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

(h) REPORTING BY THE DEPARTMENT OF LABOR.—

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

(A) the number of eligible individuals recruited, hired, and trained in contact tracing and related positions;

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

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

(D) the performance of each program supported by funds under this subtitle with respect to the indicators of performance under section 116 of the Workforce Innovation and Opportunity Act (29 U.S.C. 3141), as applicable;

(E) the number of individuals in unsubsidized employment within six months and 1 year, respectively, of the conclusion of employment in contact tracing and related positions and, of those, the number of individuals within a State, territorial, or local public health department in an occupation related to public health;

(F) any information on how eligible entities, local boards, or community-based organizations that received funding under this subsection were able to support the goals of the na-

tional system for COVID–19 testing, contact tracing, surveillance, containment, and mitigation established under section 222 of this Act; and

(G) best practices for improving and increasing the transition of individuals employed in contract tracing and related positions to unsubsidized employment.

(2) DISAGGREGATION.—All data reported under paragraph (1) shall be disaggregated by race, ethnicity, sex, age, and, with respect to individuals with barriers to employment, subpopulation of such individuals, except for when the number of participants in a category is insufficient to yield statistically reliable information or when the results would reveal personally identifiable information about an individual participant.

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

velopment, implementation, or administration, of an apprenticeship or an apprenticeship program.

(j) INFORMATION SHARING REQUIREMENT FOR HHS.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall provide the Secretary of Labor, acting through the Assistant Secretary of the Employment and Training Administration, with information on grants under section 223, including—

(1) the formula used to award such grants to State, local, Tribal, and territorial health departments;

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

(3) the geographic areas served by eligible entities that receive such grants; and

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

(k) AUTHORIZATION OF APPROPRIATIONS.—Of the amounts appropriated to carry out this subtitle, $500,000,000 shall be used by the Secretary of Labor to 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-

gard to the requirements of section 1902(a)(10)(B) (relating to comparability), in the case of an individual who is diagnosed with or presumed to have COVID–19, during such portion of such emergency period during which such individual is infected (or presumed infected) with COVID–19, the treatment of a condition that may complicate the treatment of COVID–19;''.

(2) PROHIBITION OF COST SHARING.—

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

(i) in subparagraph (F), by striking ''or'' at the end;

(ii) in subparagraph (G), by striking ''; and'' and inserting ''; ''; and

(iii) by adding at the end the following subparagraphs:

''(H) during the portion of the emergency period described in paragraph (1)(B) of section 1135(g) beginning on the date of the enactment of this subparagraph, a COVID–19 vaccine licensed under section 351 of the Public Health Service Act, or approved or authorized under

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

''(I) during such portion of the emergency period described in paragraph (1)(B) of section 1135(g), any item or service furnished for the treatment of COVID–19, including drugs approved or authorized under such section 505 or such section 564 or, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the portion of such emergency period during which such individual is infected (or presumed infected) with COVID–19, the treatment of a condition that may complicate the treatment of COVID–19; and''.

(B) APPLICATION TO ALTERNATIVE COST SHARING.—Section 1916A(b)(3)(B) of the Social Security Act (42 U.S.C. 1396o–1(b)(3)(B)) is amended—

(i) in clause (xi), by striking ''any visit'' and inserting ''any service''; and

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

''(xii) During the portion of the emergency period described in paragraph (1)(B)

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

''(xiii) During such portion of the emergency period described in paragraph (1)(B) of section 1135(g), an item or service furnished for the treatment of COVID–19, including drugs approved or authorized under such section 505 or such section 564 or, in the case of an individual who is diagnosed with or presumed to have COVID–19, during such portion of such emergency period during which such individual is infected (or presumed infected) with COVID–19, the treatment of a condition that may complicate the treatment of COVID–19.''.

(C) CLARIFICATION.—The amendments made by this subsection shall apply with respect to a State plan of a territory in the same manner as a State plan of one of the 50 States.

(b) STATE PEDIATRIC VACCINE DISTRIBUTION PROGRAM.—Section 1928 of the Social Security Act (42 U.S.C. 1396s) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking ''; and'' and inserting a semicolon;

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

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

''(C) during the portion of the emergency period described in paragraph (1)(B) of section 1135(g) beginning on the date of the enactment of this subparagraph, each vaccine-eligible child (as defined in subsection (b)) is entitled to receive a COVID–19 vaccine from a program-registered provider (as defined in subsection (h)(7)) without charge for—

''(i) the cost of such vaccine; or

''(ii) the administration of such vaccine.'';

(2) in subsection (c)(2)—

(A) in subparagraph (C)(ii), by inserting '', but, 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, may not impose a fee for the administration of a COVID–19 vaccine'' before the period; and

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

''(D) The provider will provide and administer an approved COVID–19 vaccine to a vaccine-eligible child in accordance with the same requirements as apply under the preceding subparagraphs to the provision and administration of a qualified pediatric vaccine to such a child.''; and

(3) in subsection (d)(1), in the first sentence, by inserting '', including, 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, with respect to a COVID–19 vaccine licensed under section 351 of the Public Health Service Act, or approved or authorized under section 505 or 564 of the Federal Food, Drug, and Cosmetic Act'' before the period.

(c) CHIP.—

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

''(11) COVERAGE OF COVID–19 VACCINES AND TREATMENT.—Regardless of the type of coverage elected by a State under subsection (a), child health assistance provided under such coverage for targeted low-income children and, in the case that the State elects to provide pregnancy-related assistance under such coverage pursuant to section 2112, such pregnancy-related assistance for targeted low-income pregnant women (as defined in section 2112(d)) shall include coverage, during the portion of the emergency period described in paragraph (1)(B) of section 1135(g) beginning on the date of the enactment of this paragraph, of—

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

''(B) any item or service furnished for the treatment of COVID–19, including drugs approved or authorized under such section 505 or

such section 564, or, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the portion of such emergency period during which such individual is infected (or presumed infected) with COVID–19, the treatment of a condition that may complicate the treatment of COVID–19.''.

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

(A) in the paragraph header, by inserting ''A COVID–19 VACCINE, COVID–19 TREATMENT,'' before ''OR PREGNANCY-RELATED ASSISTANCE''; and

(B) by striking ''visits described in section 1916(a)(2)(G), or'' and inserting ''services described in section 1916(a)(2)(G), vaccines described in section 1916(a)(2)(H) administered 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, items or services described in sec-

tion 1916(a)(2)(I) furnished during such emergency period, or''.

(d) CONFORMING AMENDMENTS.—Section 1937 of the Social Security Act (42 U.S.C. 1396u–7) is amended—

(1) in subsection (a)(1)(B), by inserting '', under subclause (XXIII) of section 1902(a)(10)(A)(ii),'' after ''section 1902(a)(10)(A)(i)''; and

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

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

SEC. 302. OPTIONAL COVERAGE AT NO COST SHARING OF COVID–19 TREATMENT AND VACCINES UNDER MEDICAID FOR UNINSURED INDIVIDUALS.

(a) IN GENERAL.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended, in the matter following subparagraph (G), by striking ''and any visit described in section 1916(a)(2)(G)'' and inserting the following: '', any COVID–19 vaccine that is administered during any such portion (and the administration of such vaccine), any item or service that is furnished during any such portion for the treatment of COVID–19, including drugs approved or authorized under section 505 or 564 of the Federal Food, Drug, and Cosmetic Act, or, in the case of an individual who is diagnosed with or presumed to have COVID–19, during the period such individual is infected (or presumed infected) with COVID–19, the treatment of a condition that may complicate the treatment of COVID–19, and any services described in section 1916(a)(2)(G)''.

(b) DEFINITION OF UNINSURED INDIVIDUAL.—

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

''(ss) UNINSURED INDIVIDUAL DEFINED.—For purposes of this section, the term 'uninsured individual' means, notwithstanding any other provision of this title,

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

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

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

''For purposes of subparagraph (A), care and services described in such subparagraph include any in vitro diagnostic product described in section 1905(a)(3)(B) (and the administration of such product), any COVID–19 vaccine (and the administration of such vaccine), any item or service that is furnished for the treatment of COVID–19, including drugs approved or authorized under section 505 or 564 of the Federal Food, Drug, and Cosmetic Act, or a condition that may complicate the treatment of COVID–19, and any services described in section 1916(a)(2)(G).''.

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

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

''Such term includes any indication that an alien described in paragraph (1) may have contracted COVID–19.''.

SEC. 303. COVERAGE OF TREATMENTS FOR COVID–19 AT NO COST SHARING UNDER THE MEDICARE ADVANTAGE PROGRAM.

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

''(vii) SPECIAL COVERAGE RULES FOR SPECIFIED COVID–19 TREATMENT SERVICES.—Notwithstanding clause (i), in the case of a specified COVID–19 treatment service (as defined in section 30201(b) of The Heroes Act) that is furnished during a plan year occurring during any portion of the emergency period defined in section 1135(g)(1)(B) beginning on or after the date of the enactment of this clause, a Medicare Advantage plan may not, with respect to such service, impose—

''(I) any cost-sharing requirement (including a deductible, copay-

ment, or coinsurance requirement); and

"(II) in the case such service is a critical specified COVID–19 treatment service (including ventilator services and intensive care unit services), 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 IMPOSITION OF COST SHARING OR UTILIZATION MANAGEMENT REQUIREMENTS, OF DRUGS INTENDED TO TREAT COVID–19 DURING CERTAIN EMERGENCIES.

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

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

"(I) REQUIRED INCLUSION OF DRUGS INTENDED TO TREAT COVID–19.—

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

"(I) include in any formulary—

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

"(bb) all drugs authorized under section 564 or 564A of the Federal Food, Drug, and Cosmetic Act to treat COVID–19; and

"(II) not impose any prior authorization or other utilization management requirement with respect to

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

"(ii) PERIOD DESCRIBED.—For purposes of clause (i), the period described in this clause is the period during which there exists the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act on January 31, 2020, entitled 'Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus' (including any renewal of such declaration pursuant to such section).".

(b) ELIMINATION OF COST SHARING.—

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

(A) in subsection (b)—

(i) in paragraph (1)(A), by striking ''The coverage'' and inserting ''Subject to paragraph (8), the coverage'';

(ii) in paragraph (2)—

(I) in subparagraph (A), by inserting after ''Subject to subparagraphs (C) and (D)'' the following: ''and paragraph (8)'';

(II) in subparagraph (C)(i), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (8)''; and

(III) in subparagraph (D)(i), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (8)'';

(iii) in paragraph (4)(A)(i), by striking ''The coverage'' and inserting ''Subject to paragraph (8), the coverage''; and

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

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

curs during the period during which there exists the public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act on January 31, 2020, entitled 'Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus' (including any renewal of such declaration pursuant to such section).''; and

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

''(4) SAME ELIMINATION OF COST SHARING FOR DRUGS INTENDED TO TREAT COVID–19.—The coverage is in accordance with subsection (b)(8).''.

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

(A) in paragraph (1)—

(i) in subparagraph (D)—

(I) in clause (ii), by striking ''In the case of'' and inserting ''Subject to subparagraph (F), in the case of''; and

(II) in clause (iii), by striking ''In the case of'' and inserting ''Subject to subparagraph (F), in the case of''; and

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

''(F) ELIMINATION OF COST SHARING FOR DRUGS INTENDED TO TREAT COVID–19.—Coverage that is in accordance with section 1860D–2(b)(8).''; and

(B) in paragraph (2)—

(i) in subparagraph (B), by striking ''A reduction'' and inserting ''Subject to subparagraph (F), a reduction'';

(ii) in subparagraph (D), by striking ''The substitution'' and inserting ''Subject to subparagraph (F), the substitution'';

(iii) in subparagraph (E), by inserting after ''Subject to'' the following: ''subparagraph (F) and''; and

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

''(F) ELIMINATION OF COST SHARING FOR DRUGS INTENDED TO TREAT COVID–19.—Cov-

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

(c) 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. 305. COVERAGE OF COVID–19 RELATED TREATMENT AT NO COST SHARING.

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

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

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

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

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

(B) Health care providers have taken appropriate steps under the circumstances to make a diagnosis, or confirm whether a diagnosis was made, with respect to such individual, for COVID–19, if possible.

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

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

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

(2) such items and services shall include all items or services that are relevant to the treatment or mitigation of COVID–19, regardless of whether such items or services are ordinarily covered under the terms of a group health plan or group or individual health insurance coverage offered by a health insurance issuer.

(c) ENFORCEMENT.—

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

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

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

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

(e) TERMS.—The terms ''group health plan'', ''health insurance issuer'', ''group health insurance coverage'', and ''individual health insurance coverage'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code of 1986, as applicable.

SEC. 306. REIMBURSEMENT FOR ADDITIONAL HEALTH SERVICES RELATING TO CORONAVIRUS.

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

treatment related to SARS–CoV–2 or COVID–19 for uninsured individuals'' after ''or visits described in paragraph (2) of such section for uninsured individuals''.

TITLE IV—FEDERAL HEALTH EQUITY OVERSIGHT

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

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish an interagency task force, to be known as the ''COVID–19 Racial and Ethnic Disparities Task Force'' (referred to in this section as the ''task force''), to gather data about disproportionately affected communities and provide recommendations to combat the racial and ethnic disparities in the COVID–19 response throughout the United States and in response to future public health crises.

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

(1) The Secretary of Health and Human Services.

(2) The Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

(3) The Assistant Secretary for Preparedness and Response of the Department of Health and Human Services.

(4) The Director of the Centers for Disease Control and Prevention.

(5) The Director of the National Institutes of Health.

(6) The Commissioner of Food and Drugs.

(7) The Administrator of the Federal Emergency Management Agency.

(8) The Director of the National Institute on Minority Health and Health Disparities.

(9) The Director of the Indian Health Service.

(10) The Administrator of the Centers for Medicare & Medicaid Services.

(11) The Director of the Agency for Healthcare Research and Quality.

(12) The Surgeon General.

(13) The Administrator of the Health Resources and Services Administration.

(14) The Director of the Office of Minority Health.

(15) The Secretary of Housing and Urban Development.

(16) The Secretary of Education.

(17) The Secretary of Labor.

(18) The Secretary of Defense.

(19) The Secretary of Transportation.

(20) The Secretary of the Treasury.

(21) The Administrator of the Small Business Administration.

(22) The Administrator of the Environmental Protection Agency.

(23) Five health care professionals with expertise in addressing racial and ethnic disparities, with at least one representative from a rural area, to be appointed by the Secretary.

(24) Five policy experts specializing in addressing racial and ethnic disparities in education or racial and ethnic economic inequality to be appointed by the Secretary.

(25) Six representatives from community-based organizations specializing in providing culturally competent care or services and addressing racial and ethnic disparities, to be appointed by the Secretary, with at least one representative from an urban Indian organization and one representative from a national organization that represents Tribal governments with expertise in Tribal public health.

(26) Six State, local, territorial, or Tribal public health officials representing departments of public health, who shall represent jurisdictions from different regions of the United States with relatively high concentrations of historically marginalized populations, to be appointed by the Secretary, with at least one territorial representative and one representative of a Tribal public health department.

(c) ADMINISTRATIVE PROVISIONS.—

(1) APPOINTMENT OF NON-GOVERNMENT MEMBERS.—Notwithstanding any other provision of law, the Secretary shall appoint all non-government members of the task force within 30 days of the date enactment of this section.

(2) CHAIRPERSON.—The Secretary shall serve as the chairperson of the task force. The Director of the Office of Minority Health shall serve as the vice chairperson.

(3) STAFF.—The task force shall have 10 full-time staff members.

(4) MEETINGS.—Not later than 45 days after the date of enactment of this section, the full task force shall have its first meeting. The task force shall convene at least once a month thereafter.

(5) SUBCOMMITTEES.—The chairperson and vice chairperson of the task force are authorized to establish subcommittees to consider specific issues related to the broader mission of addressing racial and ethnic disparities.

(d) FEDERAL EMERGENCY MANAGEMENT AGENCY RESOURCE ALLOCATION REPORTING AND RECOMMENDATIONS.—

(1) WEEKLY REPORTS.—Not later than 7 days after the task force first meets, and weekly thereafter, the task force shall submit to Congress and the Federal Emergency Management Agency a report that includes—

(A) a description of COVID–19 patient outcomes, including cases, hospitalizations, patients on ventilation, and mortality, disaggregated by race and ethnicity (where such data is missing, the task force shall utilize appropriate authorities to improve data collection);

(B) the identification of communities that lack resources to combat the COVID–19 pandemic, including personal protective equipment, ventilators, hospital beds, testing kits, testing supplies, vaccinations (when available), re-

sources to conduct surveillance and contact tracing, funding, staffing, and other resources the task force deems essential as needs arise;

(C) the identification of communities where racial and ethnic disparities in COVID–19 infection, hospitalization, and death rates are out of proportion to the community's population by a certain threshold, to be determined by the task force based on available public health data;

(D) recommendations about how to best allocate critical COVID–19 resources to—

(i) communities with disproportionately high COVID–19 infection, hospitalization, and death rates; and

(ii) communities identified in subparagraph (C);

(E) with respect to communities that are able to reduce racial and ethnic disparities effectively, a description of best practices involved; and

(F) an update with respect to the response of the Federal Emergency Management Agency to the task force's previous weeks' recommendations under this section.

(2) GENERAL CONSULTATION.—In submitting weekly reports and recommendations under this subsection, the task force shall consult with and notify State, local, territorial, and Tribal officials and community-based organizations from communities identified as disproportionately impacted by COVID–19.

(3) CONSULTATION WITH INDIAN TRIBES.—In submitting weekly reports and recommendations under this subsection, the Director of Indian Health Service shall, in coordination with the task force, consult with Indian Tribes and Tribal organizations that are disproportionately affected by COVID–19 on a government to government basis to identify specific needs and recommendations.

(4) DISSEMINATION.—Reports under this subsection shall be disseminated to all relevant stakeholders, including State, local, territorial, and Tribal officials, and public health departments.

(5) TRIBAL DATA.—The task force, in consultation with Indian Tribes and Tribal organizations, shall ensure that an Indian Tribe consents to any public reporting of health data.

(e) COVID–19 RELIEF OVERSIGHT AND IMPLEMENTATION REPORTS.—Not later than 14 days after the task force first meets, and not later than every 14 days there-

after, the task force shall submit to Congress and the relevant Federal agencies a report that includes—

(1) an examination of funds distributed under COVID–19-related relief and stimulus laws (enacted prior to and after the date of enactment of this Act), including the Coronavirus Preparedness and Response Emergency Supplemental Appropriations Act, 2020 (Public Law 116–123), the Families First Coronavirus Response Act (Public Law 116–127), the Coronavirus Aid, Relief, and Economic Security Act (Public Law 116–136), and the Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139), and how that distribution impacted racial and ethnic disparities with respect to the COVID–19 pandemic; and

(2) recommendations to relevant Federal agencies about how to disburse any undisbursed funding from COVID–19-related relief and stimulus laws (enacted prior to and after the date of enactment of this Act), including those laws described in paragraph (1), to address racial and ethnic disparities with respect to the COVID–19 pandemic, including recommendations to—

(A) the Department of Health and Human Services about disbursement of funds under the

Public Health and Social Service Emergency Fund;

(B) the Small Business Administration about disbursement of funds under the Paycheck Protection Program and the Economic Injury Disaster Loan Program; and

(C) the Department of Education about disbursement of funds under the Education Stabilization Fund.

(f) FINAL COVID–19 REPORTS.—Not later than 90 days after the date on which the President declares the end of the COVID–19 public health emergency first declared by the Secretary on January 31, 2020, the task force shall submit to Congress a report that—

(1) describes inequities within the health care system, implicit bias, structural racism, and social determinants of health (including housing, nutrition, education, economic, and environmental factors) that contributed to racial and ethnic health disparities with respect to the COVID–19 pandemic and how these factors contributed to such disparities;

(2) examines the initial Federal response to the COVID–19 pandemic and its impact on the racial and ethnic disparities in COVID–19 infection, hospitalization, and death rates; and

(3) contains recommendations to combat racial and ethnic disparities in future infectious disease responses, including future COVID–19 outbreaks.

(g) SUNSET AND SUCCESSOR TASK FORCE.—

(1) SUNSET.—The task force shall terminate on the date that is 90 days after the date on which the President declares the end of the COVID–19 public health emergency first declared by the Secretary on January 31, 2020.

(2) SUCCESSOR.—Upon the termination of the task force under paragraph (1), the Secretary shall establish a permanent Infectious Disease Racial and Ethnic Disparities Task Force based on the membership, convening, and reporting requirements recommended by the task force in reports submitted under this section.

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

SEC. 402. PROTECTION OF THE HHS OFFICES OF MINORITY HEALTH.

(a) IN GENERAL.—Pursuant to section 1707A of the Public Health Service Act (42 U.S.C. 300u–6a), the Offices of Minority Health established within the Centers for Disease Control and Prevention, the Health Resources

and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services, are offices that, regardless of change in the structure of the Department of Health and Human Services, shall report to the Secretary of Health and Human Services.

(b) SENSE OF CONGRESS.—It is the sense of the Congress that any effort to eliminate or consolidate such Offices of Minority Health undermines the progress achieved so far.

SEC. 403. ESTABLISH AN INTERAGENCY COUNSEL AND GRANT PROGRAMS ON SOCIAL DETERMINANTS OF HEALTH.

(a) SHORT TITLE.—This section may be cited as the ''Social Determinants Accelerator Act of 2020''.

(b) FINDINGS; PURPOSES.—

(1) FINDINGS.—Congress finds the following:

(A) There is a significant body of evidence showing that economic and social conditions have a powerful impact on individual and population health outcomes, including health disparities associated with public health emergencies, and well-being, as well as medical costs.

(B) State, local, and Tribal governments and the service delivery partners of such governments face significant challenges in coordinating benefits and services delivered through the Medicaid program and other social services programs because of the fragmented and complex nature of Federal and State funding and administrative requirements.

(C) The Federal Government should prioritize and proactively assist State and local governments to strengthen the capacity of State and local governments to improve health and social outcomes for individuals, thereby improving cost-effectiveness and return on investment.

(2) PURPOSES.—The purposes of this Act are as follows:

(A) To establish effective, coordinated Federal technical assistance to help State and local governments to improve outcomes and cost-effectiveness of, and return on investment from, health and social services programs.

(B) To build a pipeline of State and locally designed, cross-sector interventions and strategies that generate rigorous evidence about how to improve health and social outcomes, and in-

crease the cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal health and social services programs.

(C) To enlist State and local governments and the service providers of such governments as partners in identifying Federal statutory, regulatory, and administrative challenges in improving the health and social outcomes of, cost-effectiveness of, and return on investment from, Federal spending on individuals enrolled in Medicaid.

(D) To develop strategies to improve health and social outcomes without denying services to, or restricting the eligibility of, vulnerable populations.

(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.

(ii) RESPONSIBILITIES.—An employee described in this clause shall be a senior employee of the agency—

(I) whose responsibilities relate to authorities, policies, and procedures with respect to the health and well-being of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

(II) who has authority to implement and evaluate transformative initiatives that harness data or conducts rigorous evaluation to improve the impact and cost-effectiveness of federally funded services and benefits.

(C) HHS REPRESENTATION.—In addition to the designees under subparagraph (A), the Council shall include designees from at least three agencies within the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, at least one of whom shall meet the criteria under this section.

(D) OMB ROLE.—The Director of the Office of Management and Budget shall facilitate the timely resolution of Governmentwide and multiagency issues to help the Council achieve consensus recommendations described under this section.

(E) NON-FEDERAL COMPOSITION.—The Comptroller General of the United States may designate up to 6 Council designees—

(i) who have relevant subject matter expertise, including expertise implementing and evaluating transformative initiatives that harness data and conduct evaluations to improve the impact and cost-effectiveness of Federal Government services; and

(ii) that each represent—

(I) State, local, and Tribal health and human services agencies;

(II) public housing authorities or State housing finance agencies;

(III) State and local government budget offices;

(IV) State Medicaid agencies; or

(V) national consumer advocacy organizations.

(F) CHAIR.—

(i) IN GENERAL.—The Secretary shall select the Chair of the Council from among the members of the Council.

(ii) INITIATING GUIDANCE.—The Chair, on behalf of the Council, shall identify and invite individuals from diverse entities to provide the Council with advice and information pertaining to addressing social determinants of health, including—

(I) individuals from State and local government health and human services agencies;

(II) individuals from State Medicaid agencies;

(III) individuals from State and local government budget offices;

(IV) individuals from public housing authorities or State housing finance agencies;

(V) individuals from nonprofit organizations, small businesses, and philanthropic organizations;

(VI) advocates;

(VII) researchers; and

(VIII) any other individuals the Chair determines to be appropriate.

(3) DUTIES.—The duties of the Council are—

(A) to make recommendations to the Secretary and the Administrator regarding the criteria for making awards under this section;

(B) to identify Federal authorities and opportunities for use by States or local governments to improve coordination of funding and administration of Federal programs, the beneficiaries of whom include individuals, and which may be unknown or underutilized and to make information on such authorities and opportunities publicly available;

(C) to provide targeted technical assistance to States developing a social determinants accelerator plan under this section, including identifying potential statutory or regulatory pathways for implementation of the plan and assisting in identifying potential sources of funding to implement the plan;

(D) to report to Congress annually on the subjects set forth in this section;

(E) to develop and disseminate evaluation guidelines and standards that can be used to

reliably assess the impact of an intervention or approach that may be implemented pursuant to this Act on outcomes, cost-effectiveness of, and return on investment from Federal, State, local, and Tribal governments, and to facilitate technical assistance, where needed, to help to improve State and local evaluation designs and implementation;

(F) to seek feedback from State, local, and Tribal governments, including through an annual survey by an independent third party, on how to improve the technical assistance the Council provides to better equip State, local, and Tribal governments to coordinate health and social service programs;

(G) to solicit applications for grants under this section; and

(H) to coordinate with other cross-agency initiatives focused on improving the health and well-being of low-income and at-risk populations in order to prevent unnecessary duplication between agency initiatives.

(4) SCHEDULE.—Not later than 60 days after the date of the enactment of this Act, the Council shall convene to develop a schedule and plan for car-

rying out the duties described in this section, including solicitation of applications for the grants under this section.

(5) REPORT TO CONGRESS.—The Council shall submit an annual report to Congress, which shall include—

(A) a list of the Council members;

(B) activities and expenditures of the Council;

(C) summaries of the interventions and approaches that will be supported by State, local, and Tribal governments that received a grant under this section, including—

(i) the best practices and evidence-based approaches such governments plan to employ to achieve the purposes listed in this section; and

(ii) a description of how the practices and approaches will impact the outcomes, cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal governments with respect to such purposes;

(D) the feedback received from State and local governments on ways to improve the tech-

nical assistance of the Council, including findings from a third-party survey and actions the Council plans to take in response to such feedback; and

(E) the major statutory, regulatory, and administrative challenges identified by State, local, and Tribal governments that received a grant under subsection (d), and the actions that Federal agencies are taking to address such challenges.

(6) FACA APPLICABILITY.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

(7) COUNCIL PROCEDURES.—The Secretary, in consultation with the Comptroller General of the United States and the Director of the Office of Management and Budget, shall establish procedures for the Council to—

(A) ensure that adequate resources are available to effectively execute the responsibilities of the Council;

(B) effectively coordinate with other relevant advisory bodies and working groups to avoid unnecessary duplication;

(C) create transparency to the public and Congress with regard to Council membership, costs, and activities, including through use of modern technology and social media to disseminate information; and

(D) avoid conflicts of interest that would jeopardize the ability of the Council to make decisions and provide recommendations.

(d) SOCIAL DETERMINANTS ACCELERATOR GRANTS TO STATES OR LOCAL GOVERNMENTS.—

(1) GRANTS TO STATES, LOCAL GOVERNMENTS, AND TRIBES.—Not later than 180 days after the date of the enactment of this Act, the Administrator, in consultation with the Secretary and the Council, shall award on a competitive basis not more than 25 grants to eligible applicants described in this section, for the development of social determinants accelerator plans, as described in this section.

(2) ELIGIBLE APPLICANT.—An eligible applicant described in this section is a State, local, or Tribal health or human services agency that—

(A) demonstrates the support of relevant parties across relevant State, local, or Tribal jurisdictions; and

(B) in the case of an applicant that is a local government agency, provides to the Secretary a letter of support from the lead State health or human services agency for the State in which the local government is located.

(3) AMOUNT OF GRANT.—The Administrator, in coordination with the Council, shall determine the total amount that the Administrator will make available to each grantee under this section.

(4) APPLICATION.—An eligible applicant seeking a grant under this section shall include in the application the following information:

(A) The target population (or populations) that would benefit from implementation of the social determinants accelerator plan proposed to be developed by the applicant.

(B) A description of the objective or objectives and outcome goals of such proposed plan, which shall include at least one health outcome and at least one other important social outcome.

(C) The sources and scope of inefficiencies that, if addressed by the plan, could result in improved cost-effectiveness of or return on in-

vestment from Federal, State, local, and Tribal governments.

(D) A description of potential interventions that could be designed or enabled using such proposed plan.

(E) The State, local, Tribal, academic, nonprofit, community-based organizations, and other private sector partners that would participate in the development of the proposed plan and subsequent implementation of programs or initiatives included in such proposed plan.

(F) Such other information as the Administrator, in consultation with the Secretary and the Council, determines necessary to achieve the purposes of this Act.

(5) USE OF FUNDS.—A recipient of a grant under this section may use funds received through the grant for the following purposes:

(A) To convene and coordinate with relevant government entities and other stakeholders across sectors to assist in the development of a social determinant accelerator plan.

(B) To identify populations of individuals receiving medical assistance under a State plan (or a waiver of such plan) under title XIX of

the Social Security Act (42 U.S.C. 1396 et seq.) who may benefit from the proposed approaches to improving the health and well-being of such individuals through the implementation of the proposed social determinants accelerator plan.

(C) To engage qualified research experts to advise on relevant research and to design a proposed evaluation plan, in accordance with the standards and guidelines issued by the Administrator.

(D) To collaborate with the Council to support the development of social determinants accelerator plans.

(E) To prepare and submit a final social determinants accelerator plan to the Council.

(6) CONTENTS OF PLANS.—A social determinant accelerator plan developed under this section shall include the following:

(A) A description of the target population (or populations) that would benefit from implementation of the social determinants accelerator plan, including an analysis describing the projected impact on the well-being of individuals described in paragraph (5)(B).

(B) A description of the interventions or approaches designed under the social determinants accelerator plan and the evidence for selecting such interventions or approaches.

(C) The objectives and outcome goals of such interventions or approaches, including at least one health outcome and at least one other important social outcome.

(D) A plan for accessing and linking relevant data to enable coordinated benefits and services for the jurisdictions described in this section and an evaluation of the proposed interventions and approaches.

(E) A description of the State, local, Tribal, academic, nonprofit, or community-based organizations, or any other private sector organizations that would participate in implementing the proposed interventions or approaches, and the role each would play to contribute to the success of the proposed interventions or approaches.

(F) The identification of the funding sources that would be used to finance the proposed interventions or approaches.

(G) A description of any financial incentives that may be provided, including outcome-focused contracting approaches to encourage service providers and other partners to improve outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, or Tribal government spending.

(H) The identification of the applicable Federal, State, local, or Tribal statutory and regulatory authorities, including waiver authorities, to be leveraged to implement the proposed interventions or approaches.

(I) A description of potential considerations that would enhance the impact, scalability, or sustainability of the proposed interventions or approaches and the actions the grant awardee would take to address such considerations.

(J) A proposed evaluation plan, to be carried out by an independent evaluator, to measure the impact of the proposed interventions or approaches on the outcomes of, cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal governments.

(K) Precautions for ensuring that vulnerable populations will not be denied access to Medicaid or other essential services as a result of implementing the proposed plan.

(e) FUNDING.—

(1) IN GENERAL.—Out of any money in the Treasury not otherwise appropriated, there is appropriated to carry out this Act $25,000,000, of which up to $5,000,000 may be used to carry out this Act, to remain available for obligation until the date that is 5 years after the date of enactment of this Act.

(2) RESERVATION OF FUNDS.—

(A) IN GENERAL.—Of the funds made available under paragraph (1), the Secretary shall reserve not less than 20 percent to award grants to eligible applicants for the development of social determinants accelerator plans under this section intended to serve rural populations.

(B) EXCEPTION.—In the case of a fiscal year for which the Secretary determines that there are not sufficient eligible applicants to award up to 25 grants under section 4 that are intended to serve rural populations and the Secretary cannot satisfy the 20-percent requirement, the Secretary may reserve an amount

that is less than 20 percent of amounts made available under paragraph (1) to award grants for such purpose.

(3) RULE OF CONSTRUCTION.—Nothing in this Act shall prevent Federal agencies represented on the Council from contributing additional funding from other sources to support activities to improve the effectiveness of the Council.

SEC. 404. ACCOUNTABILITY AND TRANSPARENCY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Title XXXIV of the Public Health Service Act is amended by inserting after subtitle C the following:

"Subtitle D—Strengthening Accountability

"SEC. 3441. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.

"(a) IN GENERAL.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.

"(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities that receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, including through the following activities:

''(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled 'Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity' (September 1999) in conjunction with the reports by the National Academy of Sciences (formerly known as the Institute of Medicine) entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', 'Crossing the Quality Chasm: A New Health System for the 21st Century', 'In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce', 'The National Partnership for Action to End Health Disparities', and 'The Health of Lesbian, Gay, Bisexual, and Transgender People', and other related reports by the National Academy of Sciences. This plan shall be publicly disclosed for review and comment and the final plan shall address any comments or concerns that are received by the Office.

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

''(3) The review of racial, ethnic, gender identity, sexual orientation, sex, disability status, socioeconomic status, and primary language health data collected by Federal health agencies to assess health care disparities related to intentional discrimination and policies and practices that have a disparate impact on minorities. Such review shall include an assessment of health disparities in communities with a combination of these classes.

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

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

''(6) Coordination and oversight of activities of the civil rights compliance offices established under section 3442.

''(7) Ensuring—

''(A) at a minimum, compliance with the most recent version of the Office of Management and Budget statistical policy directive entitled 'Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity'; and

''(B) consideration of available data and language standards such as—

''(i) the standards for collecting and reporting data under section 3101; and

''(ii) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health.

''(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

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

''(2) staff with expertise in—

''(A) epidemiology;

''(B) statistics;

''(C) health quality assurance;

''(D) minority health and health disparities;

''(E) cultural and linguistic competency;

''(F) civil rights; and

''(G) social, behavioral, and economic determinants of health.

''(d) REPORT.—Not later than December 31, 2021, and annually thereafter, the Secretary, in collaboration with the Director of the Office for Civil Rights and the

Deputy Assistant Secretary for Minority Health, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

''(1) the number of cases filed, broken down by category;

''(2) the number of cases investigated and closed by the office;

''(3) the outcomes of cases investigated;

''(4) the staffing levels of the office including staff credentials;

''(5) the number of other lingering and emerging cases in which civil rights inequities can be demonstrated; and

''(6) the number of cases remaining open and an explanation for their open status.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.

"SEC. 3442. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL HEALTH AND HUMAN SERVICES AGENCIES.

''(a) IN GENERAL.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

''(b) PURPOSE OF OFFICES.—Each office established under subsection (a) shall ensure that recipients of Federal financial assistance under Federal health programs administer programs, services, and activities in a manner that—

''(1) does not discriminate, either intentionally or in effect, on the basis of race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity; and

''(2) promotes the reduction and elimination of disparities in health and health care based on race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity.

''(c) POWERS AND DUTIES.—The offices established in subsection (a) shall have the following powers and duties:

''(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program admin-

istered by the applicable agency, including the establishment of disparity reduction standards to encompass disparities in health and health care related to race, national origin, language, ethnicity, sex, age, disability, sexual orientation, and gender identity.

''(2) The development and implementation of program-specific guidelines that interpret and apply Department of Health and Human Services guidance under title VI of the Civil Rights Act of 1964 and section 1557 of the Patient Protection and Affordable Care Act to each Federal health program administered by the agency.

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

''(4) Oversight of data collection, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency; compliance with, at a minimum, the most recent version of the Office of Management and Budget statistical policy directive entitled 'Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Eth-

nicity'; and consideration of available data and language standards such as—

"(A) the standards for collecting and reporting data under section 3101; and

"(B) the National Standards on Culturally and Linguistically Appropriate Services of the Office of Minority Health.

"(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as disparity reduction initiatives by recipients of Federal financial assistance under Federal health programs.

"(6) Annual reports to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives on the progress in reducing disparities in health and health care through the Federal programs administered by the agency.

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

"(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Office for Civil Rights of the Department of Health and Human Services shall pro-

vide standard-setting and compliance review investigation support services to the Civil Rights Compliance Office for each agency described in subsection (a), subject to paragraph (2).

''(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights of the Department of Justice may, as appropriate, institute formal proceedings when a civil rights compliance office established under subsection (a) determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the applicable agency.

''(e) DEFINITION.—In this section, the term 'Federal health programs' mean programs—

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

''(2) under this Act that provide Federal financial assistance for health care, biomedical research, health services research, and programs designed to improve the public's health, including health service programs.''.

TITLE V—EXPANDED INSURANCE ACCESS

SEC. 501. MEDICARE SPECIAL ENROLLMENT PERIOD FOR INDIVIDUALS RESIDING IN COVID-19 EMERGENCY 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-

gency period (as described in section 1135(g)(1)(B)) ends.''.

(b) COVERAGE PERIOD FOR INDIVIDUALS TRANSITIONING FROM OTHER COVERAGE.—Section 1838(e) of the Social Security Act (42 U.S.C. 1395q(e)) is amended—

(1) by striking ''pursuant to section 1837(i)(3) or 1837(i)(4)(B)—'' and inserting the following: ''pursuant to—

''(1) section 1837(i)(3) or 1837(i)(4)(B)—'';

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving the indentation of each such subparagraph 2 ems to the right;

(3) by striking the period at the end of the subparagraph (B), as so redesignated, and inserting ''; or''; and

(4) by adding at the end the following new paragraph:

''(2) section 1837(i)(5), the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.''.

(c) FUNDING.—The Secretary of Health and Human Services shall provide for the transfer from the Federal Hospital Insurance Trust Fund (as described in section

1817 of the Social Security Act (42 U.S.C. 1395i)) and the Federal Supplementary Medical Insurance Trust Fund (as described in section 1841 of such Act (42 U.S.C. 1395t)), in such proportions as determined appropriate by the Secretary, to the Social Security Administration, of $30,000,000, to remain available until expended, for purposes of carrying out the amendments made by this section.

(d) 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. 502. SPECIAL ENROLLMENT PERIOD THROUGH EXCHANGES; FEDERAL EXCHANGE OUTREACH AND EDUCATIONAL ACTIVITIES.

(a) SPECIAL ENROLLMENT PERIOD THROUGH EXCHANGES.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)) is amended—

(1) in paragraph (6)—

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

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

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

"(E) subject to subparagraph (B) of paragraph (8), the special enrollment period described in subparagraph (A) of such paragraph."; and

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

"(8) SPECIAL ENROLLMENT PERIOD FOR CERTAIN PUBLIC HEALTH EMERGENCY.—

"(A) IN GENERAL.—The Secretary shall, subject to subparagraph (B), require an Exchange to provide—

"(i) for a special enrollment period during the emergency period described in section 1135(g)(1)(B) of the Social Security Act—

"(I) which shall begin on the date that is one week after the date of the enactment of this paragraph and which, in the case of an Exchange established or operated by the Secretary within a State pursuant to section 1321(c), shall be an 8-week period; and

"(II) during which any individual who is otherwise eligible to enroll in a

qualified health plan through the Exchange may enroll in such a qualified health plan; and

''(ii) that, in the case of an individual who enrolls in a qualified health plan through the Exchange during such enrollment period, the coverage period under such plan shall begin, at the option of the individual, on April 1, 2020, or on the first day of the month following the day the individual selects a plan through such special enrollment period.

''(B) EXCEPTION.—The requirement of subparagraph (A) shall not apply to a State-operated or State-established Exchange if such Exchange, prior to the date of the enactment of this paragraph, established or otherwise provided for a special enrollment period to address access to coverage under qualified health plans offered through such Exchange during the emergency period described in section 1135(g)(1)(B) of the Social Security Act.''.

(b) FEDERAL EXCHANGE OUTREACH AND EDUCATIONAL ACTIVITIES.—Section 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c))

is amended by adding at the end the following new paragraph:

"(3) OUTREACH AND EDUCATIONAL ACTIVITIES.—

"(A) IN GENERAL.—In the case of an Exchange established or operated by the Secretary within a State pursuant to this subsection, the Secretary shall carry out outreach and educational activities for purposes of informing potential enrollees in qualified health plans offered through the Exchange of the availability of coverage under such plans and financial assistance for coverage under such plans. Such outreach and educational activities shall be provided in a manner that is culturally and linguistically appropriate to the needs of the populations being served by the Exchange (including hard-to-reach populations, such as racial and sexual minorities, limited English proficient populations, and young adults).

"(B) LIMITATION ON USE OF FUNDS.—No funds appropriated under this paragraph shall be used for expenditures for promoting non-ACA compliant health insurance coverage.

"(C) NON-ACA COMPLIANT HEALTH INSURANCE COVERAGE.—For purposes of subparagraph (B):

"(i) The term 'non-ACA compliant health insurance coverage' means health insurance coverage, or a group health plan, that is not a qualified health plan.

"(ii) Such term includes the following:

"(I) An association health plan.

"(II) Short-term limited duration insurance.

"(D) FUNDING.—There are appropriated, out of any funds in the Treasury not otherwise appropriated, $25,000,000, to remain available until expended—

"(i) to carry out this paragraph; and

"(ii) at the discretion of the Secretary, to carry out section 1311(i), with respect to an Exchange established or operated by the Secretary within a State pursuant to this subsection.".

(c) IMPLEMENTATION.—The Secretary of Health and Human Services may implement the provisions of (including amendments made by) this section through subregulatory guidance, program instruction, or otherwise.

SEC. 503. MOMMA'S ACT.

(a) SHORT TITLE.—This section may be cited as the ''Mothers and Offspring Mortality and Morbidity Awareness Act'' or the ''MOMMA's Act''.

(b) FINDINGS.—Congress finds the following:

(1) Every year, across the United States, 4,000,000 women give birth, about 700 women suffer fatal complications during pregnancy, while giving birth or during the postpartum period, and 70,000 women suffer near-fatal, partum-related complications.

(2) The maternal mortality rate is often used as a proxy to measure the overall health of a population. While the infant mortality rate in the United States has reached its lowest point, the risk of death for women in the United States during pregnancy, childbirth, or the postpartum period is higher than such risk in many other developed nations. The estimated maternal mortality rate (per 100,000 live births) for the 48 contiguous States and Washington, DC increased from 18.8 percent in 2000 to 23.8 percent in 2014 to 26.6 percent in 2018. This estimated rate is on par with such rate for underdeveloped nations such as Iraq and Afghanistan.

(3) International studies estimate the 2015 maternal mortality rate in the United States as 26.4

per 100,000 live births, which is almost twice the 2015 World Health Organization estimation of 14 per 100,000 live births.

(4) It is estimated that more than 60 percent of maternal deaths in the United States are preventable.

(5) According to the Centers for Disease Control and Prevention, the maternal mortality rate varies drastically for women by race and ethnicity. There are 12.7 deaths per 100,000 live births for White women, 43.5 deaths per 100,000 live births for African-American women, and 14.4 deaths per 100,000 live births for women of other ethnicities. While maternal mortality disparately impacts African-American women, this urgent public health crisis traverses race, ethnicity, socioeconomic status, educational background, and geography.

(6) African-American women are 3 to 4 times more likely to die from causes related to pregnancy and childbirth compared to non-Hispanic White women.

(7) The findings described in paragraphs (1) through (6) are of major concern to researchers, academics, members of the business community, and providers across the obstetrical continuum rep-

resented by organizations such as March of Dimes; the Preeclampsia Foundation; the American College of Obstetricians and Gynecologists; the Society for Maternal-Fetal Medicine; the Association of Women's Health, Obstetric, and Neonatal Nurses; the California Maternal Quality Care Collaborative; Black Women's Health Imperative; the National Birth Equity Collaborative; Black Mamas Matter Alliance; EverThrive Illinois; the National Association of Certified Professional Midwives; PCOS Challenge: The National Polycystic Ovary Syndrome Association; and the American College of Nurse Midwives.

(8) Hemorrhage, cardiovascular and coronary conditions, cardiomyopathy, infection, embolism, mental health conditions, preeclampsia and eclampsia, polycystic ovary syndrome, infection and sepsis, and anesthesia complications are the predominant medical causes of maternal-related deaths and complications. Most of these conditions are largely preventable or manageable.

(9) Oral health is an important part of perinatal health. Reducing bacteria in a woman's mouth during pregnancy can significantly reduce her risk of developing oral diseases and spreading decay-causing bacteria to her baby. Moreover, some evi-

dence suggests that women with periodontal disease during pregnancy could be at greater risk for poor birth outcomes, such as preeclampsia, pre-term birth, and low-birth weight. Furthermore, a woman's oral health during pregnancy is a good predictor of her newborn's oral health, and since mothers can unintentionally spread oral bacteria to their babies, putting their children at higher risk for tooth decay, prevention efforts should happen even before children are born, as a matter of pre-pregnancy health and prenatal care during pregnancy.

(10) The United States has not been able to submit a formal maternal mortality rate to international data repositories since 2007. Thus, no official maternal mortality rate exists for the United States. There can be no maternal mortality rate without streamlining maternal mortality-related data from the State level and extrapolating such data to the Federal level.

(11) In the United States, death reporting and analysis is a State function rather than a Federal process. States report all deaths—including maternal deaths—on a semi-voluntary basis, without standardization across States. While the Centers for Disease Control and Prevention has the capacity and

system for collecting death-related data based on death certificates, these data are not sufficiently reported by States in an organized and standard format across States such that the Centers for Disease Control and Prevention is able to identify causes of maternal death and best practices for the prevention of such death.

(12) Vital statistics systems often underestimate maternal mortality and are insufficient data sources from which to derive a full scope of medical and social determinant factors contributing to maternal deaths. While the addition of pregnancy checkboxes on death certificates since 2003 have likely improved States' abilities to identify pregnancy-related deaths, they are not generally completed by obstetrical providers or persons trained to recognize pregnancy-related mortality. Thus, these vital forms may be missing information or may capture inconsistent data. Due to varying maternal mortality-related analyses, lack of reliability, and granularity in data, current maternal mortality informatics do not fully encapsulate the myriad medical and socially determinant factors that contribute to such high maternal mortality rates within the United States compared to other developed nations.

Lack of standardization of data and data sharing across States and between Federal entities, health networks, and research institutions keep the Nation in the dark about ways to prevent maternal deaths.

(13) Having reliable and valid State data aggregated at the Federal level are critical to the Nation's ability to quell surges in maternal death and imperative for researchers to identify long-lasting interventions.

(14) Leaders in maternal wellness highly recommend that maternal deaths be investigated at the State level first, and that standardized, streamlined, de-identified data regarding maternal deaths be sent annually to the Centers for Disease Control and Prevention. Such data standardization and collection would be similar in operation and effect to the National Program of Cancer Registries of the Centers for Disease Control and Prevention and akin to the Confidential Enquiry in Maternal Deaths Programme in the United Kingdom. Such a maternal mortalities and morbidities registry and surveillance system would help providers, academicians, lawmakers, and the public to address questions concerning the types of, causes of, and best practices to

thwart, pregnancy-related or pregnancy-associated mortality and morbidity.

(15) The United Nations' Millennium Development Goal 5a aimed to reduce by 75 percent, between 1990 and 2015, the maternal mortality rate, yet this metric has not been achieved. In fact, the maternal mortality rate in the United States has been estimated to have more than doubled between 2000 and 2014. Yet, because national data are not fully available, the United States does not have an official maternal mortality rate.

(16) Many States have struggled to establish or maintain Maternal Mortality Review Committees (referred to in this section as ''MMRC''). On the State level, MMRCs have lagged because States have not had the resources to mount local reviews. State-level reviews are necessary as only the State departments of health have the authority to request medical records, autopsy reports, and police reports critical to the function of the MMRC.

(17) The United Kingdom regards maternal deaths as a health systems failure and a national committee of obstetrics experts review each maternal death or near-fatal childbirth complication. Such committee also establishes the predominant course of

maternal-related deaths from conditions such as preeclampsia. Consequently, the United Kingdom has been able to reduce its incidence of preeclampsia to less than one in 10,000 women—its lowest rate since 1952.

(18) The United States has no comparable, coordinated Federal process by which to review cases of maternal mortality, systems failures, or best practices. Many States have active MMRCs and leverage their work to impact maternal wellness. For example, the State of California has worked extensively with their State health departments, health and hospital systems, and research collaborative organizations, including the California Maternal Quality Care Collaborative and the Alliance for Innovation on Maternal Health, to establish MMRCs, wherein such State has determined the most prevalent causes of maternal mortality and recorded and shared data with providers and researchers, who have developed and implemented safety bundles and care protocols related to preeclampsia, maternal hemorrhage, and the like. In this way, the State of California has been able to leverage its maternal mortality review board system, generate data, and apply those data to effect changes in maternal care-related protocol.

To date, the State of California has reduced its maternal mortality rate, which is now comparable to the low rates of the United Kingdom.

(19) Hospitals and health systems across the United States lack standardization of emergency obstetrical protocols before, during, and after delivery. Consequently, many providers are delayed in recognizing critical signs indicating maternal distress that quickly escalate into fatal or near-fatal incidences. Moreover, any attempt to address an obstetrical emergency that does not consider both clinical and public health approaches falls woefully under the mark of excellent care delivery. State-based maternal quality collaborative organizations, such as the California Maternal Quality Care Collaborative or entities participating in the Alliance for Innovation on Maternal Health (AIM), have formed obstetrical protocols, tool kits, and other resources to improve system care and response as they relate to maternal complications and warning signs for such conditions as maternal hemorrhage, hypertension, and preeclampsia.

(20) The Centers for Disease Control and Prevention reports that nearly half of all maternal deaths occur in the immediate postpartum period—

the 42 days following a pregnancy—whereas more than one-third of pregnancy-related or pregnancy-associated deaths occur while a person is still pregnant. Yet, for women eligible for the Medicaid program on the basis of pregnancy, such Medicaid coverage lapses at the end of the month on which the 60th postpartum day lands.

(21) The experience of serious traumatic events, such as being exposed to domestic violence, substance use disorder, or pervasive racism, can over-activate the body's stress-response system. Known as toxic stress, the repetition of high-doses of cortisol to the brain, can harm healthy neurological development, which can have cascading physical and mental health consequences, as documented in the Adverse Childhood Experiences study of the Centers for Disease Control and Prevention.

(22) A growing body of evidence-based research has shown the correlation between the stress associated with one's race—the stress of racism—and one's birthing outcomes. The stress of sex and race discrimination and institutional racism has been demonstrated to contribute to a higher risk of maternal mortality, irrespective of one's gestational age, maternal age, socioeconomic status, or indi-

vidual-level health risk factors, including poverty, limited access to prenatal care, and poor physical and mental health (although these are not nominal factors). African-American women remain the most at risk for pregnancy-associated or pregnancy-related causes of death. When it comes to preeclampsia, for example, which is related to obesity, African-American women of normal weight remain the most at risk of dying during the perinatal period compared to non-African-American obese women.

(23) The rising maternal mortality rate in the United States is driven predominantly by the disproportionately high rates of African-American maternal mortality.

(24) African-American women are 3 to 4 times more likely to die from pregnancy or maternal-related distress than are White women, yielding one of the greatest and most disconcerting racial disparities in public health.

(25) Compared to women from other racial and ethnic demographics, African-American women across the socioeconomic spectrum experience prolonged, unrelenting stress related to racial and gender discrimination, contributing to higher rates of

maternal mortality, giving birth to low-weight babies, and experiencing pre-term birth. Racism is a risk-factor for these aforementioned experiences. This cumulative stress often extends across the life course and is situated in everyday spaces where African-American women establish livelihood. Structural barriers, lack of access to care, and genetic predispositions to health vulnerabilities exacerbate African-American women's likelihood to experience poor or fatal birthing outcomes, but do not fully account for the great disparity.

(26) African-American women are twice as likely to experience postpartum depression, and disproportionately higher rates of preeclampsia compared to White women.

(27) Racism is deeply ingrained in United States systems, including in health care delivery systems between patients and providers, often resulting in disparate treatment for pain, irreverence for cultural norms with respect to health, and dismissiveness. Research has demonstrated that patients respond more warmly and adhere to medical treatment plans at a higher degree with providers of the same race or ethnicity or with providers with great ability to exercise empathy. However, the pro-

vider pool is not primed with many people of color, nor are providers (whether student-doctors in training or licensed practitioners) consistently required to undergo implicit bias, cultural competency, or empathy training on a consistent, on-going basis.

(c) IMPROVING FEDERAL EFFORTS WITH RESPECT TO PREVENTION OF MATERNAL MORTALITY.—

(1) TECHNICAL ASSISTANCE FOR STATES WITH RESPECT TO REPORTING MATERNAL MORTALITY.—Not later than one year after the date of enactment of this Act, the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), in consultation with the Administrator of the Health Resources and Services Administration, shall provide technical assistance to States that elect to report comprehensive data on maternal mortality, including oral, mental, and breastfeeding health information, for the purpose of encouraging uniformity in the reporting of such data and to encourage the sharing of such data among the respective States.

(2) BEST PRACTICES RELATING TO PREVENTION OF MATERNAL MORTALITY.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act—

(i) the Director, in consultation with relevant patient and provider groups, shall issue best practices to State maternal mortality review committees on how best to identify and review maternal mortality cases, taking into account any data made available by States relating to maternal mortality, including data on oral, mental, and breastfeeding health, and utilization of any emergency services; and

(ii) the Director, working in collaboration with the Health Resources and Services Administration, shall issue best practices to hospitals, State professional society groups, and perinatal quality collaboratives on how best to prevent maternal mortality.

(B) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $5,000,000 for each of fiscal years 2021 through 2025.

(3) ALLIANCE FOR INNOVATION ON MATERNAL HEALTH GRANT PROGRAM.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Sec-

retary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Associate Administrator of the Maternal and Child Health Bureau of the Health Resources and Services Administration, shall establish a grant program to be known as the Alliance for Innovation on Maternal Health Grant Program (referred to in this subsection as ''AIM'') under which the Secretary shall award grants to eligible entities for the purpose of—

(i) directing widespread adoption and implementation of maternal safety bundles through collaborative State-based teams; and

(ii) collecting and analyzing process, structure, and outcome data to drive continuous improvement in the implementation of such safety bundles by such State-based teams with the ultimate goal of eliminating preventable maternal mortality and severe maternal morbidity in the United States.

(B) ELIGIBLE ENTITIES.—In order to be eligible for a grant under paragraph (1), an entity shall—

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

(ii) demonstrate in such application that the entity is an interdisciplinary, multi-stakeholder, national organization with a national data-driven maternal safety and quality improvement initiative based on implementation approaches that have been proven to improve maternal safety and outcomes in the United States.

(C) USE OF FUNDS.—An eligible entity that receives a grant under paragraph (1) shall use such grant funds—

(i) to develop and implement, through a robust, multi-stakeholder process, maternal safety bundles to assist States and health care systems in aligning national, State, and hospital-level quality improvement efforts to improve maternal health outcomes, specifically the reduction of ma-

ternal mortality and severe maternal morbidity;

(ii) to ensure, in developing and implementing maternal safety bundles under subparagraph (A), that such maternal safety bundles—

(I) satisfy the quality improvement needs of a State or health care system by factoring in the results and findings of relevant data reviews, such as reviews conducted by a State maternal mortality review committee; and

(II) address topics such as—

(aa) obstetric hemorrhage;

(bb) maternal mental health;

(cc) the maternal venous system;

(dd) obstetric care for women with substance use disorders, including opioid use disorder;

(ee) postpartum care basics for maternal safety;

(ff) reduction of peripartum racial and ethnic disparities;

(gg) reduction of primary caesarean birth;

(hh) severe hypertension in pregnancy;

(ii) severe maternal morbidity reviews;

(jj) support after a severe maternal morbidity event;

(kk) thromboembolism;

(ll) optimization of support for breastfeeding; and

(mm) maternal oral health; and

(iii) to provide ongoing technical assistance at the national and State levels to support implementation of maternal safety bundles under subparagraph (A).

(D) MATERNAL SAFETY BUNDLE DEFINED.—For purposes of this subsection, the term ''maternal safety bundle'' means standardized, evidence-informed processes for maternal health care.

(E) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $10,000,000 for each of fiscal years 2021 through 2025.

(4) FUNDING FOR STATE-BASED PERINATAL QUALITY COLLABORATIVES DEVELOPMENT AND SUSTAINABILITY.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary''), acting through the Division of Reproductive Health of the Centers for Disease Control and Prevention, shall establish a grant program to be known as the State-Based Perinatal Quality Collaborative grant program under which the Secretary awards grants to eligible entities for the purpose of development and sustainability of perinatal quality collaboratives in every State, the District of Columbia, and eligible territories, in order to measurably improve perinatal care and perinatal health outcomes for pregnant and postpartum women and their infants.

(B) GRANT AMOUNTS.—Grants awarded under this subsection shall be in amounts not to exceed $250,000 per year, for the duration of the grant period.

(C) STATE-BASED PERINATAL QUALITY COLLABORATIVE DEFINED.—For purposes of this subsection, the term ''State-based perinatal quality collaborative'' means a network of multidisciplinary teams that—

(i) work to improve measurable outcomes for maternal and infant health by advancing evidence-informed clinical practices using quality improvement principles;

(ii) work with hospital-based or outpatient facility-based clinical teams, experts, and stakeholders, including patients and families, to spread best practices and optimize resources to improve perinatal care and outcomes;

(iii) employ strategies that include the use of the collaborative learning model to provide opportunities for hospitals and clinical teams to collaborate on improvement strategies, rapid-response data to provide timely feedback to hospital and

other clinical teams to track progress, and quality improvement science to provide support and coaching to hospital and clinical teams; and

(iv) have the goal of improving population-level outcomes in maternal and infant health.

(D) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this subsection, there is authorized to be appropriated $14,000,000 per year for each of fiscal years 2021 through 2025.

(5) EXPANSION OF MEDICAID AND CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—

(A) REQUIRING COVERAGE OF ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

(i) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(I) in subsection (a)(4)—

(aa) by striking ''; and (D)'' and inserting ''; (D)''; and

(bb) by inserting ''; and (E) oral health services for pregnant

and postpartum women (as defined in subsection (ee))'' after ''subsection (bb))''; and

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

''(ee) ORAL HEALTH SERVICES FOR PREGNANT AND POSTPARTUM WOMEN.—

''(1) IN GENERAL.—For purposes of this title, the term 'oral health services for pregnant and postpartum women' means dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions that are furnished to a woman during pregnancy (or during the 1-year period beginning on the last day of the pregnancy).

''(2) COVERAGE REQUIREMENTS.—To satisfy the requirement to provide oral health services for pregnant and postpartum women, a State shall, at a minimum, provide coverage for preventive, diagnostic, periodontal, and restorative care consistent with recommendations for perinatal oral health care and dental care during pregnancy from the American Academy of Pediatric Dentistry and the American College of Obstetricians and Gynecologists.''.

(ii) CHIP.—Section 2103(c)(5)(A) of the Social Security Act (42 U.S.C. 1397cc(c)(5)(A)) is amended by inserting ''or a targeted low-income pregnant woman'' after ''targeted low-income child''.

(B) EXTENDING MEDICAID COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(i) in subsection (e)—

(I) in paragraph (5)—

(aa) by inserting ''(including oral health services for pregnant and postpartum women (as defined in section 1905(ee))'' after ''postpartum medical assistance under the plan''; and

(bb) by striking ''60-day'' and inserting ''1-year''; and

(II) in paragraph (6), by striking ''60-day'' and inserting ''1-year''; and

(ii) in subsection (l)(1)(A), by striking ''60-day'' and inserting ''1-year''.

(C) EXTENDING MEDICAID COVERAGE FOR LAWFUL RESIDENTS.—Section 1903(v)(4)(A) of

the Social Security Act (42 U.S.C. 1396b(v)(4)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(D) EXTENDING CHIP COVERAGE FOR PREGNANT AND POSTPARTUM WOMEN.—Section 2112(d)(2)(A) of the Social Security Act (42 U.S.C. 1397ll(d)(2)(A)) is amended by striking ''60-day'' and inserting ''1-year''.

(E) MAINTENANCE OF EFFORT.—

(i) MEDICAID.—Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

''(5) During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect, with respect to women who are eligible for medical assistance under the State plan or under a waiver of such plan on the basis of being pregnant or having been pregnant, eligibility standards, methodologies, or procedures under the State plan or waiver that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such

plan or waiver that are in effect on the date of enactment of this paragraph.''.

(ii) CHIP.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following new paragraph:

''(4) IN ELIGIBILITY STANDARDS FOR TARGETED LOW-INCOME PREGNANT WOMEN.—During the period that begins on the date of enactment of this paragraph and ends on the date that is five years after such date of enactment, as a condition of receiving payments under subsection (a) and section 1903(a), a State that elects to provide assistance to women on the basis of being pregnant (including pregnancy-related assistance provided to targeted low-income pregnant women (as defined in section 2112(d)), pregnancy-related assistance provided to women who are eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the State child health plan (or a waiver of such plan) which is provided to women on the basis of being pregnant) shall not have in effect, with respect to such women, eligibility standards, methodologies, or procedures under such plan (or waiver)

that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) that are in effect on the date of enactment of this paragraph.''.

(F) INFORMATION ON BENEFITS.—The Secretary of Health and Human Services shall make publicly available on the internet website of the Department of Health and Human Services, information regarding benefits available to pregnant and postpartum women and under the Medicaid program and the Children's Health Insurance Program, including information on—

(i) benefits that States are required to provide to pregnant and postpartum women under such programs;

(ii) optional benefits that States may provide to pregnant and postpartum women under such programs; and

(iii) the availability of different kinds of benefits for pregnant and postpartum women, including oral health and mental health benefits, under such programs.

(G) FEDERAL FUNDING FOR COST OF EXTENDED MEDICAID AND CHIP COVERAGE FOR POSTPARTUM WOMEN.—

(i) MEDICAID.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by paragraph (1), is further amended—

(I) in subsection (b), by striking ''and (aa)'' and inserting ''(aa), and (ff)''; and

(II) by adding at the end the following:

''(ff) INCREASED FMAP FOR EXTENDED MEDICAL ASSISTANCE FOR POSTPARTUM WOMEN.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State, with respect to amounts expended by such State for medical assistance for a woman who is eligible for such assistance on the basis of being pregnant or having been pregnant that is provided during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(1) 100 percent for the first 20 calendar quarters during which this subsection is in effect; and

''(2) 90 percent for calendar quarters thereafter.''.

(ii) CHIP.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(12) ENHANCED PAYMENT FOR EXTENDED ASSISTANCE PROVIDED TO PREGNANT WOMEN.—Notwithstanding subsection (b), the enhanced FMAP, with respect to payments under subsection (a) for expenditures under the State child health plan (or a waiver of such plan) for assistance provided under the plan (or waiver) to a woman who is eligible for such assistance on the basis of being pregnant (including pregnancy-related assistance provided to a targeted low-income pregnant woman (as defined in section 2112(d)), pregnancy-related assistance provided to a woman who is eligible for such assistance through application of section 1902(v)(4)(A)(i) under section 2107(e)(1), or any other assistance under the plan (or waiver) provided to a woman who is eligible for such assistance on the basis of being pregnant) during the 305-day period that begins on the 60th day after the last day of her pregnancy (including any such assistance provided during the month in which such period ends), shall be equal to—

''(A) 100 percent for the first 20 calendar quarters during which this paragraph is in effect; and

''(B) 90 percent for calendar quarters thereafter.''.

(H) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to subparagraph (B), the amendments made by this subsection shall take effect on the first day of the first calendar quarter that begins on or after the date that is one year after the date of enactment of this Act.

(ii) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement be-

fore the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

(6) REGIONAL CENTERS OF EXCELLENCE.—Part P of title III of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 399V–7. REGIONAL CENTERS OF EXCELLENCE ADDRESSING IMPLICIT BIAS AND CULTURAL COMPETENCY IN PATIENT-PROVIDER INTERACTIONS EDUCATION.

''(a) IN GENERAL.—Not later than one year after the date of enactment of this section, the Secretary, in consultation with such other agency heads as the Secretary determines appropriate, shall award cooperative agreements for the establishment or support of regional centers of excellence addressing implicit bias and cultural competency in patient-provider interactions education for the purpose of enhancing and improving how health care pro-

fessionals are educated in implicit bias and delivering culturally competent health care.

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

''(1) be a public or other nonprofit entity specified by the Secretary that provides educational and training opportunities for students and health care professionals, which may be a health system, teaching hospital, community health center, medical school, school of public health, dental school, social work school, school of professional psychology, or any other health professional school or program at an institution of higher education (as defined in section 101 of the Higher Education Act of 1965) focused on the prevention, treatment, or recovery of health conditions that contribute to maternal mortality and the prevention of maternal mortality and severe maternal morbidity;

''(2) demonstrate community engagement and participation, such as through partnerships with home visiting and case management programs; and

''(3) provide to the Secretary such information, at such time and in such manner, as the Secretary may require.

''(c) DIVERSITY.—In awarding a cooperative agreement under subsection (a), the Secretary shall take into account any regional differences among eligible entities and make an effort to ensure geographic diversity among award recipients.

''(d) DISSEMINATION OF INFORMATION.—

''(1) PUBLIC AVAILABILITY.—The Secretary shall make publicly available on the internet website of the Department of Health and Human Services information submitted to the Secretary under subsection (b)(3).

''(2) EVALUATION.—The Secretary shall evaluate each regional center of excellence established or supported pursuant to subsection (a) and disseminate the findings resulting from each such evaluation to the appropriate public and private entities.

''(3) DISTRIBUTION.—The Secretary shall share evaluations and overall findings with State departments of health and other relevant State level offices to inform State and local best practices.

''(e) MATERNAL MORTALITY DEFINED.—In this section, the term 'maternal mortality' means death of a woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2021 through 2025.''.

(7) SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN.—Section 17(d)(3)(A)(ii) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(d)(3)(A)(ii)) is amended—

(A) by striking the clause designation and heading and all that follows through ''A State'' and inserting the following:

''(ii) WOMEN.—

''(I) BREASTFEEDING WOMEN.—A State'';

(B) in subclause (I) (as so designated), by striking ''1 year'' and all that follows through ''earlier'' and inserting ''2 years postpartum''; and

(C) by adding at the end the following:

''(II) POSTPARTUM WOMEN.—A State may elect to certify a postpartum woman for a period of 2 years.''.

(8) DEFINITIONS.—In this section:

(A) MATERNAL MORTALITY.—The term ''maternal mortality'' means death of a woman that occurs during pregnancy or within the one-year period following the end of such pregnancy.

(B) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' includes unexpected outcomes of labor and delivery that result in significant short-term or long-term consequences to a woman's health.

(d) INCREASING EXCISE TAXES ON CIGARETTES AND ESTABLISHING EXCISE TAX EQUITY AMONG ALL TOBACCO PRODUCT TAX RATES.—

(1) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of the Internal Revenue Code of 1986 is amended by striking ''$24.78'' and inserting ''$49.56''.

(2) TAX PARITY FOR PIPE TOBACCO.—Section 5701(f) of the Internal Revenue Code of 1986 is amended by striking ''$2.8311 cents'' and inserting ''$49.56''.

(3) TAX PARITY FOR SMOKELESS TOBACCO.—

(A) Section 5701(e) of the Internal Revenue Code of 1986 is amended—

(i) in paragraph (1), by striking ''$1.51'' and inserting ''$26.84'';

(ii) in paragraph (2), by striking ''50.33 cents'' and inserting ''$10.74''; and

(iii) by adding at the end the following:

''(3) SMOKELESS TOBACCO SOLD IN DISCRETE SINGLE-USE UNITS.—On discrete single-use units, $100.66 per thousand.''.

(B) Section 5702(m) of such Code is amended—

(i) in paragraph (1), by striking ''or chewing tobacco'' and inserting '', chewing tobacco, or discrete single-use unit'';

(ii) in paragraphs (2) and (3), by inserting ''that is not a discrete single-use unit'' before the period in each such paragraph; and

(iii) by adding at the end the following:

''(4) DISCRETE SINGLE-USE UNIT.—The term 'discrete single-use unit' means any product containing tobacco that—

''(A) is not intended to be smoked; and

''(B) is in the form of a lozenge, tablet, pill, pouch, dissolvable strip, or other discrete single-use or single-dose unit.''.

(4) TAX PARITY FOR SMALL CIGARS.—Paragraph (1) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''$50.33'' and inserting ''$100.66''.

(5) TAX PARITY FOR LARGE CIGARS.—

(A) IN GENERAL.—Paragraph (2) of section 5701(a) of the Internal Revenue Code of 1986 is amended by striking ''52.75 percent'' and all that follows through the period and inserting the following: ''$49.56 per pound and a proportionate tax at the like rate on all fractional parts of a pound but not less than 10.066 cents per cigar.''.

(B) GUIDANCE.—The Secretary of the Treasury, or the Secretary's delegate, may issue guidance regarding the appropriate method for determining the weight of large cigars for purposes of calculating the applicable tax under section 5701(a)(2) of the Internal Revenue Code of 1986.

(6) TAX PARITY FOR ROLL-YOUR-OWN TOBACCO AND CERTAIN PROCESSED TOBACCO.—Subsection (o)

of section 5702 of the Internal Revenue Code of 1986 is amended by inserting '', and includes processed tobacco that is removed for delivery or delivered to a person other than a person with a permit provided under section 5713, but does not include removals of processed tobacco for exportation'' after ''wrappers thereof''.

(7) CLARIFYING TAX RATE FOR OTHER TOBACCO PRODUCTS.—

(A) IN GENERAL.—Section 5701 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(i) OTHER TOBACCO PRODUCTS.—Any product not otherwise described under this section that has been determined to be a tobacco product by the Food and Drug Administration through its authorities under the Family Smoking Prevention and Tobacco Control Act shall be taxed at a level of tax equivalent to the tax rate for cigarettes on an estimated per use basis as determined by the Secretary.''.

(B) ESTABLISHING PER USE BASIS.—For purposes of section 5701(i) of the Internal Revenue Code of 1986, not later than 12 months after the later of the date of the enactment of this Act or the date that a product has been de-

termined to be a tobacco product by the Food and Drug Administration, the Secretary of the Treasury (or the Secretary of the Treasury's delegate) shall issue final regulations establishing the level of tax for such product that is equivalent to the tax rate for cigarettes on an estimated per use basis.

(8) CLARIFYING DEFINITION OF TOBACCO PRODUCTS.—

(A) IN GENERAL.—Subsection (c) of section 5702 of the Internal Revenue Code of 1986 is amended to read as follows:

''(c) TOBACCO PRODUCTS.—The term 'tobacco products' means—

''(1) cigars, cigarettes, smokeless tobacco, pipe tobacco, and roll-your-own tobacco, and

''(2) any other product subject to tax pursuant to section 5701(i).''.

(B) CONFORMING AMENDMENTS.—Subsection (d) of section 5702 of such Code is amended by striking ''cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco'' each place it appears and inserting ''tobacco products''.

(9) INCREASING TAX ON CIGARETTES.—

(A) SMALL CIGARETTES.—Section 5701(b)(1) of such Code is amended by striking ''$50.33'' and inserting ''$100.66''.

(B) LARGE CIGARETTES.—Section 5701(b)(2) of such Code is amended by striking ''$105.69'' and inserting ''$211.38''.

(10) TAX RATES ADJUSTED FOR INFLATION.—Section 5701 of such Code, as amended by subsection (g), is amended by adding at the end the following new subsection:

''(j) INFLATION ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any calendar year beginning after 2021, the dollar amounts provided under this chapter shall each be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2017' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

''(2) ROUNDING.—If any amount as adjusted under paragraph (1) is not a multiple of $0.01, such amount shall be rounded to the next highest multiple of $0.01.''.

(11) FLOOR STOCKS TAXES.—

(A) IMPOSITION OF TAX.—On tobacco products manufactured in or imported into the United States which are removed before any tax increase date and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(i) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(ii) the prior tax (if any) imposed under section 5701 of such Code on such article.

(B) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on such date for which such person is liable.

(C) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(i) LIABILITY FOR TAX.—A person holding tobacco products on any tax increase date to which any tax imposed by

paragraph (1) applies shall be liable for such tax.

(ii) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(iii) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before the date that is 120 days after the effective date of the tax rate increase.

(D) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.), or any other provision of law, any article which is located in a foreign trade zone on any tax increase date shall be subject to the tax imposed by paragraph (1) if—

(i) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act; or

(ii) such article is held on such date under the supervision of an officer of the

United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(E) DEFINITIONS.—For purposes of this subsection—

(i) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of such Code shall have the same meaning as such term has in such section.

(ii) TAX INCREASE DATE.—The term ''tax increase date'' means the effective date of any increase in any tobacco product excise tax rate pursuant to the amendments made by this section (other than subsection (j) thereof).

(iii) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(F) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(G) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with

respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(12) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as provided in paragraphs (2) through (4), the amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after the last day of the month which includes the date of the enactment of this Act.

(B) DISCRETE SINGLE-USE UNITS AND PROCESSED TOBACCO.—The amendments made by subsections (c)(1)(C), (c)(2), and (f) shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986)

after the date that is 6 months after the date of the enactment of this Act.

(C) LARGE CIGARS.—The amendments made by subsection (e) shall apply to articles removed after December 31, 2021.

(D) OTHER TOBACCO PRODUCTS.—The amendments made by subsection (g)(1) shall apply to products removed after the last day of the month which includes the date that the Secretary of the Treasury (or the Secretary of the Treasury's delegate) issues final regulations establishing the level of tax for such product.

SEC. 504. ALLOWING FOR MEDICAL ASSISTANCE UNDER MEDICAID FOR INMATES DURING 30-DAY PERIOD PRECEDING RELEASE.

(a) IN GENERAL.—The subdivision (A) following paragraph (30) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''and except during the 30-day period preceding the date of release of such individual from such public institution'' after ''medical institution''.

(b) REPORT.—Not later than June 30, 2022, the Medicaid and CHIP Payment and Access Commission shall submit a report to Congress on the Medicaid inmate exclusion under the subdivision (A) following paragraph

(30) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)). Such report may, to the extent practicable, include the following information:

(1) The number of incarcerated individuals who would otherwise be eligible to enroll for medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such a plan).

(2) Access to health care for incarcerated individuals, including a description of medical services generally available to incarcerated individuals.

(3) A description of current practices related to the discharge of incarcerated individuals, including how prisons interact with State Medicaid agencies to ensure that such individuals who are eligible to enroll for medical assistance under a State plan or waiver described in paragraph (1) are so enrolled.

(4) If determined appropriate by the Commission, recommendations for Congress, the Department of Health and Human Services, or States regarding the Medicaid inmate exclusion.

(5) Any other information that the Commission determines would be useful to Congress.

SEC. 505. PROVIDING FOR IMMEDIATE MEDICAID ELIGIBILITY FOR FORMER FOSTER YOUTH.

Section 1002(a)(2) of the SUPPORT for Patients and Communities Act (Public Law 115–271) is amended by striking ''January 1, 2023'' and inserting ''the date of enactment of the Ending Health Disparities During COVID–19 Act of 2020''.

SEC. 506. EXPANDED COVERAGE FOR FORMER FOSTER YOUTH.

(a) COVERAGE CONTINUITY FOR FORMER FOSTER CARE CHILDREN UP TO AGE 26.—

(1) IN GENERAL.—Section 1002(a)(1)(B) of the SUPPORT for Patients and Communities Act (Public Law 115–271) is amended by striking all that follows after ''item (cc),'' and inserting the following: ''by striking 'responsibility of the State' and all that follows through '475(8)(B)(iii); and' and inserting 'responsibility of a State on the date of attaining 18 years of age (or such higher age as such State has elected under section 475(8)(B)(iii)), or who were in such care at any age but subsequently left such care to enter into a legal guardianship with a kinship caregiver (without regard to whether kinship guardianship payments are being made on behalf of the child under this part) or were emancipated from such care prior to attaining age 18;' ''.

(2) AMENDMENTS TO SOCIAL SECURITY ACT.—

(A) IN GENERAL.—Section 1902(a)(10)(A)(i)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as amended by section 1002(a) of the SUPPORT for Patients and Communities Act (Public Law 115–271), is amended—

(i) in item (bb), by striking the semicolon at the end and inserting ''; and''; and

(ii) by striking item (dd).

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on January 1, 2023.

(b) OUTREACH EFFORTS FOR ENROLLMENT OF FORMER FOSTER CHILDREN.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (85), by striking ''; and'' and inserting a semicolon;

(2) in paragraph (86), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (86) the following new paragraph:

''(87) not later than January 1, 2020, establish an outreach and enrollment program, in coordination with the State agency responsible for administering

the State plan under part E of title IV and any other appropriate or interested agencies, designed to increase the enrollment of individuals who are eligible for medical assistance under the State plan under paragraph (10)(A)(i)(IX) in accordance with best practices established by the Secretary.''.

SEC. 507. REMOVING CITIZENSHIP AND IMMIGRATION BARRIERS TO ACCESS TO AFFORDABLE HEALTH CARE UNDER ACA.

(a) IN GENERAL.—

(1) PREMIUM TAX CREDITS.—Section 36B of the Internal Revenue Code of 1986 is amended—

(A) in subsection (c)(1)(B)—

(i) by amending the heading to read as follows: ''SPECIAL RULE FOR CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID DUE TO STATUS'', and

(ii) in clause (ii), by striking ''lawfully present in the United States, but'' and inserting ''who'', and

(B) by striking subsection (e).

(2) COST-SHARING REDUCTIONS.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by striking subsection (e).

(3) BASIC HEALTH PROGRAM ELIGIBILITY.—Section 1331(e)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is amended by striking ''lawfully present in the United States''.

(4) RESTRICTIONS ON FEDERAL PAYMENTS.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended by striking subsection (d).

(5) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Section 5000A(d) of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(b) CONFORMING AMENDMENTS.—

(1) Section 1411(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(a)) is amended by striking paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(2) Section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)) is amended—

(A) in the heading, by striking ''; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS''; and

(B) by striking paragraph (3).

SEC. 508. MEDICAID IN THE TERRITORIES.

(a) ELIMINATION OF GENERAL MEDICAID FUNDING LIMITATIONS (''CAP'') FOR TERRITORIES.—

(1) IN GENERAL.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), in the matter preceding paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(B) in subsection (g)(2), in the matter preceding subparagraph (A), by inserting ''and subsection (h)'' after ''paragraphs (3) and (5)''; and

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

''(h) SUNSET OF MEDICAID FUNDING LIMITATIONS FOR PUERTO RICO, THE VIRGIN ISLANDS OF THE UNITED STATES, GUAM, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections (f) and (g) shall not apply to Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa beginning with fiscal year 2020.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended by striking ", the limitation in section 1108(f),".

(B) Section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) is amended by striking paragraph (4).

(C) Section 1323(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18043(c)(1)) is amended by striking "2019" and inserting "2018".

(3) EFFECTIVE DATE.—The amendments made by this section shall apply beginning with fiscal year 2021.

(b) ELIMINATION OF SPECIFIC FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) LIMITATION FOR TERRITORIES.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in clause (2), by inserting "for fiscal years before fiscal year 2020" after "American Samoa".

(c) APPLICATION OF MEDICAID WAIVER AUTHORITY TO ALL OF THE TERRITORIES.—

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

(A) by striking ''American Samoa and the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa'';

(B) by striking ''American Samoa or the Northern Mariana Islands'' and inserting ''Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, or American Samoa'';

(C) by inserting ''(1)'' after ''(j)'';

(D) by inserting ''except as otherwise provided in this subsection,'' after ''Notwithstanding any other requirement of this title''; and

(E) by adding at the end the following:

''(2) The Secretary may not waive under this subsection the requirement of subsection (a)(10)(A)(i)(IX) (relating to coverage of adults formerly under foster care) with respect to any territory.''.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply beginning October 1, 2021.

(d) PERMITTING MEDICAID DSH ALLOTMENTS FOR TERRITORIES.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4) is amended—

(1) in paragraph (6), by adding at the end the following new subparagraph:

"(C) TERRITORIES.—

"(i) FISCAL YEAR 2020.—For fiscal year 2020, the DSH allotment for Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa shall bear the same ratio to $300,000,000 as the ratio of the number of individuals who are low-income or uninsured and residing in such respective territory (as estimated from time to time by the Secretary) bears to the sums of the number of such individuals residing in all of the territories.

"(ii) SUBSEQUENT FISCAL YEAR.—For each subsequent fiscal year, the DSH allotment for each such territory is subject to an increase in accordance with paragraph (2).''; and

(2) in paragraph (9), by inserting before the period at the end the following: ", and includes, begin-

ning with fiscal year 2021, Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa''.

SEC. 509. REMOVING MEDICARE BARRIER TO HEALTH CARE.

(a) PART A.—Section 1818(a)(3) of the Social Security Act (42 U.S.C. 1395i–2(a)(3)) is amended by striking ''an alien'' and all that follows through ''under this section'' and inserting ''an individual who is lawfully present in the United States''.

(b) PART B.—Section 1836(2) of the Social Security Act (42 U.S.C. 1395o(2)) is amended by striking ''an alien'' and all that follows through ''under this part'' and inserting ''an individual who is lawfully present in the United States''.

SEC. 510. REMOVING BARRIERS TO HEALTH CARE AND NUTRITION ASSISTANCE FOR CHILDREN, PREGNANT PERSONS, AND LAWFULLY PRESENT INDIVIDUALS.

(a) MEDICAID.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended by striking paragraph (4) and inserting the following new paragraph:

''(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and paragraph (1),

payment shall be made to a State under this section for medical assistance furnished to an alien under this title (including an alien described in such paragraph) who meets any of the following conditions:

''(i) The alien is otherwise eligible for such assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment) within either or both of the following eligibility categories:

''(I) Children under 21 years of age, including any optional targeted low-income child (as such term is defined in section 1905(u)(2)(B)).

''(II) Pregnant persons during pregnancy and during the 12-month period beginning on the last day of the pregnancy.

''(ii) The alien is lawfully present in the United States.

''(B) No debt shall accrue under an affidavit of support against any sponsor of an alien who meets the conditions specified in subparagraph (A) on the basis of the provision of medical assistance to such alien under this

paragraph and the cost of such assistance shall not be considered as an unreimbursed cost.''.

(b) SCHIP.—Subparagraph (N) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

''(N) Paragraph (4) of section 1903(v) (relating to coverage of categories of children, pregnant persons, and other lawfully present individuals).''.

(c) SUPPLEMENTAL NUTRITION ASSISTANCE.—Notwithstanding sections 401(a), 402(a), and 403(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(a); 1612(a); 1613(a)) and section 6(f) of the Food and Nutrition Act of 2008 (7 U.S.C. 2015(f)), persons who are lawfully present in the United States shall be not be ineligible for benefits under the supplemental nutrition assistance program on the basis of their immigration status or date of entry into the United States.

(d) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—Section 421(d)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(d)(3)) is amended by striking ''to the extent that a qualified alien is eligible under section 402(a)(2)(J)'' and inserting, ''to the extent that a child is a member of

a household under the supplemental nutrition assistance program''.

(e) ENSURING PROPER SCREENING.—Section 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7 U.S.C. 2020(e)(2)(B)) is amended—

(1) by redesignating clauses (vi) and (vii) as clauses (vii) and (viii); and

(2) by inserting after clause (v) the following:

''(vi) shall provide a method for implementing section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631) that does not require any unnecessary information from persons who may be exempt from that provision;''.

SEC. 511. REPEAL OF REQUIREMENT FOR DOCUMENTATION EVIDENCING CITIZENSHIP OR NATIONALITY UNDER THE MEDICAID PROGRAM.

(a) REPEAL.—Subsections (i)(22) and (x) of section 1903 of the Social Security Act (42 U.S.C. 1396b) are each repealed.

(b) CONFORMING AMENDMENTS.—

(1) STATE PAYMENTS FOR MEDICAL ASSISTANCE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by amending paragraph (46) of subsection (a) to read as follows:

''(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act;'';

(B) in subsection (e)(13)(A)(i)—

(i) in the matter preceding subclause (I), by striking ''sections 1902(a)(46)(B) and 1137(d)'' and inserting ''section 1137(d)''; and

(ii) in subclause (IV), by striking ''1902(a)(46)(B) or''; and

(C) by striking subsection (ee).

(2) PAYMENT TO STATES.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i), by redesignating paragraphs (23) through (26) as paragraphs (22) through (25), respectively; and

(B) by redesignating subsections (y) and (z) as subsections (x) and (y), respectively.

(3) REPEAL.—Subsection (c) of section 6036 of the Deficit Reduction Act of 2005 (42 U.S.C. 1396b note) is repealed.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005.

TITLE VI—COMMUNITY BASED GRANTS

SEC. 601. GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.

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

(b) AUTHORITY TO AWARD GRANTS.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the ''Secretary''), shall award grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based, and community-driven sustainable strategies to eliminate racial and ethnic health and health care disparities.

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

(1) represent a coalition—

(A) whose principal purpose is to develop and implement interventions to reduce or eliminate a health or health care disparity in a targeted racial or ethnic minority group in the community served by the coalition; and

(B) that includes—

(i) members selected from among—

(I) public health departments;

(II) community-based organizations;

(III) university and research organizations;

(IV) Indian tribes or tribal organizations (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), the Indian Health Service, or any other organization that serves Alaska Natives; and

(V) interested public or private health care providers or organizations as determined appropriate by the Secretary; and

(ii) at least 1 member from a community-based organization that represents the

targeted racial or ethnic minority group; and

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

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

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted populations, including health issues such as infant mortality, breast and cervical cancer screening and management, musculoskeletal diseases and obesity, prostate cancer screening and management, cardiovascular disease, diabetes, child and adult immunization levels, oral disease, or other health priority areas as designated by the Secretary; and

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

(d) SUSTAINABILITY.—The Secretary shall give priority to an eligible entity under this section if the entity

agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant was awarded, the entity (and each of the participating partners in the coalition represented by the entity) will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such expenditures during the fiscal year immediately preceding the first fiscal year for which the grant is awarded.

(e) NONDUPLICATION.—Any funds provided to an eligible entity through a grant under this section shall—

(1) supplement, not supplant, any other Federal funds made available to the entity for the purposes of this section; and

(2) not be used to duplicate the activities of any other health disparity grant program under this Act, including an amendment made by this Act.

(f) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(g) DISSEMINATION.—The Secretary shall encourage and enable eligible entities receiving grants under this section to share best practices, evaluation results, and reports with communities not affiliated with such entities, by

using the Internet, conferences, and other pertinent information regarding the projects funded by this section, including through using outreach efforts of the Office of Minority Health and the Centers for Disease Control and Prevention.

(h) ADMINISTRATIVE BURDENS.—The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on eligible entities receiving grants under this section.

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

SEC. 602. GRANTS TO PROMOTE HEALTH FOR UNDERSERVED COMMUNITIES.

Part Q of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399Z–3. GRANTS TO PROMOTE HEALTH FOR UNDERSERVED COMMUNITIES.

''(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities—

''(1) to promote health for underserved communities, with preference given to projects that benefit racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer, or questioning communities; and

''(2) to strengthen health outreach initiatives in medically underserved communities, including linguistically isolated populations.

''(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support the activities of community health workers, including such activities—

''(1) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act, and Medicaid under title XIX of such Act;

''(2) to educate and provide outreach in a community setting regarding health problems prevalent among underserved communities, and especially among racial and ethnic minority women, racial and ethnic minority children, adolescents, and lesbian, gay, bisexual, transgender, queer, or questioning communities;

''(3) to educate and provide experiential learning opportunities and target risk factors and healthy behaviors that impede or contribute to achieving positive health outcomes, including—

''(A) healthy nutrition;

''(B) physical activity;

''(C) overweight or obesity;

''(D) tobacco use, including the use of e-cigarettes and vaping;

''(E) alcohol and substance use;

''(F) injury and violence;

''(G) sexual health;

''(H) mental health;

''(I) musculoskeletal health and arthritis;

''(J) prenatal and postnatal care;

''(K) dental and oral health;

''(L) understanding informed consent;

''(M) stigma; and

''(N) environmental hazards;

''(4) to promote community wellness and awareness; and

''(5) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to in-

crease access to quality health care services, including preventive health services.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

''(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

''(A) describe the activities for which assistance under this section is sought;

''(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant awarded, such program provides in-language training and supervision to community health workers to enable such workers to provide authorized program activities in (at least) the most commonly used languages within a particular geographic region;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

"(D) contain an assurance that each community health worker program receiving funds under the grant will provide culturally competent services in the linguistic context most appropriate for the individuals served by the program;

"(E) contain a plan to document and disseminate project descriptions and results to other States and organizations as identified by the Secretary; and

"(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

"(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

"(ii) providing other services, as the Secretary determines to be appropriate, which may include transportation and translation services.

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

''(1) who propose to target geographic areas that—

''(A)(i) have a high percentage of residents who are uninsured or underinsured (if the targeted geographic area is located in a State that has elected to make medical assistance available under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to individuals described in such section);

''(ii) have a high percentage of underinsured residents in a particular geographic area (if the targeted geographic area is located in a State that has not so elected); or

''(iii) have a high number of households experiencing extreme poverty; and

''(B) have a high percentage of families for whom English is not their primary language or including smaller limited English-proficient communities within the region that are not otherwise reached by linguistically appropriate health services;

''(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) with documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, including minority-serving institutions. Nothing in this section shall be construed to require such collaboration.

''(f) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for ensuring the quality of the training and supervision of community health workers under the programs funded under this section and for ensuring the cost effectiveness of such programs.

''(g) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications and shall determine whether such programs are in compliance with the guidelines established under subsection (f).

''(h) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications with respect to planning, developing, and operating programs under the grant.

''(i) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served.

''(C) An evaluation of—

''(i) the effectiveness of these programs;

''(ii) the cost of these programs; and

''(iii) the impact of these programs on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(j) DEFINITIONS.—In this section:

"(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

"(A) by serving as a liaison between communities and health care agencies;

"(B) by providing guidance and social assistance to community residents;

"(C) by enhancing community residents' ability to effectively communicate with health care providers;

"(D) by providing culturally and linguistically appropriate health or nutrition education;

"(E) by advocating for individual and community health, including dental, oral, mental, and environmental health, or nutrition needs;

"(F) by taking into consideration the needs of the communities served, including the prevalence rates of risk factors that impede achieving positive healthy outcomes among women and children, especially among racial and ethnic minority women and children; and

"(G) by providing referral and followup services.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization that serves a population.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a unit of State, territorial, local, or Tribal government (including a federally recognized Tribe or Alaska Native village); or

''(B) a community-based organization.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3);

''(B) a significant portion of which is a health professional shortage area as designated under section 332; and

''(C) that includes populations that are linguistically isolated, such as geographic areas with a shortage of health professionals able to provide linguistically appropriate services.

''(5) SUPPORT.—The term 'support' means the provision of training, supervision, and materials

needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2021 through 2025.''.

SEC. 603. ADDRESSING COVID–19 HEALTH INEQUITIES AND IMPROVING HEALTH EQUITY.

(a) IN GENERAL.—Not later than 60 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 Director of the Centers for Disease Control and Prevention, shall award grants to eligible entities to establish or expand programs to improve health equity regarding COVID–19 and reduce or eliminate inequities, including racial and ethnic inequities, in the incidence, prevalence, and health outcomes of COVID–19.

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

(1) be a nongovernmental entity or consortium of entities that works to improve health and health equity in populations or communities disproportionately affected by adverse health outcomes, including—

(A) racial and ethnic minority communities;

(B) Indian Tribes, Tribal organizations, and urban Indian organizations;

(C) people with disabilities;

(D) English language learners;

(E) older adults;

(F) low-income communities;

(G) justice-involved communities;

(H) immigrant communities; and

(I) communities on the basis of their sexual orientation or gender identity;

(2) have demonstrated experience in successfully working in and partnering with such communities, and have an established record of accomplishment in improving health outcomes or preventing, reducing or eliminating health inequities, including racial and ethnic inequities, in those communities;

(3) communicate with State, local, and Tribal health departments to coordinate grant activities, as appropriate; and

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

(c) USE OF FUNDS.—An entity shall use amounts received under grant under this section to establish, improve upon, or expand programs to improve health equity regarding COVID–19 and reduce or eliminate inequities, including racial and ethnic inequities, in the incidence, prevalence, and health outcomes of COVID–19. Such uses may include—

(1) acquiring and distributing medical supplies, such as personal protective equipment, to communities that are at an increased risk of COVID–19;

(2) helping people enroll in a health insurance plan that meets minimum essential coverage;

(3) increasing the availability of COVID–19 testing and any future COVID–19 treatments or vaccines in communities that are at an increased risk of COVID–19;

(4) aiding communities and individuals in following guidelines and best practices in regards to COVID–19, including physical distancing guidelines;

(5) helping communities and COVID–19 survivors recover and cope with the long-term health impacts of COVID–19;

(6) addressing social determinants of health, such as transportation, nutrition, housing, discrimination, health care access, including mental health

care and substance use disorder prevention, treatment, and recovery, health literacy, employment status, and working conditions, education, income, and stress, that impact COVID–19 incidence, prevalence, and health outcomes, and facilitating or providing access to needed services;

(7) the provision of anti-racism and implicit and explicit bias training for health care providers and other relevant professionals;

(8) creating and disseminating culturally informed, linguistically appropriate, accessible, and medically accurate outreach and education regarding COVID–19;

(9) acquiring, retaining, and training a diverse workforce; and

(10) improving the accessibility to health care, including accessibility to health care providers, mental health care, and COVID–19 testing for people with disabilities.

(d) ADMINISTRATION.—

(1) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities that are a community-based organization or have an established history of successfully working in and partnering with the community or with popu-

lations which the entity intends to provide services under the grant. The Secretary shall also utilize available demographic data to give priority to eligible entities working with populations or communities disproportionately affected by COVID–19.

(2) GEOGRAPHICAL DIVERSITY.—The Secretary shall seek to ensure geographical diversity among grant recipients.

(3) REDUCTION OF BURDENS.—In administering the grant program under this section, the Secretary shall make every effort to minimize unnecessary administrative burdens on eligible entities receiving such grants.

(4) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to eligible entities on best practices for applying grants under this section.

(e) DURATION.—A grant awarded under this section shall be for a period of 3 years.

(f) REPORTING.—

(1) BY GRANTEE.—Not later than 180 days after the end of a grant period under this section, the grantee shall submit to the Secretary a report on the activities conducted under the grant, including—

(A) a description of the impact of grant activities, including on—

(i) outreach and education related to COVID–19; and

(ii) improving public health activities related to COVID–19, including physical distancing;

(B) the number of individuals reached by the activities under the grant and, to the extent known, the disaggregated demographic data of such individuals, such as by race, ethnicity, sex (including sexual orientation and gender identity), income, disability status, or primary language; and

(C) any other information the Secretary determines is necessary.

(2) BY SECRETARY.—Not later than 1 year after the end of the grant program under this section, the Secretary shall submit to Congress a report on the grant program, including a summary of the information gathered under paragraph (1).

(g) SUPPLEMENT, NOT SUPPLANT.—Grants awarded under this Act shall be used to supplement and not supplant any other Federal funds made available to carry out the activities described in this Act.

(h) FUNDING.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to carry out this section, $500,000,000 for each of fiscal years 2020 through 2022.

SEC. 604. IMPROVING SOCIAL DETERMINANTS OF HEALTH.

(a) FINDINGS.—Congress finds the following:

(1) Healthy People 2020 defines social determinants of health as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

(2) One of the overarching goals of Healthy People 2020 is to ''create social and physical environments that promote good health for all''.

(3) Healthy People 2020 developed a ''place-based'' organizing framework, reflecting five key areas of social determinants of health namely—

(A) economic stability;

(B) education;

(C) social and community context;

(D) health and health care; and

(E) neighborhood and built environment.

(4) It is estimated that medical care accounts for only 10 to 20 percent of the modifiable contributors to healthy outcomes for a population.

(5) The Centers for Medicare & Medicaid Services has indicated the importance of the social determinants in its work stating that, ''As we seek to foster innovation, rethink rural health, find solutions to the opioid epidemic, and continue to put patients first, we need to take into account social determinants of health and recognize their importance.''.

(6) The Department of Health and Human Services' Public Health 3.0 initiative recognizes the role of public health in working across sectors on social determinants of health, as well as the role of public health as chief health strategist in communities.

(7) Through its Health Impact in 5 Years initiative, the Centers for Disease Control and Prevention has highlighted nonclinical, community-wide approaches that show positive health impacts, results within five years, and cost effectiveness or cost savings over the lifetime of the population or earlier.

(8) Health departments and the Centers for Disease Control and Prevention are not funded for such cross-cutting work.

(9) Providing grants to public health departments and other eligible entities to coordinate cross-sector collaboration will allow a community-wide, evi-

dence-based approach to address underlying social determinants of health.

(b) SOCIAL DETERMINANTS OF HEALTH PROGRAM.—

(1) PROGRAM.—To the extent and in the amounts made available in advance in appropriations Acts, the Director of the Centers for Disease Control and Prevention (in this section referred to as the ''Director'') shall carry out a program, to be known as the Social Determinants of Health Program (in this section referred to as the ''Program''), to achieve the following goals:

(A) Improve health outcomes and reduce health inequities by coordinating social determinants of health activities across the Centers for Disease Control and Prevention.

(B) Improve the capacity of public health agencies and community organizations to address social determinants of health in communities.

(2) ACTIVITIES.—To achieve the goals listed in paragraph (1), the Director shall carry out activities including the following:

(A) Coordinating across the Centers for Disease Control and Prevention to ensure that

relevant programs consider and incorporate social determinants of health in grant awards and other activities.

(B) Awarding grants under subsection (c) to State, local, territorial, and Tribal health agencies and organizations, and to other eligible entities, to address social determinants of health in target communities.

(C) Awarding grants under subsection (d) to nonprofit organizations and public or other nonprofit institutions of higher education—

(i) to conduct research on best practices to improve social determinants of health;

(ii) to provide technical assistance, training, and evaluation assistance to grantees under subsection (c); and

(iii) to disseminate best practices to grantees under subsection (c).

(D) Coordinating, supporting, and aligning activities of the Centers for Disease Control and Prevention related to social determinants of health with activities of other Federal agencies related to social determinants of health, including such activities of agencies in the Depart-

ment of Health and Human Services such as the Centers for Medicare & Medicaid Services.

(E) Collecting and analyzing data related to the social determinants of health.

(c) GRANTS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH.—

(1) IN GENERAL.—The Director, as part of the Program, shall award grants to eligible entities to address social determinants of health in their communities.

(2) ELIGIBILITY.—To be eligible to apply for a grant under this subsection, an entity shall be—

(A) a State, local, territorial, or Tribal health agency or organization;

(B) a qualified nongovernmental entity, as defined by the Director; or

(C) a consortium of entities that includes a State, local, territorial, or Tribal health agency or organization.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A grant under this subsection shall be used to address social determinants of health in a target community by designing and implementing innovative, evidence-based, cross-sector strategies.

(B) TARGET COMMUNITY.—For purposes of this subsection, a target community shall be a State, county, city, or other municipality.

(4) PRIORITY.—In awarding grants under this subsection, the Director shall prioritize applicants proposing to serve target communities with significant unmet health and social needs, as defined by the Director.

(5) APPLICATION.—To seek a grant under this subsection, an eligible entity shall—

(A) submit an application at such time, in such manner, and containing such information as the Director may require;

(B) propose a set of activities to address social determinants of health through evidence-based, cross-sector strategies, which activities may include—

(i) collecting quantifiable data from health care, social services, and other entities regarding the most significant gaps in health-promoting social, economic, and environmental needs;

(ii) identifying evidence-based approaches to meeting the nonmedical, social needs of populations identified by data 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

Social Security Act (42 U.S.C. 1396b(m)(1)(A))), Medicare Advantage plans under part C of title XVIII of such Act (42 U.S.C. 1395w–21 et seq.), and health insurance issuers and group health plans (as such terms are defined in section 2791 of the Public Health Service Act);

(iii) other relevant stakeholders and initiatives in areas of need, such as the Accountable Health Communities Model of the Centers for Medicare & Medicaid Services, health homes under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), community-based organizations, and human services organizations;

(iv) other non-health care sector organizations, including organizations focusing on transportation, housing, or food access; and

(v) local employers; and

(D) identify key health inequities in the target community and demonstrate how the proposed efforts of the eligible entity would address such inequities.

(6) MONITORING AND EVALUATION.—As a condition of receipt of a grant under this subsection, a grantee shall agree to submit an annual report to the Director describing the activities carried out through the grant and the outcomes of such activities.

(7) INDEPENDENT NATIONAL EVALUATION.—

(A) IN GENERAL.—Not later than 5 years after the first grants are awarded under this subsection, the Director shall provide for the commencement of an independent national evaluation of the Program under this subsection.

(B) REPORT TO CONGRESS.—Not later than 60 days after receiving the results of such independent national evaluation, the Director shall report such results to the Congress.

(d) RESEARCH AND TRAINING.—The Director, as part of the Program—

(1) shall award grants to nonprofit organizations and public or other nonprofit institutions of higher education—

(A) to conduct research on best practices to improve social determinants of health;

(B) to provide technical assistance, training, and evaluation assistance to grantees under subsection (c); and

(C) to disseminate best practices to grantees under subsection (c); and

(2) may require a grantee under paragraph (1) to provide technical assistance and capacity building to entities that are eligible entities under subsection (c) but not receiving funds through such subsection.

(e) FUNDING.—

(1) IN GENERAL.—There is authorized to be appropriated to carry out this section, $50,000,000 for each of fiscal years 2021 through 2026.

(2) ALLOCATION.—Of the amount made available to carry out this section for a fiscal year, not less than 75 percent shall be used for grants under subsections (c) and (d).

SEC. 605. FUNDING TO STATES, LOCALITIES, AND COMMUNITY-BASED ORGANIZATIONS FOR EMERGENCY AID AND SERVICES.

(a) FUNDING FOR STATES.—

(1) INCREASE IN FUNDING FOR SOCIAL SERVICES BLOCK GRANT PROGRAM.—

(A) APPROPRIATION.—Out of any money in the Treasury of the United States not other-

wise appropriated, there are appropriated $9,600,000,000, which shall be available for payments under section 2002 of the Social Security Act.

(B) DEADLINE FOR DISTRIBUTION OF FUNDS.—Within 45 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall distribute the funds made available by this paragraph, which shall be made available to States on an emergency basis for immediate obligation and expenditure.

(C) SUBMISSION OF REVISED PRE-EXPENDITURE REPORT.—Within 90 days after a State receives funds made available by this paragraph, the State shall submit to the Secretary a revised pre-expenditure report pursuant to title XX of the Social Security Act that describes how the State plans to administer the funds.

(D) OBLIGATION OF FUNDS BY STATES.—A State to which funds made available by this paragraph are distributed shall obligate the funds not later than December 31, 2020.

(E) EXPENDITURE OF FUNDS BY STATES.—A grantee to which a State (or a sub-

grantee to which a grantee) provides funds made available by this paragraph shall expend the funds not later than December 31, 2021.

(2) RULES GOVERNING USE OF ADDITIONAL FUNDS.—A State to which funds made available by paragraph (1)(B) are distributed shall use the funds in accordance with the following:

(A) PURPOSE.—

(i) IN GENERAL.—The State shall use the funds only to support the provision of emergency services to disadvantaged children, families, and households.

(ii) DISADVANTAGED DEFINED.—In this paragraph, the term ''disadvantaged'' means, with respect to an entity, that the entity—

(I) is an individual, or is located in a community, that is experiencing material hardship;

(II) is a household in which there is a child (as defined in section 12(d) of the Richard B. Russell National School Lunch Act) or a child served under section 11(a)(1) of such Act, who, if not for the closure of the

school attended by the child during a public health emergency designation and due to concerns about a COVID–19 outbreak, would receive free or reduced price school meals pursuant to such Act;

(III) is an individual, or is located in a community, with barriers to employment; or

(IV) is located in a community that, as of the date of the enactment of this Act, is not experiencing a 56-day downward trajectory of—

(aa) influenza-like illnesses;

(bb) COVID-like syndromic cases;

(cc) documented COVID–19 cases; or

(dd) positive test results as a percentage of total COVID–19 tests.

(B) PASS-THROUGH TO LOCAL ENTITIES.—

(i) In the case of a State in which a county administers or contributes finan-

cially to the non-Federal share of the amounts expended in carrying out a State program funded under title IV of the Social Security Act, the State may pass funds so made available through to—

(I) the chief elected official of the city or urban county that administers the program; or

(II) local government and community-based organizations.

(ii) In the case of any other State, the State shall—

(I) pass the funds through to—

(aa)(AA) local governments that will expend or distribute the funds in consultation with community-based organizations with experience serving disadvantaged families or individuals; or

(BB) community-based organizations with experience serving disadvantaged families and individuals; and

(bb) sub-State areas in proportions based on the population

of disadvantaged individuals living in the areas; and

(II) report to the Secretary on how the State determined the amounts passed through pursuant to this clause.

(C) METHODS.—

(i) IN GENERAL.—The State shall use the funds only for—

(I) administering emergency services;

(II) providing short-term cash, non-cash, or in-kind emergency disaster relief;

(III) providing services with demonstrated need in accordance with objective criteria that are made available to the public;

(IV) operational costs directly related to providing services described in subclauses (I), (II), and (III);

(V) local government emergency social service operations; and

(VI) providing emergency social services to rural and frontier commu-

nities that may not have access to other emergency funding streams.

(ii) ADMINISTERING EMERGENCY SERVICES DEFINED.—In clause (i), the term ''administering emergency services'' means—

(I) providing basic disaster relief, economic, and well-being necessities to ensure communities are able to safely observe shelter-in-place and social distancing orders;

(II) providing necessary supplies such as masks, gloves, and soap, to protect the public against infectious disease; and

(III) connecting individuals, children, and families to services or payments for which they may already be eligible.

(D) PROHIBITIONS.—

(i) NO INDIVIDUAL ELIGIBILITY DETERMINATIONS BY GRANTEES OR SUBGRANTEES.—Neither a grantee to which the State provides the funds nor any subgrantee 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.—

(A) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall make grants to federally recognized Indian Tribes and Tribal organizations.

(B) AMOUNT OF GRANT.—The amount of the grant for an Indian Tribe or Tribal organization shall bear the same ratio to the amount appropriated by paragraph (3) as the total amount of grants awarded to the Indian Tribe or Tribal organization under the Low-Income Home Energy Assistance Act of 1981 and the Community Service Block Grant for fiscal year 2020 bears to the total amount of grants awarded to all Indian Tribes and Tribal organizations under such Act and such Grant for the fiscal year.

(2) RULES GOVERNING USE OF FUNDS.—An entity to which a grant is made under paragraph (1) shall obligate the funds not later than December 31, 2020, and the funds shall be expended by grantees and subgrantees not later than December 31, 2021, and used in accordance with the following:

(A) PURPOSE.—

(i) IN GENERAL.—The grantee shall use the funds only to support the provision of emergency services to disadvantaged households.

(ii) DISADVANTAGED DEFINED.—In clause (i), the term ''disadvantaged'' means, with respect to an entity, that the entity—

(I) is an individual, or is located in a community, that is experiencing material hardship;

(II) is a household in which there is a child (as defined in section 12(d) of the Richard B. Russell National School Lunch Act) or a child served under section 11(a)(1) of such Act, who, if not for the closure of the school attended by the child during a public health emergency designation and due to concerns about a COVID–19 outbreak, would receive free or reduced price school meals pursuant to such Act;

(III) is an individual, or is located in a community, with barriers to employment; or

(IV) is located in a community that, as of the date of the enactment of this Act, is not experiencing a 56-day downward trajectory of—

(aa) influenza-like illnesses;

(bb) COVID-like syndromic cases;

(cc) documented COVID–19 cases; or

(dd) positive test results as a percentage of total COVID–19 tests.

(B) METHODS.—

(i) IN GENERAL.—The grantee shall use the funds only for—

(I) administering emergency services;

(II) providing short-term, non-cash, in-kind emergency disaster relief; and

(III) tribal emergency social service operations.

(ii) ADMINISTERING EMERGENCY SERVICES DEFINED.—In clause (i), the term ''administering emergency services'' means—

(I) providing basic economic and well-being necessities to ensure communities are able to safely observe shelter-in-place and social distancing orders;

(II) providing necessary supplies such as masks, gloves, and soap, to protect the public against infectious disease; and

(III) connecting individuals, children, and families to services or payments for which they may already be eligible.

(C) PROHIBITIONS.—

(i) NO INDIVIDUAL ELIGIBILITY DETERMINATIONS BY GRANTEES OR SUBGRANTEES.—Neither the grantee nor any subgrantee may exercise individual eligibility determinations for the purpose of administering short-term, non-cash, in-kind emergency disaster relief to communities.

(ii) BAN ON USE FOR CERTAIN COSTS REIMBURSABLE BY FEMA.—The grantee 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.

(3) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $400,000,000 to carry out this subsection.

SEC. 606. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.

(a) VALUE OF BENEFITS.—Notwithstanding any other provision of law, beginning on June 1, 2020, and for each subsequent month through September 30, 2021, the value of benefits determined under section 8(a) of the Food and Nutrition Act of 2008 (7 U.S.C. 2017(a)), and consolidated block grants for Puerto Rico and American Samoa determined under section 19(a) of such Act (7 U.S.C. 2028(a)), shall be calculated using 115 percent of the June 2019 value of the thrifty food plan (as defined in section 3 of such Act (7 U.S.C. 2012)) if the value of the benefits and block grants would be greater under that calculation than in the absence of this subsection.

(b) MINIMUM AMOUNT.—

(1) IN GENERAL.—The minimum value of benefits determined under section 8(a) of the Food and Nutrition Act of 2008 (7 U.S.C. 2017(a)) for a household of not more than 2 members shall be $30.

(2) EFFECTIVENESS.—Paragraph (1) shall remain in effect until the date on which 8 percent of the value of the thrifty food plan for a household containing 1 member, rounded to the nearest whole dollar increment, is equal to or greater than $30.

(c) REQUIREMENTS FOR THE SECRETARY.—In carrying out this section, the Secretary shall—

(1) consider the benefit increases described in each of subsections (a) and (b) to be a ''mass change'';

(2) require a simple process for States to notify households of the increase in benefits;

(3) consider section 16(c)(3)(A) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(c)(3)(A)) to apply to any errors in the implementation of this section, without regard to the 120-day limit described in that section;

(4) disregard the additional amount of benefits that a household receives as a result of this section in determining the amount of overissuances under

section 13 of the Food and Nutrition Act of 2008 (7 U.S.C. 2022); and

(5) set the tolerance level for excluding small errors for the purposes of section 16(c) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(c)) at $50 through September 30, 2021.

(d) PROVISIONS FOR IMPACTED WORKERS.—Notwithstanding any other provision of law, the requirements under subsections (d)(1)(A)(ii) and (o) of section 6 of the Food and Nutrition Act of 2008 (7 U.S.C. 2015) shall not be in effect during the period beginning on June 1, 2020, and ending 2 years after the date of enactment of this Act.

(e) ADMINISTRATIVE EXPENSES.—

(1) IN GENERAL.—For the costs of State administrative expenses associated with carrying out this section and administering the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), the Secretary shall make available $150,000,000 for fiscal year 2020 and $150,000,000 for fiscal year 2021.

(2) TIMING FOR FISCAL YEAR 2020.—Not later than 60 days after the date of the enactment of this

Act, the Secretary shall make available to States amounts for fiscal year 2020 under paragraph (1).

(3) ALLOCATION OF FUNDS.—Funds described in paragraph (1) shall be made available as grants to State agencies for each fiscal year as follows:

(A) 75 percent of the amounts available for each fiscal year shall be allocated to States based on the share of each State of households that participate in the supplemental nutrition assistance program as reported to the Department of Agriculture for the most recent 12-month period for which data are available, adjusted by the Secretary (as of the date of the enactment of this Act) for participation in disaster programs under section 5(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(h)); and

(B) 25 percent of the amounts available for each fiscal year shall be allocated to States based on the increase in the number of households that participate in the supplemental nutrition assistance program as reported to the Department of Agriculture over the most recent 12-month period for which data are available, adjusted by the Secretary (as of the date of the

enactment of this Act) for participation in disaster programs under section 5(h) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(h)).

(f) SNAP RULES.—No funds (including fees) made available under this Act or any other Act for any fiscal year may be used to finalize, implement, administer, enforce, carry out, or otherwise give effect to—

(1) the final rule entitled ''Supplemental Nutrition Assistance Program: Requirements for Able-Bodied Adults Without Dependents'' published in the Federal Register on December 5, 2019 (84 Fed. Reg. 66782);

(2) the proposed rule entitled ''Revision of Categorical Eligibility in the Supplemental Nutrition Assistance Program (SNAP)'' published in the Federal Register on July 24, 2019 (84 Fed. Reg. 35570); or

(3) the proposed rule entitled ''Supplemental Nutrition Assistance Program: Standardization of State Heating and Cooling Standard Utility Allowances'' published in the Federal Register on October 3, 2019 (84 Fed. Reg. 52809).

(g) CERTAIN EXCLUSIONS FROM SNAP INCOME.—A Federal pandemic unemployment compensation payment made to an individual under section 2104 of the

CARES Act (Public Law 116–136) shall not be regarded as income and shall not be regarded as a resource for the month of receipt and the following 9 months, for the purpose of determining eligibility for such individual or any other individual for benefits or assistance, or the amount of benefits or assistance, under any programs authorized under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(h) PUBLIC AVAILABILITY.—Not later than 10 days after the date of the receipt or issuance of each document listed below, the Secretary shall make publicly available on the website of the Department of Agriculture the following documents:

(1) Any State agency request to participate in the supplemental nutrition assistance program online program under section 7(k).

(2) Any State agency request to waive, adjust, or modify statutory or regulatory requirements under the Food and Nutrition Act of 2008 related to the COVID–19 outbreak.

(3) The Secretary's approval or denial of each such request under paragraphs (1) or (2).

(i) FUNDING.—There are hereby appropriated to the Secretary, out of any money not otherwise appropriated, such sums as may be necessary to carry out this section.

TITLE VII—CULTURALLY AND LINGUISTICALLY COMPETENT CARE

SEC. 701. ENSURING STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE.

(a) APPLICABILITY.—This section shall apply to any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or any program or activity that is administered by an executive agency or any entity established under title I of the Patient Protection and Affordable Care Act (42 U.S.C. 18001 et seq.) (or amendments made thereby).

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

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

(2) shall educate and train governance, leadership, and workforce at all levels and across all disciplines of the program or activity in culturally and

linguistically appropriate policies and practices on an ongoing basis at least yearly;

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

(4) shall for each language group consisting of individuals with limited English proficiency that constitutes 5 percent or 500 individuals, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered in the service area of the program or activity, make available at a fifth grade reading level—

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

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

(C) signage; and

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

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

(6) shall conduct initial and ongoing organizational assessments of culturally and linguistically appropriate services-related activities and integrate valid linguistic, competence-related National Standards for Culturally and Linguistically Appropriate Services (CLAS) measures into the internal audits, performance improvement programs, patient satisfaction assessments, continuous quality improvement activities, and outcomes-based evaluations of the program or activity and develop ways to standardize the assessments, and such assessments must occur at least yearly;

(7) shall ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320–2 note), data on an individual required 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;

(11) shall regularly make available to the public information about their progress and successful innovations in implementing the standards under this section and provide public notice in their communities about the availability of this information; and

(12) shall, if requested, regularly make available to the head of each Federal entity from which Federal funds are provided, information about the progress and successful innovations of the program or activity in implementing the standards under this section as required by the head of such entity.

(c) COMMENTS ACCEPTED THROUGH NOTICE AND COMMENT RULEMAKING.—An agency carrying out a program described in subsection (a) shall ensure that comments with respect to such program that are accepted through notice and comment rulemaking be accepted in all languages, may not require such comments to be submitted only in English, and must ensure these comments are considered equally as comments submitted in English during the agency's review of comments submitted.

SEC. 702. CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE IN THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as amended by section 104, is further amended by adding at the end the following:

"Subtitle B—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

"SEC. 3403. DEFINITIONS.

''(a) IN GENERAL.—In this title:

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

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

''(3) CULTURALLY AND LINGUISTICALLY APPROPRIATE.—The term 'culturally and linguistically appropriate' means being respectful of and respon-

sive to the cultural and linguistic needs of all individuals.

''(4) EFFECTIVE COMMUNICATION.—The term 'effective communication' means an exchange of information between the provider of health care or health-care-related services and the recipient of such services who is limited in English proficiency, or has a communication impairment such as a hearing, vision, speaking, or learning impairment, that enables access to, understanding of, and benefit from health care or health-care-related services, and full participation in the development of their treatment plan.

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

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

any such program that is affiliated with the health care group.

''(7) HEALTH CARE SERVICES.—The term 'health care services' means services that address physical as well as mental health conditions in all care settings.

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

''(9) HEALTH EDUCATOR.—The term 'health educator' includes a professional with a baccalaureate degree who is responsible for designing, implementing, and evaluating individual and population health promotion and chronic disease prevention programs.

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

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

''(12) INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY.—The term 'individual with limited English proficiency' means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.

''(13) INTEGRATED HEALTH CARE DELIVERY SYSTEM.—The term 'integrated health care delivery system' means an interdisciplinary system that brings together providers from the primary health, mental health, substance use disorder, and related disciplines to improve the health outcomes of an individual. Such providers may include hospitals, health, mental health, or substance use disorder clinics and providers, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation centers, and employed, independent, or contracted physicians.

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

''(15) LANGUAGE ACCESS.—The term 'language access' means the provision of language services to

an individual with limited English proficiency or an individual with communication disabilities designed to enhance that individual's access to, understanding of, or benefit from health care services or health-care-related services.

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

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

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

''(C) taglines.

''(17) MINORITY.—

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

''(B) POPULATIONS.—The term 'minority', with respect to populations, refers to racial and

ethnic minority groups, members of sexual and gender minority groups, and individuals with a disability.

''(18) MINORITY GROUP.—The term 'minority group' has the meaning given the term 'racial and ethnic minority group'.

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

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

''(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—

''(A) means an interpreter who by means of a remote interpreting service or an on-site appearance;

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

''(ii) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology; and

''(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).

''(22) QUALIFIED INTERPRETER FOR AN INDIVIDUAL WITH LIMITED ENGLISH PROFICIENCY.—The term 'qualified interpreter for an individual with limited English proficiency' means an interpreter

who via a remote interpreting service or an on-site appearance—

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

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

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

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

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

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

"(C) is able to translate effectively, accurately, and impartially to and from such lan-

guages and English, using any necessary specialized vocabulary, terminology, and phraseology.

''(24) RACIAL AND ETHNIC MINORITY GROUP.—The term 'racial and ethnic minority group' means Indians and Alaska Natives, African Americans (including Caribbean Blacks, Africans, and other Blacks), Asian Americans, Hispanics (including Latinos), and Native Hawaiians and other Pacific Islanders.

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

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

''(27) STATE.—Notwithstanding section 2, the term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto

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

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

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

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

ficiency, of video remote interpreting services that are—

"(A) in real-time, full-motion video, and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and

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

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

''(b) REFERENCE.—In any reference in this title to a regulatory provision applicable to a 'handicapped individual', the term 'handicapped individual' in such provision shall have the same meaning as the term 'individual with a disability' as defined in subsection (a).

"CHAPTER 1—RESOURCES AND INNOVATION FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

"SEC. 3404. ROBERT T. MATSUI CENTER FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE.

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

''(1) INTERPRETATION SERVICES.—The Center shall provide resources via the internet to identify and link health care providers to competent interpreter and translation services.

''(2) TRANSLATION OF WRITTEN MATERIAL.—

''(A) VITAL DOCUMENTS.—The Center 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

post all translated forms on its website so that other entities may use the same translations.

"(3) TOLL-FREE CUSTOMER SERVICE TELEPHONE NUMBER.—The Center shall provide, through a toll-free number, a customer service line for individuals with limited English proficiency—

"(A) to obtain information about federally conducted or funded health programs, including the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the State Children's Health Insurance Program under title XXI of such Act, marketplace coverage available pursuant to title XXVII of this Act and the Patient Protection and Affordable Care Act, and other sources of free or reduced care including federally qualified health centers, title X clinics, and public health departments;

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

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

"(4) HEALTH INFORMATION CLEARINGHOUSE.—

"(A) IN GENERAL.—The Center shall develop and maintain an information clearinghouse to facilitate the provision of language services by providers of health care services and health-care-related services to reduce medical errors, improve medical outcomes, improve cultural competence, reduce health care costs caused by miscommunication with individuals with limited English proficiency, and reduce or eliminate the duplication of efforts to translate materials. The clearinghouse shall include the information described in subparagraphs (B) through (F) and make such information available on the internet and in print.

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

"(i) Administrative and legal documents, including—

"(I) intake forms;

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

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

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

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

"(iii) Public health, patient education, and outreach materials, such as 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.

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

"(E) CULTURALLY AND LINGUISTICALLY APPROPRIATE MATERIALS.—The Center shall provide information relating to culturally and linguistically appropriate health care for minority populations residing in the United States to all health care providers and health-care-related services at no cost. Such information shall include—

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

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

"(iii) culturally and linguistically appropriate training tools;

"(iv) strategic plans to increase cultural and linguistic appropriateness in 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

publicly available information about the progress of entities receiving grants under section 3402 regarding successful innovations in implementing the obligations under this subsection and provide public notice in the entities' communities about the availability of this information.

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

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

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

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

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

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

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

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2021 through 2025.

"SEC. 3405. INNOVATIONS IN CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE GRANTS.

''(a) IN GENERAL.—

''(1) GRANTS.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve culturally and linguistically appropriate access to health care services for individuals with limited English proficiency.

''(2) COORDINATION.—The Director of the Agency for Healthcare Research and Quality shall coordinate with, and ensure the participation of, other agencies including the Health Resources and Services Administration, the National Institute on Minority Health and Health Disparities at the National Institutes of Health, and the Office of Minority Health, regarding the design and evaluation of the grants program.

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

''(1) be—

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

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

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

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

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

''(F) a public hospital;

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

''(H) any other entity designated by the Secretary; and

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

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

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

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

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

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

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

''(6) develop and implement grievance resolution processes that are culturally and linguistically appropriate and capable of identifying, preventing, and resolving complaints by individuals with limited English proficiency;

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

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

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

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

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

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

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

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

''(e) EVALUATION.—

''(1) BY GRANTEES.—An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes, in the manner and to the extent required by the Secretary, the activities carried out with funds received under the grant, and how such activities improved access to health care services and health-care-related services and the quality of health care for individuals with limited English proficiency. Such evaluation shall be collected and disseminated through the Robert T. Matsui Center for Culturally and Linguistically Appropriate Health Care established under section 3401. The Director of the Agency for Healthcare Research and Quality shall notify grantees of the availability of technical assistance for the evaluation and provide such assistance upon request.

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2021 through 2025.

"SEC. 3406. RESEARCH ON CULTURAL AND LANGUAGE COMPETENCE.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall expand research concerning language access in the provision of health care services.

''(b) ELIGIBILITY.—The Director of the Agency for Healthcare Research and Quality may conduct the research described in subsection (a) or enter into contracts with other individuals or organizations to conduct such research.

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

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

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

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

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

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

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

''(C) effective privacy safeguards for collected data.

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

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

''(A) provider type;

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

''(C) type of encounter;

''(D) time of encounter, including regular business hours and after hours; and

''(E) location of encounter.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2021 through 2025.".

SEC. 703. TRAINING TOMORROW'S DOCTORS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE: GRADUATE MEDICAL EDUCATION.

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

"(L) TREATMENT OF CULTURALLY AND LINGUISTICALLY APPROPRIATE TRAINING.—In determining a hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program for education and training in culturally and linguistically appropriate service delivery, which shall include all diverse populations including people with disabilities and the Lesbian, gay, bisexual, transgender, queer, questioning, questioning and intersex (LGBTQIA) community, shall be counted to-

ward the determination of full-time equivalency.''.

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

(1) by redesignating the clause (x) added by section 5505(b) of the Patient Protection and Affordable Care Act as clause (xi); and

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

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

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

SEC. 704. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

(a) LANGUAGE ACCESS GRANTS FOR MEDICARE PROVIDERS.—

(1) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

English learners, is disproportionally underserved.

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

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

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

(A) at least 6 grants to providers of services described in paragraph (2)(A)(i);

(B) at least 6 grants to service providers described in paragraph (2)(A)(ii);

(C) at least 6 grants to organizations described in paragraph (2)(A)(iii); and

(D) at least 6 grants to sponsors described in paragraph (2)(A)(iv).

(4) CONSIDERATIONS IN AWARDING GRANTS.—

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

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

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

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

(iv) The grantees serve Medicare beneficiaries in at least two geographic regions, as defined by the Secretary.

(v) The grantees serve Medicare beneficiaries in at least two large metropolitan statistical areas with racial, ethnic, sexual, gender, disability, and economically diverse populations.

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

(i) a community organization; or

(ii) a consortia of community organizations, State agencies, and local agencies, that has experience in providing language services.

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

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

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

(i) interpreter and translation services that—

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

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

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

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

(aa) onsite interpretation;

(bb) telephonic interpretation; or

(cc) video interpretation; and

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

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

(i) in the case of a Medicare beneficiary who is an English learner if—

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

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

(ii) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or trans-

lation services would jeopardize the health of the patient.

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

(D) MEDICARE ADVANTAGE ORGANIZATIONS AND PDP SPONSORS.—If a grantee is a Medicare Advantage organization offering a Medicare Advantage plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) or a PDP sponsor offering a prescription drug plan under part D of such title (42 U.S.C. 1395w–101 et seq.), such entity must provide at least 50 percent of the grant funds that the entity receives under this subsection directly to the entity's network providers (including all health providers and pharmacists) for the purpose of providing support for such providers to provide competent language serv-

ices to Medicare beneficiaries who are English learners.

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

(6) DETERMINATION OF AMOUNT OF GRANT PAYMENTS.—

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

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

(ii) data provided by the grantee, if the grantee routinely collects data on the

primary language of the Medicare beneficiaries that the grantee serves and the Secretary determines that the data is accurate and shows a greater number of English learners than would be estimated using the data under clause (i).

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

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

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

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

(B) ensure the linguistic competence of bilingual providers;

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

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

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

(F) ensure that—

(i) primary language data are collected for recipients of language services and such data are consistent with standards developed under title XXXIV of the Public Health Service Act, as added by section 202 of this Act, to the extent such standards are available upon the initiation of the demonstration program; and

(ii) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the

Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, primary language data are collected on the parent or legal guardian of such recipient.

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

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

(A) The number of Medicare beneficiaries to whom competent language services are provided.

(B) The primary languages of those Medicare beneficiaries.

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

(D) Whether such language services were provided by employees of the grantee or

through a contract with external contractors or agencies.

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

(F) The costs of providing competent language services.

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

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

(A) An analysis of the patient outcomes and the costs of furnishing care to the Medicare beneficiaries who are English learners participating in the project as compared to such outcomes and costs for such Medicare beneficiaries not participating, based on the data provided

under paragraph (9) and any other information available to the Secretary.

(B) The effect of delivering language services on—

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

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

(iii) patient satisfaction;

(iv) health outcomes; and

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

(C) The extent to which bilingual staff, interpreters, and translators providing services under such demonstration were trained or accredited and the nature of accreditation or training needed by type of provider, service, or other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to Medicare beneficiaries if such services are expanded pursuant to section 1115A(c) of the Social Security Act (42 U.S.C. 1315a(c)).

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

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

(12) ENGLISH LEARNER DEFINED.—In this subsection, the term ''English learner'' has the meaning given such term in section 8101(20) of the Elementary and Secondary Education Act of 1965, except that subparagraphs (A), (B), and (D) of such section shall not apply.

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

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

(A) in subsection (aa)(1)—

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

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

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

''(D) language assistance services as defined in subsection (jjj)(1),''; and

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

''Language Assistance Services and Related Terms

''(kkk)(1) The term 'language assistance services' means 'language access' or 'language assistance services' (as those terms are defined in section 3400 of the Public Health Service Act) furnished by a 'qualified interpreter for an individual with limited English proficiency' or a 'qualified translator' (as those terms are defined in such section 3400) to an 'individual with limited English proficiency' (as defined in such section 3400) or an 'English learner' (as defined in paragraph (2)).

''(2) The term 'English learner' has the meaning given that term in section 8101(20) of the Elementary and Secondary Education Act of 1965, except that subparagraphs (A), (B), and (D) of such section shall not apply.''.

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

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

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

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

''(K) language assistance services (as defined in section 1861(jjj)(1)).''.

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

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

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

(C) by inserting after paragraph (9) the following new paragraph:

''(10) in the case of language assistance services (as defined in section 1861(jjj)(1)), 100 percent of the reasonable charges for such services, as determined in consultation with the Medicare Payment Advisory Commission.''.

(4) WAIVER OF BUDGET NEUTRALITY.—For the 3-year period beginning on the date of enactment of this section, the budget neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply with respect to language assistance services (as defined in section 1861(kkk)(1) of such Act).

(c) MEDICARE PARTS C AND D.—

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

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

''(5) REPORTING REQUIREMENTS RELATING TO EFFECTIVE LANGUAGE SERVICES.—A contract under this part shall require a Medicare Advantage organi-

zation (and, through application of section 1860D–12(b)(3)(D), a contract under section 1860D–12 shall require a PDP sponsor) to annually submit (for each year of the contract) a report that contains information on the internal policies and procedures of the organization (or sponsor) related to recruitment and retention efforts directed to workforce diversity and linguistically and culturally appropriate provision of services in each of the following contexts:

''(A) The collection of data in a manner that meets the requirements of title I of the Ending Health Disparities During COVID–19 Act of 2020, regarding the enrollee population.

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

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

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

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

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

(1) PAYMENTS TO STATES.—Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)), as amended by section 203(g)(3), is further amended by—

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

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

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

(2) STATE PLAN REQUIREMENTS.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking ''and (29)'' and inserting ''(29), and (30)''.

(3) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by—

(A) in paragraph (29), by striking ''and'' at the end;

(B) by redesignating paragraph (30) as paragraph (31); and

(C) by inserting after paragraph (29) the following new paragraph:

''(30) language assistance services, as such term is defined in section 1861(kkk)(1), provided in a timely manner to individuals with limited English proficiency as defined in section 3400 of the Public Health Service Act; and''.

(4) USE OF DEDUCTIONS AND COST SHARING.—Section 1916(a)(2) of the Social Security Act (42 U.S.C. 1396o(a)(2)) is amended by—

(A) by striking ''or'' at the end of subparagraph (D);

(B) by striking ''; and'' at the end of subparagraph (E) and inserting '', or''; and

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

''(F) language assistance services described in section 1905(a)(29); and''.

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

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

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

''(10) LANGUAGE ASSISTANCE SERVICES.—The child health assistance provided to a targeted low-income child shall include coverage of language assistance services, as such term is defined in section 1861(jjj)(1), provided in a timely manner to individuals with limited English proficiency (as defined in section 3400 of the Public Health Service Act).''; and

(C) in subsection (e)(2)—

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

(ii) by inserting ''or subsection (c)(10)'' after ''subsection (c)(1)(D)''.

(6) DEFINITION OF CHILD HEALTH ASSISTANCE.—Section 2110(a)(27) of the Social Security Act (42 U.S.C. 1397jj(a)(27)) is amended by strik-

ing ''translation'' and inserting ''language assistance services as described in section 2103(c)(10)''.

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

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

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

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

(A) in subsection (a)(1), by striking ''75'' and inserting ''90''; and

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

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

(1) PAYMENT OF COSTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall make payments (on a quarterly basis) directly to eligible entities to support the provision of language assistance services to English learners in an amount equal to an eligible entity's eligible costs for providing such services for the quarter.

(B) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services such sums as may be necessary for each of fiscal years 2021 through 2025.

(C) RELATION TO MEDICAID DSH.—Payments under this subsection shall not offset or reduce payments under section 1923 of the Social Security Act (42 U.S.C. 1396r–4), nor shall payments under such section be consid-

ered when determining uncompensated costs associated with the provision of language assistance services for the purposes of this section.

(2) METHODOLOGY FOR PAYMENT OF CLAIMS.—

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

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

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

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

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

(5) REPORTING REQUIREMENTS.—

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

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

(6) DEFINITIONS.—In this subsection:

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

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

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

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

(i) is a Medicaid provider that is—

(I) a physician;

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

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

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

(iii) prepares and submits an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require, to ascertain the entity's eligibility for funding under this subsection.

(C) ENGLISH LEARNER.—The term ''English learner'' has the meaning given such term in section 8101(20) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801(20)), except that subparagraphs (A), (B), and (D) of such section shall not apply.

(D) LANGUAGE ASSISTANCE SERVICES.—The term ''language assistance services'' has the meaning given such term in section 1861(kkk)(1) of the Social Security Act, as added by subsection (b).

(f) APPLICATION OF CIVIL RIGHTS ACT OF 1964, SECTION 1557 OF THE AFFORDABLE CARE ACT, AND

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

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided and subject to paragraph (2), the amendments made by this section shall take effect on January 1, 2021.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature

that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 705. REQUIREMENTS FOR HEALTH PROGRAMS OR ACTIVITIES RECEIVING FEDERAL FUNDS.

(a) COVERED ENTITY; COVERED PROGRAM OR ACTIVITY.—In this section—

(1) the term ''covered entity'' has the meaning given such term in section 92.4 of title 42, Code of Federal Regulations, as in effect on May 16, 2016; and

(2) the term ''covered program or activity'' has the meaning given such term in section 92.4 of title 42, Code of Federal Regulations, as in effect on May 16, 2016.

(b) REQUIREMENTS.—A covered entity, in order to ensure the right of individuals with limited English proficiency to receive access to high-quality health care through the covered program or activity, shall—

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

(2) offer and provide appropriate language assistance services at no additional charge to each patient that is an individual with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(3) notify patients of their right to receive language services in their primary language; and

(4) utilize only qualified interpreters for an individual with limited English proficiency or qualified translators, except as provided in subsection (c).

(c) EXEMPTIONS.—The requirements of subsection (b)(4) shall not apply as follows:

(1) When a patient requests the use of family, friends, or other persons untrained in interpretation or translation if each of the following conditions are met:

(A) The interpreter requested by the patient is over the age of 18.

(B) The covered entity informs the patient in the primary language of the patient that he or she has the option of having the entity provide to the patient an interpreter and translation services without charge.

(C) The covered entity informs the patient that the entity may not require an individual

with a limited English proficiency to use a family member or friend as an interpreter.

(D) The covered entity evaluates whether the person the patient wishes to use as an interpreter is competent. If the covered entity has reason to believe that such person is not competent as an interpreter, the entity provides its own interpreter to protect the covered entity from liability if the patient's interpreter is later found not competent.

(E) If the covered entity has reason to believe that there is a conflict of interest between the interpreter and patient, the covered entity may not use the patient's interpreter.

(F) The covered entity has the patient sign a waiver, witnessed by at least 1 individual not related to the patient, that includes the information stated in subparagraphs (A) through (E) and is translated into the patient's primary language.

(2) When a medical emergency exists and the delay directly associated with obtaining competent interpreter or translation services would jeopardize the health of the patient, but only until a competent interpreter or translation service is available.

(d) RULE OF CONSTRUCTION.—Subsection (c)(2) shall not be construed to mean that emergency rooms or similar entities that regularly provide health care services in medical emergencies are exempt from legal or regulatory requirements related to competent interpreter services.

SEC. 706. REPORT ON FEDERAL EFFORTS TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.

(a) REPORT.—Not later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall enter into a contract with the National Academy of Medicine for the preparation and publication of a report that describes Federal efforts to ensure that all individuals with limited English proficiency have meaningful access to health care services and health-care-related services that are culturally and linguistically appropriate. Such report shall include—

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

(2) a description and analysis of best practices, model programs, guidelines, and other effective strategies for providing access to culturally and linguistically appropriate health care services;

(3) recommendations on the development and implementation of policies and practices by providers of health care services and health-care-related services for individuals with limited English proficiency, including people with cognitive, hearing, vision, or print impairments;

(4) recommend guidelines or standards for health literacy and plain language, informed consent, discharge instructions, and written communications, and for improvement of health care access;

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

(6) a description of the costs associated with or savings related to the provision of language services.

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

SEC. 707. HEALTH PROFESSIONS COMPETENCIES TO ADDRESS RACIAL AND ETHNIC MENTAL HEALTH DISPARITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Assistant Secretary

for Mental Health and Substance Use, shall award grants to qualified national organizations for the purposes of—

(1) developing, and disseminating to health professional educational programs curricula or core competencies addressing mental health inequities among racial and ethnic minority groups for use in the training of students in the professions of social work, psychology, psychiatry, marriage and family therapy, mental health counseling, peer support, and substance abuse counseling; and

(2) certifying community health workers and peer wellness specialists with respect to such curricula and core competencies and integrating and expanding the use of such workers and specialists into health care and community-based settings to address mental health disparities among racial and ethnic minority groups.

(b) CURRICULA; CORE COMPETENCIES.—Organizations receiving funds under subsection (a) may use the funds to engage in the following activities related to the development and dissemination of curricula or core competencies described in subsection (a)(1):

(1) Formation of committees or working groups comprised of experts from accredited health professions schools to identify core competencies relating

to mental health disparities among racial and ethnic minority groups.

(2) Planning of workshops in national fora to allow for public input, including input from communities of color with lived experience, into the educational needs associated with mental health disparities among racial and ethnic minority groups.

(3) Dissemination and promotion of the use of curricula or core competencies in undergraduate and graduate health professions training programs nationwide.

(4) Establishing external stakeholder advisory boards to provide meaningful input into policy and program development and best practices to reduce mental health inequities among racial and ethnic groups, including participation from communities of color with lived experience of the impacts of mental health disparities.

(c) DEFINITIONS.—In this section:

(1) QUALIFIED NATIONAL ORGANIZATION.—The term ''qualified national organization'' means a national organization that focuses on the education of students in programs of social work, occupational therapy, psychology, psychiatry, and marriage and family therapy.

(2) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given to such term in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g)).

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

SEC. 708. STUDY ON THE UNINSURED.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(1) conduct a study, in accordance with the standards under section 3101 of the Public Health Service Act (42 U.S.C. 300kk), on the demographic characteristics of the population of individuals who do not have health insurance coverage or oral health coverage; and

(2) predict, based on such study, the demographic characteristics of the population of individuals who would remain without health insurance coverage after the end of any annual open enrollment or any special enrollment period or upon enactment and implementation of any legislative changes to the

Patient Protection and Affordable Care Act (Public Law 111–148) that affect the number of persons eligible for coverage.

(b) REPORTING REQUIREMENTS.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to the Congress the results of the study under subsection (a)(1) and the prediction made under subsection (a)(2).

(2) REPORTING OF DEMOGRAPHIC CHARACTERISTICS.—The Secretary shall—

(A) report the demographic characteristics under paragraphs (1) and (2) of subsection (a) on the basis of racial and ethnic group, and shall stratify the reporting on each racial and ethnic group by other demographic characteristics that can impact access to health insurance coverage, such as sexual orientation, gender identity, primary language, disability status, sex, socioeconomic status, age group, and citizenship and immigration status, in a manner consistent with title I of this Act, including the amendments made by such title; and

(B) not use such report to engage in or anticipate any deportation or immigration related

enforcement action by any entity, including the Department of Homeland Security.

TITLE VIII—AID TO PROVIDERS SERVING MINORITY COMMUNITIES

SEC. 801. TEMPORARY INCREASE IN MEDICAID DSH ALLOTMENTS.

(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 subparagraph (E)'' and inserting ''and subparagraphs (E) and (F)''; and

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

''(F) TEMPORARY INCREASE IN ALLOTMENTS 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, notwithstanding subparagraphs (B) and (C). For each fiscal year after fiscal year 2021, the DSH allotment for a State for such fiscal year is

equal to the DSH allotment that would have been determined under this paragraph for such fiscal year if this subparagraph had not been enacted.''.

(b) DSH ALLOTMENT ADJUSTMENT FOR TENNESSEE.—Section 1923(f)(6)(A)(vi) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)(A)(vi)) is amended—

(1) by striking ''Notwithstanding any other provision of this subsection'' and inserting the following:

''(I) IN GENERAL.—Notwithstanding any other provision of this subsection (except as provided in subclause (II) of this clause)''; and

(2) by adding at the end the following:

''(II) TEMPORARY INCREASE IN ALLOTMENTS.—The DSH allotment for Tennessee for each of fiscal years 2020 and 2021 shall be equal to $54,427,500.''.

(c) SENSE OF CONGRESS.—It is the sense of Congress that a State should prioritize making payments under the State plan of the State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) to disproportionate share hospitals that have

a higher share of COVID–19 patients relative to other such hospitals in the State.

SEC. 802. COVID–19-RELATED TEMPORARY INCREASE OF MEDICAID FMAP.

(a) IN GENERAL.—Section 6008 of the Families First Coronavirus Response Act (42 U.S.C. 1396d note) is amended—

(1) in subsection (a)—

(A) by inserting ''(or, if later, June 30, 2021)'' after ''last day of such emergency period occurs''; and

(B) by striking ''6.2 percentage points.'' and inserting ''the percentage points specified in subsection (e). In no case may the application of this section result in the Federal medical assistance percentage determined for a State being more than 95 percent.''; and

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

''(e) SPECIFIED PERCENTAGE POINTS.—For purposes of subsection (a), the percentage points specified in this subsection are—

''(1) for each calendar quarter occurring during the period beginning on the first day of the emergency period described in paragraph (1)(B) of sec-

tion 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) and ending on June 30, 2020, 6.2 percentage points;

''(2) for each calendar quarter occurring during the period beginning on July 1, 2020, and ending on June 30, 2021, 14 percentage points; and

''(3) for each calendar quarter, if any, occurring during the period beginning on July 1, 2021, and ending on the last day of the calendar quarter in which the last day of such emergency period occurs, 6.2 percentage points.

''(f) CLARIFICATIONS.—

''(1) In the case of a State that treats an individual described in subsection (b)(3) as eligible for the benefits described in such subsection, for the period described in subsection (a), expenditures for medical assistance and administrative costs attributable to such individual that would not otherwise be included as expenditures under section 1903 of the Social Security Act shall be regarded as expenditures under the State plan approved under title XIX of the Social Security Act or for administration of such State plan.

''(2) The limitations on payment under subsections (f) and (g) of section 1108 of the Social Se-

curity Act (42 U.S.C. 1308) shall not apply to Federal payments made under section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)) attributable to the increase in the Federal medical assistance percentage under this section.

''(3) Expenditures attributable to the increased Federal medical assistance percentage under this section shall not be counted for purposes of the limitations under section 2104(b)(4) of such Act (42 U.S.C. 1397dd(b)(4)).

''(4) Notwithstanding the first sentence of section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)), the application of the increase under this section may result in the enhanced FMAP of a State for a fiscal year under such section exceeding 85 percent, but in no case may the application of such increase before application of the second sentence of such section result in the enhanced FMAP of the State exceeding 95 percent.

''(g) SCOPE OF APPLICATION.—An increase in the Federal medical assistance percentage for a State under this section shall not be taken into account for purposes of payments under part D of title IV of the Social Security Act (42 U.S.C. 651 et seq.).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect and apply as if included in the enactment of section 6008 of the Families First Coronavirus Response Act (Public Law 116–127).

SEC. 803. APPROPRIATION FOR PRIMARY HEALTH CARE.

For an additional amount for ''Department of Health and Human Services—Health Resources and Services Administration—Primary Health Care'', $7,600,000,000, to remain available until September 30, 2025, for necessary expenses to prevent, prepare for, and respond to coronavirus, for grants and cooperative agreements under the Health Centers Program, as defined by section 330 of the Public Health Service Act, and for grants to Federally qualified health centers, as defined in section 1861(aa)(4)(B) of the Social Security Act, and for eligible entities under the Native Hawaiian Health Care Improvement Act, including maintenance or expansion of health center and system capacity and staffing levels: *Provided*, That sections 330(r)(2)(B), 330(e)(6)(A)(iii), and 330(e)(6)(B)(iii) shall not apply to funds provided under this heading in this section: *Provided further*, That funds provided under this heading in this section may be used to (1) purchase equipment and supplies to conduct mobile testing for SARS–CoV–2 or COVID–19; (2) purchase and maintain mobile vehicles and equipment to conduct such

testing; and (3) hire and train laboratory personnel and other staff to conduct such mobile testing: *Provided further*, That such amount is designated by the Congress as being for an emergency requirement pursuant to section 251(b)(2)(A)(i) of the Balanced Budget and Emergency Deficit Control Act of 1985.

SEC. 804. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as amended by sections 104 and 702, is further amended by adding at the following:

"Subtitle C—Reconstruction and Improvement Grants for Public Health Care Facilities Serving Pacific Islanders and the Insular Areas

"SEC. 3407. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

''(a) IN GENERAL.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Centers for Medicare & Medicaid Services, shall award grants to eligible entities for the conduct of dem-

onstration projects to improve the quality of and access to health care.

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

''(1) be a health center, hospital, health plan, health system, community clinic, or other health entity determined appropriate by the Secretary—

''(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

''(B) that provides care or treatment for a substantial number of patients who are uninsured, are receiving assistance under a State plan under title XIX of the Social Security Act (or under a waiver of such plan), or are members of vulnerable populations, as determined by the Secretary; and

''(C)(i) with respect to which, not less than 50 percent of the entity's patient population is made up of racial and ethnic minority groups; or

''(ii) that—

''(I) serves a disproportionate percentage of local patients that are from a racial and ethnic minority group, or that has a

patient population, at least 50 percent of which is composed of individuals with limited English proficiency; and

"(II) provides an assurance that amounts received under the grant will be used only to support quality improvement activities in the racial and ethnic minority population served; and

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

"(c) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants under subsection (b)(2) that—

"(1) demonstrate an intent to operate as part of a health care partnership, network, collaborative, coalition, or alliance where each member entity contributes to the design, implementation, and evaluation of the proposed intervention; or

"(2) intend to use funds to carry out system-wide changes with respect to health care quality improvement, including—

"(A) improved systems for data collection and reporting;

"(B) innovative collaborative or similar processes;

"(C) group programs with behavioral or self-management interventions;

"(D) case management services;

"(E) physician or patient reminder systems;

"(F) educational interventions; or

"(G) other activities determined appropriate by the Secretary.

"(d) USE OF FUNDS.—An entity shall use amounts received under a grant under subsection (a) to support the implementation and evaluation of health care quality improvement activities or minority health and health care disparity reduction activities that include—

"(1) with respect to health care systems, activities relating to improving—

"(A) patient safety;

"(B) timeliness of care;

"(C) effectiveness of care;

"(D) efficiency of care;

"(E) patient centeredness; and

"(F) health information technology; and

"(2) with respect to patients, activities relating to—

''(A) staying healthy;

''(B) getting well, mentally and physically;

''(C) living effectively with illness or disability;

''(D) coping with end-of-life issues; and

''(E) shared decision making.

''(e) COMMON DATA SYSTEMS.—The Secretary shall provide financial and other technical assistance to grantees under this section for the development of common data systems.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.

''SEC. 3408. CENTERS OF EXCELLENCE.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall designate centers of excellence at public hospitals, and other health systems serving large numbers of minority patients, that—

''(1) meet the requirements of section 3451(b)(1);

''(2) demonstrate excellence in providing care to minority populations; and

''(3) demonstrate excellence in reducing disparities in health and health care.

''(b) REQUIREMENTS.—A hospital or health system that serves as a center of excellence under subsection (a) shall—

''(1) design, implement, and evaluate programs and policies relating to the delivery of care in racially, ethnically, and linguistically diverse populations;

''(2) provide training and technical assistance to other hospitals and health systems relating to the provision of quality health care to minority populations; and

''(3) develop activities for graduate or continuing medical education that institutionalize a focus on cultural competence training for health care providers.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2026.

"SEC. 3409. RECONSTRUCTION AND IMPROVEMENT GRANTS FOR PUBLIC HEALTH CARE FACILITIES SERVING PACIFIC ISLANDERS AND THE INSULAR AREAS.

''(a) IN GENERAL.—The Secretary shall provide direct financial assistance to designated health care providers and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving health care facilities and services in a culturally competent and sustainable manner.

''(b) ELIGIBILITY.—To be eligible to receive direct financial assistance under subsection (a), an entity shall be a public health facility or community health center located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, or Hawaii that—

''(1) is owned or operated by—

''(A) the Government of American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, or Hawaii or a unit of local government; or

''(B) a nonprofit organization; and

''(2)(A) provides care or treatment for a substantial number of patients who are uninsured, receiving assistance under title XVIII of the Social Security Act, or a State plan under title XIX of such Act (or under a waiver of such plan), or who are members of a vulnerable population, as determined by the Secretary; or

''(B) serves a disproportionate percentage of local patients that are from a racial and ethnic minority group.

''(c) REPORT.—Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary shall submit to the Congress and the President a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii. In preparing such report, the Secretary shall—

''(1) consult with and obtain information on all health care facilities needs from the entities receiving direct financial assistance under subsection (a);

''(2) include all amounts of Federal assistance received by each such entity in the preceding fiscal year;

''(3) review the total unmet needs of health care facilities serving American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii, including needs for renovation and expansion of existing facilities;

''(4) include a strategic plan for addressing the needs of each such population identified in the report; and

''(5) evaluate the effectiveness of the care provided by measuring patient outcomes and cost measures.

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

SEC. 805. PANDEMIC PREMIUM PAY FOR ESSENTIAL WORKERS.

(a) IN GENERAL.— Beginning 3 days after an essential work employer receives a grant under section 806 from the Secretary of the Treasury, the essential work employer shall—

(1) be required to comply with subsections (b) through (h); and

(2) be subject to the enforcement requirements of section 807.

(b) PANDEMIC PREMIUM PAY.—

(1) IN GENERAL.—An essential work employer receiving a grant under section 806 shall, in accordance with this subsection, provide each essential worker of the essential work employer with premium pay at a rate equal to $13 for each hour of work performed by the essential worker for the employer from January 27, 2020, until the date that is 60 days after the last day of the COVID–19 Public Health Emergency.

(2) MAXIMUM AMOUNTS.—The total amount of all premium pay under this subsection that an essential work employer is required to provide to an essential worker, including through any retroactive payment under paragraph (3), shall not exceed—

(A) for an essential worker who is not a highly-compensated essential worker, $10,000 reduced by employer payroll taxes with respect to such premium pay; or

(B) for a highly-compensated essential worker, $5,000 reduced by employer payroll taxes with respect to such premium pay.

(3) RETROACTIVE PAYMENT.—For all work performed by an essential worker during the period from January 27, 2020, through the date on which

the essential work employer of the worker receives a grant under this title, the essential work employer shall use a portion of the amount of such grant to provide such worker with premium pay under this subsection for such work at the rate provided under paragraph (1). Such amount shall be provided to the essential worker as a lump sum in the next paycheck (or other payment form) that immediately follows the receipt of the grant by the essential work employer. In any case where it is impossible for the employer to arrange for payment of the amount due in such paycheck (or other payment form), such amounts shall be paid as soon as practicable, but in no event later than the second paycheck (or other payment form) following the receipt of the grant by the essential work employer.

(4) NO EMPLOYER DISCRETION.—An essential work employer receiving a grant under section 806 shall not have any discretion to determine which portions of work performed by an essential worker qualify for premium pay under this subsection, but shall pay such premium pay for any increment of time worked by the essential worker for the essential work employer up to the maximum amount applicable to the essential worker under paragraph (2).

(c) PROHIBITION ON REDUCING COMPENSATION AND DISPLACEMENT.—

(1) IN GENERAL.—Any payments made to an essential worker as premium pay under subsection (b) shall be in addition to all other compensation, including all wages, remuneration, or other pay and benefits, that the essential worker otherwise receives from the essential work employer.

(2) REDUCTION OF COMPENSATION.—An essential work employer receiving a grant under section 806 shall not, during the period beginning on the date of enactment of this Act and ending on the date that is 60 days after the last day of the COVID–19 Public Health Emergency, reduce or in any other way diminish, any other compensation, including the wages, remuneration, or other pay or benefits, that the essential work employer provided to the essential worker on the day before the date of enactment of this Act.

(3) DISPLACEMENT.—An essential work employer shall not take any action to displace an essential worker (including partial displacement such as a reduction in hours, wages, or employment benefits) for purposes of hiring an individual for an equivalent position at a rate of compensation that is less than

is required to be provided to an essential worker under paragraph (2).

(d) DEMARCATION FROM OTHER COMPENSATION.—The amount of any premium pay paid under subsection (b) shall be clearly demarcated as a separate line item in each paystub or other document provided to an essential worker that details the remuneration the essential worker received from the essential work employer for a particular period of time. If any essential worker does not otherwise regularly receive any such paystub or other document from the employer, the essential work employer shall provide such paystub or other document to the essential worker for the duration of the period in which the essential work employer provides premium pay under subsection (b).

(e) EXCLUSION FROM WAGE-BASED CALCULATIONS.—Any premium pay under subsection (b) paid to an essential worker under this section by an essential work employer receiving a grant under section 806 shall be excluded from the amount of remuneration for work paid to the essential worker for purposes of—

(1) calculating the essential worker's eligibility for any wage-based benefits offered by the essential work employer;

(2) computing the regular rate at which such essential worker is employed under section 7 of the

Fair Labor Standards Act of 1938 (29 U.S.C. 207); and

(3) determining whether such essential worker is exempt from application of such section 7 under section 13(a)(1) of such Act (29 U.S.C. 213(a)(1)).

(f) ESSENTIAL WORKER DEATH.—

(1) IN GENERAL.—In any case in which an essential worker of an essential work employer receiving a grant under section 806 exhibits symptoms of COVID–19 and dies, the essential work employer shall pay as a lump sum to the next of kin of the essential worker for premium pay under subsection (b)—

(A) for an essential worker who is not a highly-compensated essential worker, the amount determined under subsection (b)(2)(A) minus the total amount of any premium pay the worker received under subsection (b) prior to the death; or

(B) for a highly-compensated essential worker, the amount determined under subsection (b)(2)(B) minus the amount of any premium pay the worker received under subsection (b) prior to the death.

(2) TREATMENT OF LUMP SUM PAYMENTS.—

(A) TREATMENT AS PREMIUM PAY.—For purposes of this title, any payment made under this subsection shall be treated as a premium pay under subsection (b).

(B) TREATMENT FOR PURPOSES OF INTERNAL REVENUE CODE OF 1986.—For purposes of the Internal Revenue Code of 1986, any payment made under this subsection shall be treated as a payment for work performed by the essential worker.

(g) APPLICATION TO SELF-DIRECTED CARE WORKERS FUNDED THROUGH MEDICAID OR THE VETERAN-DIRECTED CARE PROGRAM.—

(1) MEDICAID.—In the case of an essential work employer receiving a grant under section 806 that is a covered employer described in paragraph (4) who, under a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan, has opted to receive items or services using a self-directed service delivery model, the preceding requirements of this section, including the requirements to provide premium pay under subsection (b) (including a lump sum payment in the event of an essential worker death under subsection (f)) and the requirements of

sections 806 and 807, shall apply to the State Medicaid agency responsible for the administration of such plan or waiver with respect to self-directed care workers employed by that employer. In administering payments made under this title to such self-directed care workers on behalf of such employers, a State Medicaid agency shall—

(A) exclude and disregard any payments made under this title to such self-directed workers from the individualized budget that applies to the items or services furnished to the individual client employer under the State Medicaid plan or waiver;

(B) to the extent practicable, administer and provide payments under this title directly to such self-directed workers through arrangements with entities that provide financial management services in connection with the self-directed service delivery models used under the State Medicaid plan or waiver; and

(C) ensure that individual client employers of such self-directed workers are provided notice of, and comply with, the prohibition under section 807(b)(1)(B).

(2) VETERAN-DIRECTED CARE PROGRAM.—In the case of an essential work employer that is a covered employer described in paragraph (4) who is a veteran participating in the Veteran Directed Care program administered by the VA Office of Geriatrics & Extended Care of the Veterans Health Administration, the preceding requirements of this section and sections 806 and 807, shall apply to such VA Office of Geriatrics & Extended Care with respect to self-directed care workers employed by that employer. Paragraph (1) of this subsection shall apply to the administration by the VA Office of Geriatrics & Extended Care of payments made under this title to such self-directed care workers on behalf of such employers in the same manner as such requirements apply to State Medicaid agencies.

(3) PENALTY ENFORCEMENT.—The Secretary of Labor shall consult with the Secretary of Health and Human Services and the Secretary of Veterans Affairs regarding the enforcement of penalties imposed under section 807(b)(2) with respect to violations of subparagraph (A) or (B) of section 807(b)(1) that involve self-directed workers for which the requirements of this section and sections 806 and 807 are applied to a State Medicaid agency

under paragraph (1) or the VA Office of Geriatrics & Extended Care under paragraph (2).

(4) COVERED EMPLOYER DESCRIBED.—For purposes of paragraphs (1) and (2), a covered employer described in this paragraph means—

(A) an entity or person that contracts directly with a State, locality, Tribal government, or the Federal Government, to provide care (which may include items and services) through employees of such entity or person to individuals under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan, or under any other program established or administered by a State, locality, Tribal government, or the Federal Government;

(B) a subcontractor of an entity or person described in subparagraph (A);

(C) an individual client (or a representative on behalf of an individual client), an entity, or a person, that employs an individual to provide care (which may include items and services) to the individual client under a self-di-

rected service delivery model through a program established or administered by a State, locality, Tribal government, or the Federal Government; or

(D) an individual client (or a representative on behalf of an individual client) that, on their own accord, employs an individual to provide care (which may include items and services) to the individual client using the individual client's own finances.

(h) INTERACTION WITH STAFFORD ACT.—Nothing in this section shall nullify, supersede, or otherwise change a State's ability to seek reimbursement under section 403 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170b) for the costs of premium pay based on pre-disaster labor policies for eligible employees.

(i) CALCULATION OF PAID LEAVE UNDER FFCRA AND FMLA.—

(1) FAMILIES FIRST CORONAVIRUS RESPONSE ACT.—Section 5110(5)(B) of the Families First Coronavirus Response Act (29 U.S.C. 2601 note) is amended by adding at the end the following:

"(iii) PANDEMIC PREMIUM PAY.—Compensation received by an employee

under section 807(b) of the EHDC Act of 2020 shall be included as remuneration for employment paid to the employee for purposes of computing the regular rate at which such employee is employed.''.

(2) FAMILY AND MEDICAL LEAVE ACT OF 1993.—Section 110(b)(2)(B) of the Family and Medical Leave Act of 1993 (29 U.S.C. 2620(b)(2)(B)) is amended by adding at the end the following:

''(iii) PANDEMIC PREMIUM PAY.—Compensation received by an employee under section 807(b) of the EHDC Act of 2020 shall be included as remuneration for employment paid to the employee for purposes of computing the regular rate at which such employee is employed.''.

SEC. 806. COVID–19 HEROES FUND GRANTS.

(a) GRANTS.—

(1) FOR PANDEMIC PREMIUM PAY.—The Secretary of the Treasury shall, subject to the availability of amounts provided in this title, award a grant to each essential work employer that applies for a grant, in accordance with this section, for the 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-

viding remuneration to for services or labor, who are paid wages or remuneration by the employer at a rate that is less than the equivalent of $200,000 per year; and

(B) the amount obtained by multiplying $5,000 by the number of highly-compensated essential workers the employer certifies, in the application submitted under subsection (c)(1), as employing, or providing remuneration to for services or labor, who are paid wages or remuneration by the employer at a rate that is equal to or greater than the equivalent of $200,000 per year.

(2) NO PARTIAL GRANTS.—The Secretary of the Treasury shall not award a grant under this section in an amount less than the maximum described in paragraph (1).

(c) GRANT APPLICATION AND DISBURSAL.—

(1) APPLICATION.—Any essential work employer seeking a grant under subsection (a)(1) shall submit an application to the Secretary of the Treasury at such time, in such manner, and complete with such information as the Secretary may require.

(2) NOTICE AND CERTIFICATION.—

(A) IN GENERAL.—The Secretary of the Treasury shall, within 15 days after receiving a complete application from an essential work employer eligible for a grant under this section—

(i) notify the employer of the Secretary's findings with respect to the requirements for the grant; and

(ii)(I) if the Secretary finds that the essential work employer meets the requirements under this section for a grant under subsection (a), provide a certification to the employer—

(aa) that the employer has met such requirements;

(bb) of the amount of the grant payment that the Secretary has determined the employer shall receive based on the requirements under this section; or

(II) if the Secretary finds that the essential work employer does not meet the requirements under this section for a grant under subsection (a), provide a notice of denial stating the reasons for the denial and provide an opportunity for administra-

tive review by not later than 10 days after the denial.

(B) TRANSFER.—Not later than 7 days after making a certification under subparagraph (A)(ii) with respect to an essential work employer, the Secretary of the Treasury shall make the appropriate transfer to the employer of the amount of the grant.

(d) USE OF FUNDS.—

(1) IN GENERAL.—An essential work employer receiving a grant under this section shall use the amount of the grant solely for the following purposes:

(A) Providing premium pay under section 805(b) to essential workers in accordance with the requirements for such payments under such section, including providing payments described in section 805(f) to the next of kin of essential workers in accordance with the requirements for such payments under such section.

(B) Paying employer payroll taxes with respect to premium pay amounts described in subparagraph (A), including such payments described in section 805(f).

Each dollar of a grant received by an essential work employer under this title shall be used as provided in subparagraph (A) or (B) or returned to the Secretary of the Treasury.

(2) NO OTHER USES AUTHORIZED.—An essential work employer who uses any amount of a grant for a purpose not required under paragraph (1) shall be—

(A) considered to have misused funds in violation of section 805; and

(B) subject to the enforcement and remedies provided under section 807.

(3) REFUND.—

(A) IN GENERAL.—If an essential work employer receives a grant under this section and, for any reason, does not provide every dollar of such grant to essential workers in accordance with the requirements of this title, then the employer shall refund any such dollars to the Secretary of the Treasury not later than June 30, 2021. Any amounts returned to the Secretary shall be deposited into the Fund and be available for any additional grants under this section.

(B) REQUIREMENT FOR NOT REDUCING COMPENSATION.—An essential work employer who is required to refund any amount under this paragraph shall not reduce or otherwise diminish an eligible worker's compensation or benefits in response to or otherwise due to such refund.

(e) RECORDKEEPING.—An essential work employer that receives a grant under this section shall—

(1) maintain records, including payroll records, demonstrating how each dollar of funds received through the grant were provided to essential workers; and

(2) provide such records to the Secretary of the Treasury or the Secretary of Labor upon the request of either such Secretary.

(f) RECOUPMENT.—In addition to all other enforcement and remedies available under this title or any other law, the Secretary of the Treasury shall establish a process under which the Secretary shall recoup the amount of any grant awarded under subsection (a)(1) if the Secretary determines that the essential work employer receiving the grant—

(1) did not provide all of the dollars of such grant to the essential workers of the employer;

(2) did not, in fact, have the number of essential workers certified by the employer in accordance with subparagraphs (A) and (B) of subsection (b)(1);

(3) did not pay the essential workers for the number of hours the employer claimed to have paid; or

(4) otherwise misused funds or violated this title.

(g) SPECIAL RULE FOR CERTAIN EMPLOYEES OF TRIBAL EMPLOYERS.—Essential workers of Tribal employers who receive funds under title II shall not be eligible to receive funds from grants under this section.

(h) TAX TREATMENT.—

(1) EXCLUSION FROM INCOME.—For purposes of the Internal Revenue Code of 1986, any grant received by an essential work employer under this section shall not be included in the gross income of such essential work employer.

(2) DENIAL OF DOUBLE BENEFIT.—

(A) IN GENERAL.—In the case of an essential work employer that receives a grant under this section—

(i) amounts paid under subsections (b) or (f) of section 805 shall not be taken

into account as wages for purposes of sections 41, 45A, 51, or 1396 of the Internal Revenue Code of 1986 or section 2301 of the CARES Act (Public Law 116–136); and

(ii) any deduction otherwise allowable under such Code for applicable payments during any taxable year shall be reduced (but not below zero) by the excess (if any) of—

(I) the aggregate amounts of grants received under this section; over

(II) the sum of any amount refunded under subsection (d) plus the aggregate amount of applicable payments made for all preceding taxable years.

(B) APPLICABLE PAYMENTS.—For purposes of this paragraph, the term ''applicable payments'' means amounts paid as premium pay under subsections (b) or (f) of section 805 and amounts paid for employer payroll taxes with respect to such amounts.

(C) AGGREGATION RULE.—Rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1986 shall apply for purposes of this section.

(3) INFORMATION REPORTING.—The Secretary of the Treasury shall submit to the Commissioner of Internal Revenue statements containing—

(A) the name and tax identification number of each essential work employer receiving a grant under this section;

(B) the amount of such grant; and

(C) any amounts refunded under subsection (d)(3).

(i) REPORTS.—

(1) IN GENERAL.—Not later than 30 days after obligating the last dollar of the funds appropriated under this title, the Secretary of the Treasury shall submit a report, to the Committees of Congress described in paragraph (2), that—

(A) certifies that all funds appropriated under this title have been obligated; and

(B) indicates the number of pending applications for grants under this section that will be rejected due to the lack of funds.

(2) COMMITTEES OF CONGRESS.—The Committees of Congress described in this paragraph are—

(A) the Committee on Ways and Means of the House of Representatives;

(B) the Committee on Education and Labor of the House of Representatives;

(C) the Committee on Finance of the Senate; and

(D) the Committee on Health, Education, Labor, and Pensions of the Senate.

SEC. 807. ENFORCEMENT AND OUTREACH.

(a) DUTIES OF SECRETARY OF LABOR.—The Secretary of Labor shall—

(1) have authority to enforce the requirements of section 805, in accordance with subsections (b) through (e);

(2) conduct outreach as described in subsection (f); and

(3) coordinate with the Secretary of the Treasury as needed to carry out the Secretary of Labor's responsibilities under this section.

(b) PROHIBITED ACTS, PENALTIES, AND ENFORCEMENT.—

(1) PROHIBITED ACTS.—It shall be unlawful for a person to—

(A) violate any provision of section 805 applicable to such person; or

(B) discharge or in any other manner discriminate against any essential worker because such essential worker has filed any complaint or instituted or caused to be instituted any proceeding under or related to this title, or has testified or is about to testify in any such proceeding.

(2) ENFORCEMENT AND PENALTIES.—

(A) PREMIUM PAY VIOLATIONS.—A violation described in paragraph (1)(A) shall be deemed a violation of section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) and unpaid amounts required under this section shall be treated as unpaid overtime compensation under such section 7 for the purposes of sections 15 and 16 of such Act (29 U.S.C. 215 and 216).

(B) DISCHARGE OR DISCRIMINATION.—A violation of paragraph (1)(B) shall be deemed a violation of section 15(a)(3) of the Fair Labor Standards Act of 1938 (29 U.S.C. 215(a)(3)).

(c) INVESTIGATION.—

(1) IN GENERAL.—To ensure compliance with the provisions of section 805, including any regulation or order issued under that section, the Secretary of Labor shall have the investigative authority provided under section 11(a) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(a)). For the purposes of any investigation provided for in this subsection, the Secretary of Labor shall have the subpoena authority provided for under section 9 of such Act (29 U.S.C. 209).

(2) STATE AGENCIES.—The Secretary of Labor may, for the purpose of carrying out the functions and duties under this section, utilize the services of State and local agencies in accordance with section 11(b) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(b)).

(d) ESSENTIAL WORKER ENFORCEMENT.—

(1) RIGHT OF ACTION.—An action alleging a violation of paragraph (1) or (2) of subsection (b) may be maintained against an essential work employer receiving a grant under section 806 in any Federal or State court of competent jurisdiction by one or more essential workers or their representative for and on behalf of the essential workers, or the essential workers and others similarly situated, in the

same manner, and subject to the same remedies (including attorney's fees and costs of the action), as an action brought by an employee alleging a violation of section 7 or 15(a)(3), respectively, of the Fair Labor Standards Act of 1938 (29 U.S.C. 207, 215(a)(3)).

(2) NO WAIVER.—In an action alleging a violation of paragraph (1) or (2) of subsection (b) brought by one or more essential workers or their representative for and on behalf of the persons as described in paragraph (1), to enforce the rights in section 805, no court of competent jurisdiction may grant the motion of an essential work employer receiving a grant under section 806 to compel arbitration, under chapter 1 of title 9, United States Code, or any analogous State arbitration statute, of the claims involved. An essential worker's right to bring an action described in paragraph (1) or subsection (b)(2)(A) on behalf of similarly situated essential workers to enforce such rights may not be subject to any private agreement that purports to require the essential workers to pursue claims on an individual basis.

(e) RECORDKEEPING.—An essential work employer receiving a grant under section 806 shall make, keep, and

preserve records pertaining to compliance with section 805 in accordance with section 11(c) of the Fair Labor Standards Act of 1938 (29 U.S.C. 211(c)) and in accordance with regulations prescribed by the Secretary of Labor.

(f) OUTREACH AND EDUCATION.—Out of amounts appropriated to the Secretary of the Treasury under section 805 for a fiscal year, the Secretary of the Treasury shall transfer to the Secretary of Labor, $3,000,000, of which the Secretary of Labor shall use—

(1) $2,500,000 for outreach to essential work employers and essential workers regarding the premium pay under section 805; and

(2) $500,000 to implement an advertising campaign encouraging large essential work employers to provide the same premium pay provided for by section 805 using the large essential work employers' own funds and without utilizing grants under this title.

(g) CLARIFICATION OF ENFORCING OFFICIAL.—Nothing in the Government Employee Rights Act of 1991 (42 U.S.C. 2000e–16a et seq.) or section 3(e)(2)(C) of the Fair Labor Standards Act of 1938 (29 U.S.C. 203(e)(2)(C)) shall be construed to prevent the Secretary of Labor from carrying out the authority of the Secretary under this section in the case of State employees described

in section 304(a) of the Government Employee Rights Act of 1991 (42 U.S.C. 2000e–16c(a)).

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

SEC. 901. HRSA ASSISTANCE TO HEALTH CENTERS FOR PROMOTION OF HEALTH IT.

The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, shall expand and intensify the programs and activities of the Administration (directly or through grants or contracts) to provide technical assistance and resources to health centers (as defined in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a))) to adopt and meaningfully use certified EHR technology for the management of chronic diseases and health conditions and reduction of health disparities.

SEC. 902. ASSESSMENT OF IMPACT OF HEALTH IT ON RACIAL AND ETHNIC MINORITY COMMUNITIES; OUTREACH AND ADOPTION OF HEALTH IT IN SUCH COMMUNITIES.

(a) NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.—Not later than 18 months after the date of enactment of this Act, the National Coordi-

nator for Health Information Technology (referred to in this section as the ''National Coordinator'') shall—

(1) conduct an evaluation of the level of interoperability, access, use, and accessibility of electronic health records in racial and ethnic minority communities, focusing on whether patients in such communities have providers who use electronic health records, and the degree to which patients in such communities can access, exchange, and use without special effort their health information in those electronic health records, and indicating whether such providers—

(A) are participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan);

(B) have received incentive payments or incentive payment adjustments under Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in subsection (c)(2));

(C) are MIPS eligible professionals, as defined in paragraph (1)(C) of section 1848(q) of the Social Security Act (42 U.S.C. 1395w–

4(q)), for purposes of the Merit-Based Incentive Payment System under such section; or

(D) have been recruited by any of the Health Information Technology Regional Extension Centers established under section 3012 of the Public Health Service Act (42 U.S.C. 300jj–32);

(2) publish the results of such evaluation including the race and ethnicity of such providers and the populations served by such providers; and

(3) not later than 12 months after the enactment of this Act, shall promulgate a certification criterion and module of certified EHR technology that stratifies quality measures by disparity characteristics, including race, ethnicity, language, gender, gender identity, sexual orientation, socioeconomic status, and disability status, as those characteristics are defined in certified EHR technology; and reports to Centers for Medicare & Medicaid Services the quality measures stratified by race and at least two other disparity characteristics.

The term ''quality measures'' refers to the quality measures specified in MIPS.

(b) NATIONAL CENTER FOR HEALTH STATISTICS.—As soon as practicable after the date of enactment of this

Act, the Director of the National Center for Health Statistics shall provide to Congress a more detailed analysis of the data presented in National Center for Health Statistics data brief entitled ''Adoption of Certified Electronic Health Record Systems and Electronic Information Sharing in Physician Offices: United States, 2013 and 2014'' (NCHS Data Brief No. 236).

(c) CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—As part of the process of collecting information, with respect to a provider, at registration and attestation for purposes of Medicare and Medicaid Electronic Health Records Incentive Programs (as defined in paragraph (2)) or the Merit-Based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)), the Secretary of Health and Human Services shall collect the race and ethnicity of such provider.

(2) MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS DEFINED.—For purposes of paragraph (1), the term ''Medicare and Medicaid Electronic Health Records Incentive Programs'' means the incentive programs under section 1814(l)(3), subsections (a)(7) and (o)

of section 1848, subsections (l) and (m) of section 1853, subsections (b)(3)(B)(ix)(I) and (n) of section 1886, and subsections (a)(3)(F) and (t) of section 1903 of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w–4, 1395w–23, 1395ww, and 1396b).

(d) NATIONAL COORDINATOR'S ASSESSMENT OF IMPACT OF HIT.—Section 3001(c)(6)(C) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)(C)) is amended—

(1) in the heading by inserting ", RACIAL AND ETHNIC MINORITY COMMUNITIES," after "HEALTH DISPARITIES";

(2) by inserting ", in communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), including people with disabilities in these groups," after "communities with health disparities";

(3) by striking "The National Coordinator" and inserting the following:

"(i) IN GENERAL.—The National Coordinator"; and

(4) by adding at the end the following:

"(ii) CRITERIA.—In any publication under clause (i), the National Coordinator

shall include best practices for encouraging partnerships between the Federal Government, States, and private entities to expand outreach for and the adoption of certified EHR technology in communities with a high proportion of individuals from racial and ethnic minority groups (as so defined), while also maintaining the accessibility requirements of section 508 of the Rehabilitation Act of 1973 to encourage patient involvement in patient health care. The National Coordinator shall—

"(I) not later than 6 months after the submission of the report required under section 822 of the Ending Health Disparities During COVID–19 Act of 2020, establish criteria for evaluating the impact of health information technology on communities with a high proportion of individuals from racial and ethnic minority groups (as so defined) taking into account the findings in such report; and

"(II) not later than 1 year after the submission of such report, conduct and publish the results of an evaluation of such impact.".

SEC. 903. EXTENDING FUNDING TO STRENGTHEN THE HEALTH IT INFRASTRUCTURE IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

Section 3011 of the Public Health Service Act (42 U.S.C. 300jj–31) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting ", including with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))" before the colon; and

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

"(e) ANNUAL REPORT ON EXPENDITURES.—The National Coordinator shall report annually to Congress on activities and expenditures under this section.".

SEC. 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.

Section 3014(e) of the Public Health Service Act (42 U.S.C. 300jj–34(e)) is amended, in the matter preceding paragraph (1), by inserting ", including with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g))" after "health care provider to".

SEC. 905. AUTHORIZATION OF APPROPRIATIONS.

Section 3018 of the Public Health Service Act (42 U.S.C. 300jj–38) is amended by striking "fiscal years 2009 through 2013" and inserting "fiscal years 2021 through 2026".

SEC. 906. DATA COLLECTION AND ASSESSMENTS CONDUCTED IN COORDINATION WITH MINORITY-SERVING INSTITUTIONS.

Section 3001(c)(6) of the Public Health Service Act (42 U.S.C. 300jj–11(c)(6)) is amended by adding at the end the following new subparagraph:

"(F) DATA COLLECTION AND ASSESSMENTS CONDUCTED IN COORDINATION WITH MINORITY-SERVING INSTITUTIONS.—

"(i) IN GENERAL.—In carrying out subparagraph (C) with respect to communities with a high proportion of individuals from racial and ethnic minority groups (as defined in section 1707(g)), the National Coordinator shall, to the greatest extent possible, coordinate with an entity described in clause (ii).

"(ii) MINORITY-SERVING INSTITUTIONS.—For purposes of clause (i), an entity described in this clause is a Historically Black College or University, a Hispanic-serving institution, a tribal college or university, or an Asian-American-, Native American-, or Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.".

SEC. 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) enter into an agreement with the National Academies of Sciences, Engineering, and Medicine to conduct a study on the development, implementation, and effectiveness of health information technology within medically underserved areas (as described in subsection (c)); and

(2) submit a report to Congress describing the results of such study, including any recommendations for legislative or administrative action.

(b) STUDY.—The study described in subsection (a)(1) shall—

(1) identify barriers to successful implementation of health information technology in medically underserved areas;

(2) survey a cross-section of individuals in medically underserved areas and report their opinions about the various topics of study;

(3) examine the degree of interoperability among health information technology and users of health information technology in medically underserved areas, including patients, providers, and community services;

(4) examine the impact of health information technology on providing quality care and reducing the cost of care to individuals in such areas, includ-

ing the impact of such technology on improved health outcomes for individuals, including which technology worked for which population and how it improved health outcomes for that population;

(5) examine the impact of health information technology on improving health care-related decisions by both patients and providers in such areas;

(6) identify specific best practices for using health information technology to foster the consistent provision of physical accessibility and reasonable policy accommodations in health care to individuals with disabilities in such areas;

(7) assess the feasibility and costs associated with the use of health information technology in such areas;

(8) evaluate whether the adoption and use of qualified electronic health records (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) is effective in reducing health disparities, including analysis of clinical quality measures reported by providers who are participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan), pursuant to pro-

grams to encourage the adoption and use of certified EHR technology;

(9) identify providers in medically underserved areas that are not electing to adopt and use electronic health records and determine what barriers are preventing those providers from adopting and using such records; and

(10) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers in those systems.

(c) MEDICALLY UNDERSERVED AREA.—The term ''medically underserved area'' means—

(1) a population that has been designated as a medically underserved population under section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(2) an area that has been designated as a health professional shortage area under section 332 of the Public Health Service Act (42 U.S.C. 254e);

(3) an area or population that has been designated as a medically underserved community under section 799B of the Public Health Service Act (42 U.S.C. 295p); or

(4) another area or population that—

(A) experiences significant barriers to accessing quality health services; and

(B) has a high prevalence of diseases or conditions described in title VII, with such diseases or conditions having a disproportionate impact on racial and ethnic minority groups (as defined in section 1707(g) of the Public Health Service Act (42 U.S.C. 300u–6(g))) or a subgroup of people with disabilities who have specific functional impairments.

SEC. 908. STUDY ON THE EFFECTS OF CHANGES TO TELEHEALTH UNDER THE MEDICARE AND MEDICAID PROGRAMS DURING THE COVID-19 EMERGENCY.

(a) IN GENERAL.—Not later than 1 year after the end of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study and submit to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an interim report on any changes made to the provision or availability of telehealth services under part A or B of title XVIII of the Social

Security Act (42 U.S.C. 1395 et seq.) during such period. Such report shall include the following:

(1) A summary of utilization of all health care services furnished under such part A or B during such period, including the number of—

(A) in-person outpatient visits, inpatient admissions, and in-person emergency department visits; and

(B) telehealth visits, broken down by—

(i) the number of such visits furnished via audio-visual technology compared to the number of such visits furnished via audio-only technology;

(ii) the number of such visits furnished by each type of provider of services or supplier (as defined in section 1861 of such Act (42 U.S.C. 1395x) and including a Federally qualified health center or rural health clinic (as so defined)), including a specification of the specialty of each such provider or supplier (if applicable); and

(iii) the type of service provided, including level of service and diagnoses associated with the telehealth visit.

(2) A description of any changes in utilization patterns for the care settings described in paragraph (1) over the course of such period compared to such patterns prior to such period.

(3) An analysis of utilization of telehealth services under such part A or B during such period, broken down by age, sex (including sexual orientation and gender identity where possible), race and ethnicity, disability status, primary language, geographic region (including by rural health areas (as defined by the Health Resources & Services Administration), non-rural health areas, health professional shortage areas (as defined in section 332(a)(1) of the Public Health Service Act (42 U.S.C. 254e(a)(1))), medically underserved communities (as defined in section 799B(6) of such Act (42 U.S.C. 295p(6))), areas with medically underserved populations (as defined in section 330(b)(3) of such Act (42 U.S.C. 254b(b)(3))), and by State), and income level (as measured directly or indirectly, such as by patient's zip code tabulation area median income as publicly reported by the United States Census Bureau), and of any trends in such utilization during such period, so broken down. Such analysis shall include the number of telehealth visits performed by

providers of services or suppliers licensed in a State different from the State where the individual receiving such telehealth services is located at the time such services are furnished. Such analysis may not include any individually identifiable information or protected health information.

(4) A description of expenditures and any savings under such part A or B attributable to use of such telehealth services during such period.

(5) A description of any instances of fraud identified by the Secretary, acting through the Office of the Inspector General or other relevant agencies and departments, with respect to such telehealth services furnished under such part A or B during such period and a comparison of the number of such instances with the number of instances of fraud so identified with respect to in-person services so furnished during such period.

(6) A description of any privacy concerns with respect to the furnishing of such telehealth services (such as cybersecurity or ransomware concerns), including a description of any actions taken by the Secretary, acting through the Health Sector Cybersecurity Coordination Center or other relevant agencies and departments, during such period to as-

sist health care providers secure telecommunications systems.

(7) An analysis of health care quality related to telehealth (which may include patient health outcomes (such as morbidity, mortality, healthcare utilization, and disease-specific management metrics), safety metrics, quality measures, health equity focused measures, patient satisfaction, provider satisfaction, and other inputs and sources as determined by the Secretary).

(8) An analysis of any other outcomes or metrics related to telehealth, as determined appropriate by the Secretary.

(b) INPUT.—In conducting the study and submitting the report under subsection (a), the Secretary—

(1)(A) consult with relevant stakeholders (such as patients, caregivers, patient advocacy groups, minority or tribal groups (including Urban Indian Organization (UIOs)), health care professionals (including behavioral health professionals), hospitals, State medical boards, State nursing boards, the Federation of State Medical Boards, National Council of State Boards of Nursing, medical professional employers (such as hospitals, medical groups, staffing companies), telehealth groups, health profes-

sional liability providers, public and private payers, and State leaders); and

(B) solicit public comments on such report before the submission of such report; and

(2) shall endeavor to include as many racially, ethnically, geographically, linguistically, and professionally diverse perspectives as possible.

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

(1) update and finalize the interim report under subsection (a); and

(2) submit such updated and finalized report to the committees specified in such subsection.

(d) GRANTS FOR MEDICAID REPORTS.—

(1) IN GENERAL.—Not later than 2 years after the end of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (42 U.S.C. 1320b–5(g)(1)(B)), the Secretary shall award grants to States with a State plan (or waiver of such plan) in effect under title XIX of the Social Security Act (42 U.S.C. 1396r) that submit an application under this subsection for purposes of enabling such States to study and submit reports to the Secretary on any changes made to the provision or availability of tele-

health services under such plans (or such waivers) during such period.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), a State shall—

(A) provide benefits for telehealth services under the State plan (or waiver of such plan) in effect under title XIX of the Social Security Act (42 U.S.C. 1396r);

(B) be able to differentiate telehealth from in-person visits within claims data submitted under such plan (or such waiver) during such period; and

(C) submit to the Secretary an application at such time, in such manner, and containing such information (including the amount of the grant requested) as the Secretary may require.

(3) USE OF FUNDS.—An State shall use amounts received under a grant under this subsection to conduct a study and report findings regarding the effects of changes to telehealth services offered under the State plan (or waiver of such plan) of such State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during such period in accordance with paragraph (4).

(4) REPORTS.—

(A) INTERIM REPORT.—Not later 1 year after the date a State receives a grant under this subsection, the State shall submit to the Secretary an interim report that—

(i) details any changes made to the provision or availability of telehealth benefits (such as eligibility, coverage, or payment changes) under the State plan (or waiver of such plan) of the State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during the emergency period described in paragraph (1); and

(ii) contains—

(I) a summary and description of the type described in paragraphs (1) and (2), respectively, of subsection (a); and

(II) to the extent practicable, an analysis of the type described in paragraph (3) of subsection (a),

except that any reference in such subsection to ''such part A or B'' shall, for purposes of subclauses (I) and (II), be treated as a reference to such State plan (or waiver).

(B) FINAL REPORT.—Not later than 3 years after the date a State receives a grant under this subsection, the State shall update and finalize the interim report and submit such final report to the Secretary.

(C) REPORT BY SECRETARY.—Not later than the earlier of the date that is 1 year after the submission of all final reports under subparagraph (B) and December 31, 2028, the Secretary shall submit to Congress a report on the grant program, including a summary of the reports received from States under this paragraph.

(5) MODIFICATION AUTHORITY.—The Secretary may modify any deadline described in paragraph (4) or any information required to be included in a report made under this subsection to provide flexibility for States to modify the scope of the study and timeline for such reports.

(6) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical assistance as may be necessary to a State receiving a grant under this subsection in order to assist such state in conducting studies and submitting reports under this subsection.

(7) STATE.—For purposes of this subsection, the term ''State'' means each of the several States, the District of Columbia, and each territory of the United States.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) MEDICARE.—For the purpose of carrying out subsections (a) through (c), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2020 through 2024.

(2) MEDICAID.—For the purpose of carrying out subsection (d), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2022 through 2028.

SEC. 909. COVID–19 DESIGNATION OF IMMEDIATE SPECIAL AUTHORITY OF SPECTRUM FOR TRIBES' EMERGENCY RESPONSE IN INDIAN COUNTRY.

(a) FINDINGS.—Congress finds the following:

(1) The immediate grant of emergency special temporary authority of available spectrum that will efficiently support temporary wireless broadband networks and allow Indian Tribes to provide Tribal members with wireless broadband service over Tribal lands or Hawaiian Home Lands during the COVID–19 crisis due to the increased demand for tele-

communications and disproportionate impacts of the COVID–19 pandemic in Indian Country is essential.

(2) Reservations are the most digitally disconnected areas in the United States that lack basic access to broadband and wireless services at rates comparable to, and in some cases lower than, third-world countries.

(3) In 2018, the Government Accountability Office and the Federal Communications Commission reported that only 65 percent of American Indian and Alaska Natives (AI/ANs) living on Tribal lands had access to fixed broadband services, and only 68 percent of AI/AN households on rural Tribal lands had telephone services. This is a stark comparison to only 8 percent of the national average that lacks access to fixed broadband services.

(4) Indian Tribes have previously encountered substantial barriers to accessing broadband and other communications services on Tribal lands to deploy telecommunication services for the safety and well-being of Tribal members and to decrease the alarming rates of unnecessary loss of lives that AI/ANs disproportionately experience, especially through the lack of access to health care services and emergency resources, as demonstrated during

the COVID–19 pandemic that continues to disproportionately impact Indian Country.

(5) Indian Tribes' lack of access to broadband services on Tribal lands and Hawaiian Home Lands during the COVID–19 pandemic further highlights the digital divide in Indian Country.

(6) The Government Accountability Office found that health information technology systems at the Indian Health Service rank as the Federal Government's third-highest need for agency system modernization, since 50 percent of Indian Health Service facilities depend on outdated circuit connections based on one or two TI circuit lines (3 Mbps), creating slower response times than any other health facility system in the United States.

(7) A 2018 Tribal health reform comment filed with the Federal Communications Commission has further stated that approximately 1.5 million people living on Tribal lands lack access to broadband and, of the 75 percent of rural Indian Health Service facilities, many still lack reliable broadband networks for American Indians and Alaska Natives (AI/ANs) to access telehealth or clinical health care services, which is a critical need in the most geographically isolated areas of the country with some of the high-

est poverty rates, and lack of access to reliable transportation.

(8) The Bureau of Indian Education has stated that recent estimates from 142 out of 174 schools have indicated that approximately 15 to 95 percent of students do not have access to internet services at home depending on Bureau school location and limitations on data caps during the COVID–19 crisis.

(b) DEPLOYMENT OF WIRELESS BROADBAND SERVICE ON TRIBAL LANDS AND HAWAIIAN HOME LANDS.—

(1) FUNDING OF GRANTS FOR IMMEDIATE DEPLOYMENT OF WIRELESS BROADBAND SERVICE ON TRIBAL LANDS AND HAWAIIAN HOME LANDS.—In addition to any other amounts made available, out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated—

(A) $297,500,000 for grants under the community facilities grant program under section 306(a)(19) of the Consolidated Farm and Rural Development Act to Indian Tribes, qualifying Tribal entities, and the Director of the Department of Hawaiian Home Lands, for the immediate deployment of wireless broadband service on Tribal lands and Hawaiian Home

Lands, respectively, through the use of emergency special temporary authority granted under paragraph (2) of this subsection, including backhaul costs, repairs to damaged infrastructure, the cost of the repairs to which would be less expensive than the cost of new infrastructure and would support the emergency special temporary use, and the Federal share applicable to grants from such amount shall be 100 percent, which amount shall remain available for one year from the enactment of this Act; and

(B) $3,000,000 for grants under the community facilities technical assistance and training grant program under section 306(a)(26) of such Act, without regard to sections 306(a)(26)(B) and 306(a)(26)(C) of such Act, to assist Indian Tribes, qualifying Tribal entities, and the Director of the Department of Hawaiian Home Lands in preparing applications for the grants referred to in subparagraph (B) of this paragraph, which amount shall remain available for one year from the enactment of this Act.

Grants referred to under subparagraph (B) shall be available to Indian Tribes, qualifying Tribal entities and shall also be available to inter-Tribal government organizations, universities, and colleges with Tribal serving institutions for the purposes stated herein.

(2) EMERGENCY SPECIAL TEMPORARY AUTHORITY TO USE AVAILABLE AND EFFICIENT SPECTRUM ON TRIBAL LANDS AND HAWAIIAN HOME LANDS.—

(A) GRANT OF AUTHORITY.—Not later than 10 days after receiving a request from an Indian Tribe, a qualifying Tribal entity, or the Director of the Department of Hawaiian Home Lands for emergency special temporary authority to use electromagnetic spectrum described in subparagraph (C) for the provision of wireless broadband service over the Tribal lands over which the Indian Tribe or qualifying Tribal entity has jurisdiction or (in the case of a request from the Director of the Department of Hawaiian Home Lands) over the Hawaiian Home Lands, allowing unlicensed radio transmitters to operate for such provision on such spectrum at locations on such Tribal lands or Hawaiian Home Lands where such spectrum is not being

used, the Commission shall grant such request on a secondary non-interference basis.

(B) DURATION.—A grant of emergency special temporary authority under subparagraph (A) shall be for a period of operation to begin not later than 6 months after the date of the enactment of this Act and to remain in operation for not longer than 6 months, absent extensions granted by the Commission pursuant to the procedures of the Commission relating to special temporary authority.

(C) ELECTROMAGNETIC SPECTRUM DESCRIBED.—The electromagnetic spectrum described in this subparagraph for utilization on the temporary basis is any portion of the electromagnetic spectrum—

(i) that is—

(I) between the frequencies of 2496 megahertz and 2690 megahertz, inclusive;

(II) in the white spaces of the television broadcast spectrum between the frequencies of 470 megahertz and 790 megahertz, inclusive, excluding those frequencies utilized for other

purposes under subpart H of part 15 of title 47, Code of Federal Regulations;

(III) between the frequencies of 5925 megahertz and 7125 megahertz, inclusive; or

(IV) between frequencies of 3550 megahertz and 3700 megahertz, inclusive; and

(ii) with respect to the Tribal lands or Hawaiian Home Lands over which authority to use such spectrum is requested under subparagraph (A), is not assigned to any licensee.

(3) DEFINITIONS.—In this subsection:

(A) COMMISSION.—The term ''Commission'' means the Federal Communications Commission.

(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 individually identified and federally recognized In-

dian or Alaska Native Tribe, band, nation, pueblo, village, community, affiliated tribal group, or component reservation in the list published pursuant to section 104(a) of the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. 5131(a)).

(D) QUALIFYING TRIBAL ENTITY.—The term ''qualifying Tribal entity'' means an entity designated by the Indian Tribe with jurisdiction over particular Tribal lands for which the spectrum access is sought. The following may be designated as a qualifying Tribal entity:

(i) Indian Tribes.

(ii) Tribal consortia which consists of two or more Indian Tribes, or an Indian Tribe and an entity that is more than 50 percent owned and controlled by one or more Indian Tribes.

(iii) Federally chartered Tribal corporations created under section 17 of the Indian Reorganization Act (25 U.S.C. 5124), and created under section 4 of the Oklahoma Indian Welfare Act (25 U.S.C. 5204).

(iv) Entities that are more than 50 percent owned and controlled by an Indian Tribe or Indian Tribes.

(E) ENTITY THAT IS MORE THAN 50 PERCENT OWNED AND CONTROLLED BY ONE OR MORE INDIAN TRIBES.—The term ''entity that is more than 50 percent owned and controlled by one or more Indian Tribes'' means an entity over which one or more Indian Tribes have both de facto and de jure control of the entity. De jure control of the entity is evidenced by ownership of greater than 50 percent of the voting stock of a corporation, or in the case of a partnership, general partnership interests. De facto control of an entity is determined on a case-by-case basis. An Indian Tribe or Indian Tribes must demonstrate indicia of control to establish that such Indian Tribe or Indian Tribes retain de facto control of the applicant seeking eligibility as a ''qualifying Tribal entity'', including the following:

(i) The Indian Tribe or Indian Tribes constitute or appoint more than 50 percent of the board of directors or management committee of the entity.

(ii) The Indian Tribe or Indian Tribes have authority to appoint, promote, demote, and fire senior executives who control the day-to-day activities of the entity.

(iii) The Indian Tribe or Indian Tribes play an integral role in the management decisions of the entity.

(iv) The Indian Tribe or Indian Tribes have the authority to make decisions or otherwise engage in practices or activities that determine or significantly influence—

(I) the nature or types of services offered by such an entity;

(II) the terms upon which such services are offered; or

(III) the prices charged for such services.

(F) TRIBAL LANDS.—The term ''Tribal lands'' has the meaning given that term in section 73.7000 of title 47, Code of Federal Regulations, as of April 16, 2020, and includes the definition ''Indian Country'' as defined in section 1151 of title 18, United States Code, and

includes fee simple and restricted fee land held by an Indian Tribe.

(G) WIRELESS BROADBAND SERVICE.—The term ''wireless broadband service'' means wireless broadband internet access service that is delivered—

(i) with a download speed of not less than 25 megabits per second and an upload speed of not less than 3 megabits per second; and

(ii) through—

(I) mobile service;

(II) fixed point-to-point multipoint service;

(III) fixed point-to-point service; or

(IV) broadcast service.

SEC. 910. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) IN GENERAL.—For purposes of expediting the provision of telehealth services, for which payment is made under the Medicare Program, across State lines, the Secretary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facili-

tate the adoption of provisions allowing for multistate practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(3) MEDICARE PROGRAM.—The term ''Medicare Program'' means the program of health insurance administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

TITLE X—PUBLIC AWARENESS

SEC. 1001. AWARENESS CAMPAIGNS.

The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and in coordination with other offices and agencies, as appropriate, shall award competitive grants or contracts to one or more public or private entities, including faith-based organizations, to carry out multi-

lingual and culturally appropriate awareness campaigns. Such campaigns shall—

(1) be based on available scientific evidence;

(2) increase awareness and knowledge of COVID–19, including countering stigma associated with COVID–19;

(3) improve information on the availability of COVID–19 diagnostic testing; and

(4) promote cooperation with contact tracing efforts.

SEC. 1002. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality with respect to grants under subsection (c)(1) and through the Administrator of the Health Resources and Services Administration with respect to grants under subsection (c)(2), in consultation with the Director of the National Institute on Minority Health and Health Disparities and the Deputy Assistant Secretary for Minority Health, shall award grants to eligible entities to improve health care for patient populations that have low functional health literacy.

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

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

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

(c) USE OF FUNDS.—

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

(A) to define and increase the understanding of health literacy;

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

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

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

(2) HEALTH RESOURCES AND SERVICES ADMINISTRATION.—A grant awarded under subsection (a) through the Administrator of the Health Resources and Services Administration shall be used to conduct

demonstration projects for interventions for patients with low health literacy that may include—

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

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

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

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

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

(F) the conduct of educational campaigns concerning health directed specifically at patients with mental disabilities, including those with cognitive and intellectual disabilities, designed to reduce the incidence of low health literacy among these populations, which shall have instructional materials in the plain language standards promulgated under the Plain

Writing Act of 2010 (5 U.S.C. 301 note) for Federal agencies; and

(G) other activities determined appropriate by the Administrator.

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

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

SEC. 1003. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.

(a) GRANTS AUTHORIZED.—The Secretary of Education is authorized to provide grants to eligible entities for the provision of English as a second language (in this section referred to ''ESL'') instruction and shall determine, after consultation with appropriate stakeholders, the mechanism for administering and distributing such grants.

(b) ELIGIBLE ENTITY DEFINED.—In this section, the term ''eligible entity'' means a State or community-based organization that employs and serves minority populations.

(c) APPLICATION.—An eligible entity may apply for a grant under this section by submitting such information as the Secretary of Education may require and in such form and manner as the Secretary may require.

(d) USE OF GRANT.—As a condition of receiving a grant under this section, an eligible entity shall—

(1) develop and implement a plan for assuring the availability of ESL instruction that effectively integrates information about the nature of the United States health care system, how to access care, and any special language skills that may be required for individuals to access and regularly negotiate the system effectively;

(2) develop a plan, including, where appropriate, public-private partnerships, for making ESL instruction progressively available to all individuals seeking instruction; and

(3) maintain current ESL instruction efforts by using funds available under this section to supplement rather than supplant any funds expended for ESL instruction in the State as of January 1, 2020.

(e) ADDITIONAL DUTIES OF THE SECRETARY.—The Secretary of Education shall—

(1) collect and publicize annual data on how much Federal, State, and local governments spend on ESL instruction;

(2) collect data from State and local governments to identify the unmet needs of English language learners for appropriate ESL instruction, including—

(A) the preferred written and spoken language of such English language learners;

(B) the extent of waiting lists for ESL instruction, including how many programs maintain waiting lists and, for programs that do not have waiting lists, the reasons why not;

(C) the availability of programs to geographically isolated communities;

(D) the impact of course enrollment policies, including open enrollment, on the availability of ESL instruction;

(E) the number individuals in the State and each participating locality;

(F) the effectiveness of the instruction in meeting the needs of individuals receiving instruction and those needing instruction;

(G) as assessment of the need for programs that integrate job training and ESL in-

struction, to assist individuals to obtain better jobs; and

(H) the availability of ESL slots by State and locality;

(3) determine the cost and most appropriate methods of making ESL instruction available to all English language learners seeking instruction; and

(4) not later than 1 year after the date of enactment of this Act, issue a report to Congress that assesses the information collected in paragraphs (1), (2), and (3) and makes recommendations on steps that should be taken to progressively realize the goal of making ESL instruction available to all English language learners seeking instruction.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Education $250,000,000 for each of fiscal years 2021 through 2024 to carry out this section.

SEC. 1004. INFLUENZA, COVID–19, AND PNEUMONIA VACCINATION CAMPAIGN.

(a) IN GENERAL.—The Secretary of Health and Human Services shall—

(1) enhance the annual campaign by the Department of Health and Human Services to increase

the number of people vaccinated each year for influenza, pneumonia, and COVID–19; and

(2) include in such campaign the use of written educational materials, public service announcements, physician education, and any other means which the Secretary deems effective.

(b) MATERIALS AND ANNOUNCEMENTS.—In carrying out the annual campaign described in subsection (a), the Secretary of Health and Human Services shall ensure that—

(1) educational materials and public service announcements are readily and widely available in communities experiencing disparities in the incidence and mortality rates of influenza, pneumonia, and COVID–19; and

(2) the campaign uses targeted, culturally appropriate messages and messengers to reach underserved communities.

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

reporting deadline in subsection (b)) field studies to better understand health inequities that are not currently tracked by the Secretary. Such studies shall include an analysis of—

(1) the impact of socioeconomic status on health care access and disease outcomes, including COVID–19 outcomes;

(2) the impact of disability status on health care access and disease outcomes, including COVID–19 outcomes;

(3) the impact of language preference on health care access and disease outcomes, including COVID–19 outcomes;

(4) factors contributing to disparities in health outcomes for the COVID–19 pandemic; and

(5) other topics related to disparities in health outcomes for the COVID–19 pandemic, as determined by the Secretary.

(b) REPORT.—Not later than December 31, 2021, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate an initial report on the results of the field studies under this section.

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

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

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

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $25,000,000, to remain available until expended.

SEC. 1103. EXPANDING CAPACITY FOR HEALTH OUTCOMES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities to develop and expand the use of technology-enabled collaborative learning and capacity building models to respond to ongoing and real-time learning, health care information sharing, and capacity building needs related to COVID–19.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall have experience providing technology-enabled collaborative learning and capacity building health care services—

(1) in rural areas, frontier areas, health professional shortage areas, or medically underserved area; or

(2) to medically underserved populations or Indian Tribes.

(c) USE OF FUNDS.—An eligible entity receiving a grant under this section shall use funds received through the grant—

(1) to advance quality of care in response to COVID–19, with particular emphasis on rural and underserved areas and populations;

(2) to protect medical personnel and first responders through sharing real-time learning through virtual communities of practice;

(3) to improve patient outcomes for conditions affected or exacerbated by COVID–19, including improvement of care for patients with complex chronic conditions; and

(4) to support rapid uptake by health care professionals of emerging best practices and treatment protocols around COVID–19.

(d) OPTIONAL ADDITIONAL USES OF FUNDS.—An eligible entity receiving a grant under this section may use funds received through the grant for—

(1) equipment to support the use and expansion of technology-enabled collaborative learning and capacity building models, including hardware and software that enables distance learning, health care provider support, and the secure exchange of electronic health information;

(2) the participation of multidisciplinary expert team members to facilitate and lead technology-enabled collaborative learning sessions, and professionals and staff assisting in the development and execution of technology-enabled collaborative learning;

(3) the development of instructional programming and the training of health care providers and other professionals that provide or assist in the provision of services through technology-enabled collaborative learning and capacity building models; and

(4) other activities consistent with achieving the objectives of the grants awarded under this section.

(e) TECHNOLOGY-ENABLED COLLABORATIVE LEARNING AND CAPACITY BUILDING MODEL DEFINED.—In this section, the term ''technology-enabled collaborative learning and capacity building model'' has the meaning given that term in section 2(7) of the Expanding Capacity

for Health Outcomes Act (Public Law 114–270; 130 Stat. 1395).

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

SEC. 1104. DATA COLLECTION AND ANALYSIS GRANTS TO MINORITY-SERVING INSTITUTIONS.

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

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

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

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

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

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

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2021 through 2025.

SEC. 1105. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding after section 505F the following:

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

''(a) PREAPPROVAL STUDIES.—If there is evidence that there may be 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 a drug or biological product or if such product addresses a disease that disproportionately impacts certain racial

or ethnic groups or other demographic characteristics (such as age, sex, gender), then—

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

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

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

''(b) POSTMARKET STUDIES.—

''(1) IN GENERAL.—If there is evidence that there may be 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 a drug for which there is an approved application under section 505 of this Act or of a biological product for which there is an approved li-

cense under section 351 of the Public Health Service Act, the Secretary may by order require the holder of the approved application or license to conduct, by a date specified by the Secretary, postmarket studies to investigate the disparity.

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

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

''(4) MODIFICATIONS OF STUDY DESIGN.—The Secretary may, by order and as necessary, modify any aspect of the design of a postmarket study required in an order under paragraph (1) after issuing such order.

''(5) STUDY RESULTS.—The results from a 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,

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

''(d) DEFINITION.—The term 'evidence that there may be 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', with respect to a drug or biological product, includes—

''(1) evidence that there is a disparity on the basis of racial or ethnic background or other demographic characteristics (such as age, sex, gender) as to safety or effectiveness of a drug or biological product in the same chemical class as the drug or biological product;

''(2) evidence that there is a disparity on the basis of racial or ethnic background or other demographic characteristics (such as age, sex, gender) in the way the drug or biological product is metabolized;

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

''(4) if such product addresses a disease/condition that evidence shows disproportionately impacts certain racial or ethnic groups or other demographic characteristics (such as age, sex, gender).''.

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

''(ee) If it is a drug and the holder of the approved application under section 505 or license under section 351 of the Public Health Service Act for the drug has failed to complete the investigations or studies, or comply with any other requirement, of section 505G.''.

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

SEC. 1106. GAO AND NIH REPORTS.

(b) GAO REPORT ON NIH GRANT RACIAL AND ETHNIC DIVERSITY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the racial and ethnic diversity among the following groups:

(A) All applicants for grants, contracts, and cooperative agreements awarded by the National Institutes of Health during the period beginning on January 1, 2009, and ending December 31, 2019.

(B) All recipients of such grants, contracts, and cooperative agreements during such period.

(C) All members of the peer review panels of such applicants and recipients, respectively.

(2) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General shall complete the study under paragraph (1) and submit to Congress a report containing the results of such study.

(c) GAO REPORT.—Not later than one year after the date of the enactment of this Act and biennially thereafter until 2024, the Comptroller General of the United States shall submit to Congress a report that identifies—

(1) the racial and ethnic diversity of community-based organizations that applied for Federal funding provided pursuant to Coronavirus Preparedness and Response Supplemental Appropriations Act (Public Law 116–123), Families First Coronavirus Response Act (Public Law 116–127), Coronavirus Aid, Relief, and Economic Security Act (Public Law 116–136), and Paycheck Protection Program and Health Care Enhancement Act (Public Law 116–139);

(2) the percentage of such organizations that were awarded such funding; and

(3) the impact of such community-based organizations' efforts on reducing health disparities within racial and ethnic minority groups.

(d) ANNUAL REPORT ON ACTIVITIES OF NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES.—The Director of the National Institute on Minority Health and Health Disparities shall prepare an annual report on the activities carried out or to be carried out by such institute, and shall submit each such report to the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Energy and Commerce of the House of Representatives, the Secretary of Health and Human Services, and the Director of the National Institutes of Health. With respect to the fiscal year involved, the report shall—

(1) describe and evaluate the progress made in health disparities research conducted or supported by institutes and centers of the National Institutes of Health;

(2) summarize and analyze expenditures made for activities with respect to health disparities research conducted or supported by the National Institutes of Health;

(3) include a separate statement applying the requirements of paragraphs (1) and (2) specifically to minority health disparities research; and

(4) contain such recommendations as the Director of the Institute considers appropriate.

SEC. 1107. HEALTH IMPACT ASSESSMENTS.

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

(1) Health Impact Assessment is a tool to help planners, health officials, decision makers, and the public make more informed decisions about the potential health effects of proposed plans, policies, programs, and projects in order to maximize health benefits and minimize harms.

(2) Health Impact Assessments fosters community leadership, ownership and participation in decision-making processes.

(3) Health Impact Assessments can build community support and reduce opposition to a project or policy, thereby facilitating economic growth by aiding the development of consensus regarding new development proposals.

(4) Health Impact Assessments facilitate collaboration across sectors.

(b) PURPOSES.—It is the purpose of this section to—

(1) provide more information about the potential human health effects of policy decisions and the distribution of those effects;

(2) improve how health is considered in planning and decisionmaking processes; and

(3) build stronger, healthier communities through the use of Health Impact Assessment.

(c) HEALTH IMPACT ASSESSMENTS.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 796A, is further amended by adding at the end the following:

"SEC. 399V–12. HEALTH IMPACT ASSESSMENTS.

''(a) DEFINITIONS.—In this section:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Environmental Protection Agency.

''(2) DIRECTOR.—The term 'Director' means the Director of the Centers for Disease Control and Prevention.

''(3) HEALTH IMPACT ASSESSMENT.—The term 'health impact assessment' means a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a popu-

lation and the distribution of those effects within the population. Such term includes identifying and recommending appropriate actions on monitoring and maximizing potential benefits and minimizing the potential harms.

''(4) HEALTH DISPARITY.—The term 'health disparity' means a particular type of health difference that is closely linked with social, economic, or environmental disadvantage and that adversely affects groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; citizenship status; or other characteristics historically linked to discrimination or exclusion.

''(b) ESTABLISHMENT.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

''(1) in consultation with the Director of the National Center for Chronic Disease Prevention and Health Promotion and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Depart-

ment of Agriculture, establish a program at the National Center for Environmental Health at the Centers for Disease Control and Prevention focused on advancing the field of health impact assessment that includes—

"(A) collecting and disseminating best practices;

"(B) administering capacity building grants to States to support grantees in initiating health impact assessments, in accordance with subsection (d);

"(C) providing technical assistance;

"(D) developing training tools and providing training on conducting health impact assessment and the implementation of built environment and health indicators;

"(E) making information available, as appropriate, regarding the existence of other community healthy living tools, checklists, and indices that help connect public health to other sectors, and tools to help examine the effect of the indoor built environment and building codes on population health;

"(F) conducting research and evaluations of health impact assessments; and

''(G) awarding competitive extramural research grants;

''(2) develop guidance and guidelines to conduct health impact assessments in accordance with subsection (c); and

''(3) establish a grant program to allow States to fund eligible entities to conduct health impact assessments.

''(c) GUIDANCE.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Ending Health Disparities during COVID-19 Act of 2020, the Secretary, acting through the Director, shall issue final guidance for conducting the health impact assessments. In developing such guidance the Secretary shall—

''(A) consult with the Director of the National Center for Environmental Health and, the Director of the National Center for Chronic Disease Prevention and Health Promotion, and relevant offices within the Department of Housing and Urban Development, the Department of Transportation, and the Department of Agriculture; and

''(B) consider available international health impact assessment guidance, North American

health impact assessment practice standards, and recommendations from the National Academy of Science.

''(2) CONTENT.—The guidance under this subsection shall include—

''(A) background on national and international efforts to bridge urban planning, climate forecasting, and public health institutions and disciplines, including a review of health impact assessment best practices internationally;

''(B) evidence-based direct and indirect pathways that link land-use planning, transportation, and housing policy and objectives to human health outcomes;

''(C) data resources and quantitative and qualitative forecasting methods to evaluate both the status of health determinants and health effects, including identification of existing programs that can disseminate these resources;

''(D) best practices for inclusive public involvement in conducting health impact assessments; and

''(E) technical assistance for other agencies seeking to develop their own guidelines and procedures for health impact assessment.

"(d) GRANT PROGRAM.—

"(1) IN GENERAL.—The Secretary, acting through the Director and in collaboration with the Administrator, shall—

"(A) award grants to States to fund eligible entities for capacity building or to prepare health impact assessments; and

"(B) ensure that States receiving a grant under this subsection further support training and technical assistance for grantees under the program by funding and overseeing appropriate local, State, Tribal, Federal, institution of higher education, or nonprofit health impact assessment experts to provide such technical assistance.

"(2) APPLICATIONS.—

"(A) IN GENERAL.—To be eligible to receive a grant under this section, an eligible entity shall—

"(i) be a State, Indian tribe, or tribal organization that includes individuals or populations the health of which are, or will be, affected by an activity or a proposed activity; and

"(ii) submit to the Secretary an application in accordance with this subsection, at such time, in such manner, and containing such additional information as the Secretary may require.

"(B) INCLUSION.—An application under this subsection shall include a list of proposed activities that require or would benefit from conducting a health impact assessment within six months of awarding funds. The list should be accompanied by supporting documentation, including letters of support, from potential conductors of health impact assessments for the listed proposed activities. Each application should also include an assessment by the eligible entity of the health of the population of its jurisdiction and describe potential adverse or positive effects on health that the proposed activities may create.

"(C) PREFERENCE.—Preference in awarding funds under this section may be given to eligible entities that demonstrate the potential to significantly improve population health or lower health care costs as a result of potential health impact assessment work.

''(3) USE OF FUNDS.—

''(A) IN GENERAL.—An entity receiving a grant under this section shall use such grant funds to conduct health impact assessment capacity building or to fund subgrantees in conducting a health impact assessment for a proposed activity in accordance with this subsection.

''(B) PURPOSES.—The purposes of a health impact assessment under this subsection are—

''(i) to facilitate the involvement of tribal, State, and local public health officials in community planning, transportation, housing, and land use decisions and other decisions affecting the built environment to identify any potential health concern or health benefit relating to an activity or proposed activity;

''(ii) to provide for an investigation of any health-related issue of concern raised in a planning process, an environmental impact assessment process, or policy appraisal relating to a proposed activity;

''(iii) to describe and compare alternatives (including no-action alternatives) to a proposed activity to provide clarification with respect to the potential health outcomes associated with the proposed activity and, where appropriate, to the related benefit-cost or cost-effectiveness of the proposed activity and alternatives;

''(iv) to contribute, when applicable, to the findings of a planning process, policy appraisal, or an environmental impact statement with respect to the terms and conditions of implementing a proposed activity or related mitigation recommendations, as necessary;

''(v) to ensure that the disproportionate distribution of negative impacts among vulnerable populations is minimized as much as possible;

''(vi) to engage affected community members and ensure adequate opportunity for public comment on all stages of the health impact assessment;

''(vii) where appropriate, to consult with local and county health departments

and appropriate organizations, including planning, transportation, and housing organizations and providing them with information and tools regarding how to conduct and integrate health impact assessment into their work; and

''(viii) to inspect homes, water systems, and other elements that pose risks to lead exposure, with an emphasis on areas that pose a higher risk to children.

''(4) ASSESSMENTS.—Health impact assessments carried out using grant funds under this section shall—

''(A) take appropriate health factors into consideration as early as practicable during the planning, review, or decisionmaking processes;

''(B) assess the effect on the health of individuals and populations of proposed policies, projects, or plans that result in modifications to the built environment; and

''(C) assess the distribution of health effects across various factors, such as race, income, ethnicity, age, disability status, gender, and geography.

''(5) ELIGIBLE ACTIVITIES.—

"(A) IN GENERAL.—Eligible entities funded under this subsection shall conduct an evaluation of any proposed activity to determine whether it will have a significant adverse or positive effect on the health of the affected population in the jurisdiction of the eligible entity, based on the criteria described in subparagraph (B).

"(B) CRITERIA.—The criteria described in this subparagraph include, as applicable to the proposed activity, the following:

"(i) Any substantial adverse effect or significant health benefit on health outcomes or factors known to influence health, including the following:

"(I) Physical activity.

"(II) Injury.

"(III) Mental health.

"(IV) Accessibility to health-promoting goods and services.

"(V) Respiratory health.

"(VI) Chronic disease.

"(VII) Nutrition.

''(VIII) Land use changes that promote local, sustainable food sources.

''(IX) Infectious disease, including COVID–19.

''(X) Health disparities.

''(XI) Existing air quality, ground or surface water quality or quantity, or noise levels.

''(XII) Lead exposure.

''(XIII) Drinking water quality and accessibility.

''(ii) Other factors that may be considered, including—

''(I) the potential for a proposed activity to result in systems failure that leads to a public health emergency, pandemic, or other infectious or biochemical agent;

''(II) the probability that the proposed activity will result in a significant increase in tourism, economic development, or employment in the jurisdiction of the eligible entity;

"(III) any other significant potential hazard or enhancement to human health, as determined by the eligible entity; or

"(IV) whether the evaluation of a proposed activity would duplicate another analysis or study being undertaken in conjunction with the proposed activity.

"(C) FACTORS FOR CONSIDERATION.—In evaluating a proposed activity under subparagraph (A), an eligible entity may take into consideration any reasonable, direct, indirect, or cumulative effect that can be clearly related to potential health effects and that is related to the proposed activity, including the effect of any action that is—

"(i) included in the long-range plan relating to the proposed activity;

"(ii) likely to be carried out in coordination with the proposed activity;

"(iii) dependent on the occurrence of the proposed activity; or

''(iv) likely to have a disproportionate impact on high-risk or vulnerable populations.

''(6) REQUIREMENTS.—A health impact assessment prepared with funds awarded under this subsection shall incorporate the following, after conducting the screening phase (identifying projects or policies for which a health impact assessment would be valuable and feasible) through the application process:

''(A) SCOPING.—Identifying which health effects to consider and the research methods to be utilized.

''(B) ASSESSING RISKS AND BENEFITS.—Assessing the baseline health status and factors known to influence the health status in the affected community, which may include aggregating and synthesizing existing health assessment evidence and data from the community.

''(C) DEVELOPING RECOMMENDATIONS.—Suggesting changes to proposals to promote positive or mitigate adverse health effects.

''(D) REPORTING.—Synthesizing the assessment and recommendations and communicating the results to decision makers.

''(E) MONITORING AND EVALUATING.—Tracking the decision and implementation effect on health determinants and health status.

''(7) PLAN.—An eligible entity that is awarded a grant under this section shall develop and implement a plan, to be approved by the Director, for meaningful and inclusive stakeholder involvement in all phases of the health impact assessment. Stakeholders may include community leaders, community-based organizations, youth-serving organizations, planners, public health experts, State and local public health departments and officials, health care experts or officials, housing experts or officials, and transportation experts or officials.

''(8) SUBMISSION OF FINDINGS.—An eligible entity that is awarded a grant under this section shall submit the findings of any funded health impact assessment activities to the Secretary and make these findings publicly available.

''(9) ASSESSMENT OF IMPACTS.—An eligible entity that is awarded a grant under this section shall ensure the assessment of the distribution of health impacts (related to the proposed activity) across race, ethnicity, income, age, gender, disability status, and geography.

''(10) CONDUCT OF ASSESSMENT.—To the greatest extent feasible, a health impact assessment shall be conducted under this section in a manner that respects the needs and timing of the decision-making process it evaluates.

''(11) METHODOLOGY.—In preparing a health impact assessment under this subsection, an eligible entity or partner shall follow the guidance published under subsection (c).

''(e) HEALTH IMPACT ASSESSMENT DATABASE.—The Secretary, acting through the Director and in collaboration with the Administrator, shall establish, maintain, and make publicly available a health impact assessment database, including—

''(1) a catalog of health impact assessments received under this section;

''(2) an inventory of tools used by eligible entities to conduct health impact assessments; and

''(3) guidance for eligible entities with respect to the selection of appropriate tools described in paragraph (2).

''(f) EVALUATION OF GRANTEE ACTIVITIES.—The Secretary shall award competitive grants to Prevention Research Centers, or nonprofit organizations or academic

institutions with expertise in health impact assessments to—

"(1) assist grantees with the provision of training and technical assistance in the conducting of health impact assessments;

"(2) evaluate the activities carried out with grants under subsection (d); and

"(3) assist the Secretary in disseminating evidence, best practices, and lessons learned from grantees.

"(g) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of the Ending Health Disparities During COVID–19 Act of 2020, the Secretary shall submit to Congress a report concerning the evaluation of the programs under this section, including recommendations as to how lessons learned from such programs can be incorporated into future guidance documents developed and provided by the Secretary and other Federal agencies, as appropriate.

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

"SEC. 399V–13. IMPLEMENTATION OF RESEARCH FINDINGS TO IMPROVE HEALTH OUTCOMES THROUGH THE BUILT ENVIRONMENT.

''(a) RESEARCH GRANT PROGRAM.—The Secretary, in collaboration with the Administrator of the Environmental Protection Agency (referred to in this section as the 'Administrator'), shall award grants to public agencies or private nonprofit institutions to implement evidence-based programming to improve human health through improvements to the built environment and subsequently human health, by addressing—

''(1) levels of physical activity;

''(2) consumption of nutritional foods;

''(3) rates of crime;

''(4) air, water, and soil quality;

''(5) risk or rate of injury;

''(6) accessibility to health-promoting goods and services;

''(7) chronic disease rates;

''(8) community design;

''(9) housing; or transportation options;

''(10) ability to reduce the spread of infectious diseases (such as COVID–19); and

''(11) other factors, as the Secretary determines appropriate.

''(b) APPLICATIONS.—A public agency or private nonprofit institution desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such agreements, assurances, and information as the Secretary, in consultation with the Administrator, may require.

''(c) RESEARCH.—The Secretary, in consultation with the Administrator, shall support, through grants awarded under this section, research that—

''(1) uses evidence-based research to improve the built environment and human health;

''(2) examines—

''(A) the scope and intensity of the impact that the built environment (including the various characteristics of the built environment) has on the human health; or

''(B) the distribution of such impacts by—

''(i) location; and

''(ii) population subgroup;

''(3) is used to develop—

''(A) measures and indicators to address health impacts and the connection of health to the built environment;

''(B) efforts to link the measures to transportation, land use, and health databases; and

"(C) efforts to enhance the collection of built environment surveillance data;

"(4) distinguishes carefully between personal attitudes and choices and external influences on behavior to determine how much the association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

"(5)(A) identifies or develops effective intervention strategies focusing on enhancements to the built environment that promote increased use physical activity, access to nutritious foods, or other health-promoting activities by residents; and

"(B) in developing the intervention strategies under subparagraph (A), ensures that the intervention strategies will reach out to high-risk or vulnerable populations, including low-income urban and rural communities and aging populations, in addition to the general population.

"(d) SURVEYS.—The Secretary may allow recipients of grants under this section to use such grant funds to support the expansion of national surveys and data tracking systems to provide more detailed information about the connection between the built environment and health.

''(e) PRIORITY.—In awarding grants under this section, the Secretary and the Administrator shall give priority to entities with programming that incorporates—

''(1) interdisciplinary approaches; or

''(2) the expertise of the public health, physical activity, urban planning, land use, and transportation research communities in the United States and abroad.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section. The Secretary may allocate not more than 20 percent of the amount so appropriated for a fiscal year for purposes of conducting research under subsection (c).''.

SEC. 1108. TRIBAL FUNDING TO RESEARCH HEALTH INEQUITIES INCLUDING COVID–19.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Director of the Indian Health Service, in coordination with Tribal Epidemiology Centers and other Federal agencies, as appropriate, shall conduct or support research and field studies for the purposes of improved understanding of Tribal health inequities among American Indians and Alaska Natives, including with respect to—

(1) disparities related to COVID–19;

(2) public health surveillance and infrastructure regarding unmet needs in Indian country and Urban Indian communities;

(3) population-based health disparities;

(4) barriers to health care services;

(5) the impact of socioeconomic status; and

(6) factors contributing to Tribal health inequities.

(b) CONSULTATION, CONFER, AND COORDINATION.—In carrying out this section, the Director of the Indian Health Service shall—

(1) consult with Indian Tribes and Tribal organizations;

(2) confer with Urban Indian organizations;

(3) coordinate with the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health.

(c) PROCESS.—Not later than 60 days after the date of enactment of this Act, the Director of the Indian Health Service shall establish a nationally representative panel to establish processes and procedures for the research and field studies conducted or supported under subsection (a). The Director shall ensure that, at a minimum, the panel consists of the following individuals:

(1) Elected Tribal leaders or their designees.

(2) Tribal public health practitioners and experts from the national and regional levels.

(d) DUTIES.—The panel established under subsection (c) shall, at a minimum—

(1) advise the Director of the Indian Health Service on the processes and procedures regarding the design, implementation, and evaluation of, and reporting on, research and field studies conducted or supported under this section;

(2) develop and share resources on Tribal public health data surveillance and reporting, including best practices; and

(3) carry out such other activities as may be appropriate to establish processes and procedures for the research and field studies conducted or supported under subsection (a).

(e) REPORT.—Not later than 1 year after expending all funds made available to carry out this section, the Director of the Indian Health Service, in coordination with the panel established under subsection (c), shall submit an initial report on the results of the research and field studies under this section to—

(1) the Committee on Energy and Commerce and the Committee on Natural Resources of the House of Representatives; and

(2) the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate.

(f) TRIBAL DATA SOVEREIGNTY.—The Director of the Indian Health Service shall ensure that all research and field studies conducted or supported under this section are tribally-directed and carried out in a manner which ensures Tribal-direction of all data collected under this section—

(1) according to Tribal best practices regarding research design and implementation, including by ensuring the consent of the Tribes involved to public reporting of Tribal data;

(2) according to all relevant and applicable Tribal, professional, institutional, and Federal standards for conducting research and governing research ethics;

(3) with the prior and informed consent of any Indian Tribe participating in the research or sharing data for use under this section; and

(4) in a manner that respects the inherent sovereignty of Indian Tribes, including Tribal governance of data and research.

(g) FINAL REPORT.—Not later than December 31, 2023, the Director of the Indian Health Service shall—

(1) update and finalize the initial report under subsection (e); and

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

(h) DEFINITIONS.—In this section:

(1) The terms ''Indian Tribe'' and ''Tribal organization'' have the meanings given to such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304).

(2) The term ''Urban Indian organization'' has the meaning given to such term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $25,000,000, to remain available until expended.

SEC. 1109. RESEARCH ENDOWMENTS AT BOTH CURRENT AND FORMER CENTERS OF EXCELLENCE.

Paragraph (1) of section 464z–3(h) of the Public Health Service Act (42 U.S.C. 285t(h)) is amended to read as follows:

''(1) IN GENERAL.—The Director of the Institute may carry out a program to facilitate minority health disparities research and other health dispari-

ties research by providing for research endowments—

''(A) at current or former centers of excellence under section 736; and

''(B) at current or former centers of excellence under section 464z–4.''.

TITLE XII—EDUCATION

SEC. 1201. GRANTS FOR SCHOOLS OF MEDICINE IN DIVERSE AND UNDERSERVED AREAS.

Subpart II of part C of title VII of the Public Health Service Act is amended by inserting after section 749B of such Act (42 U.S.C. 293m) the following:

''SEC. 749C. SCHOOLS OF MEDICINE IN UNDERSERVED AREAS.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may award grants to institutions of higher education (including multiple institutions of higher education applying jointly) for the establishment, improvement, and expansion of an allopathic or osteopathic school of medicine, or a branch campus of an allopathic or osteopathic school of medicine.

''(b) PRIORITY.—In selecting grant recipients under this section, the Secretary shall give priority to institutions of higher education that—

''(1) propose to use the grant for an allopathic or osteopathic school of medicine, or a branch campus of an allopathic or osteopathic school of medicine, in a combined statistical area with fewer than 200 actively practicing physicians per 100,000 residents according to the medical board (or boards) of the State (or States) involved;

''(2) have a curriculum that emphasizes care for diverse and underserved populations; or

''(3) are minority-serving institutions described in the list in section 371(a) of the Higher Education Act of 1965.

''(c) USE OF FUNDS.—The activities for which a grant under this section may be used include—

''(1) planning and constructing—

''(A) a new allopathic or osteopathic school of medicine in an area in which no other school is based; or

''(B) a branch campus of an allopathic or osteopathic school of medicine in an area in which no such school is based;

''(2) accreditation and planning activities for an allopathic or osteopathic school of medicine or branch campus;

''(3) hiring faculty and other staff to serve at an allopathic or osteopathic school of medicine or branch campus;

''(4) recruitment and enrollment of students at an allopathic or osteopathic school of medicine or branch campus;

''(5) supporting educational programs at an allopathic or osteopathic school of medicine or branch campus;

''(6) modernizing infrastructure or curriculum at an existing allopathic or osteopathic school of medicine or branch campus thereof;

''(7) expanding infrastructure or curriculum at existing an allopathic or osteopathic school of medicine or branch campus; and

''(8) other activities that the Secretary determines further the development, improvement, and expansion of an allopathic or osteopathic school of medicine or branch campus thereof.

''(d) DEFINITIONS.—In this section:

''(1) The term 'branch campus' means a geographically separate site at least 100 miles from the main campus of a school of medicine where at least one student completes at least 60 percent of the stu-

dent's training leading to a degree of doctor of medicine.

''(2) The term 'institution of higher education' has the meaning given to such term in section 101(a) of the Higher Education Act of 1965.

''(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $1,000,000,000, to remain available until expended.''.

SEC. 1202. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXIV of the Public Health Service Act, as amended by as amended by sections 104, 702, and 806, is amended by adding at the end the following:

''Subtitle D—Diversifying the Health Care Workplace

''SEC. 3410. NATIONAL WORKING GROUP ON WORKFORCE DIVERSITY.

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

''(b) REPRESENTATION.—In establishing the national working group under subsection (a):

''(1) The grantee shall ensure that the group has representatives of each of the following:

''(A) The Health Resources and Services Administration.

''(B) The Department of Health and Human Services Data Council.

''(C) The Office of Minority Health of the Department of Health and Human Services.

''(D) The Substance Abuse and Mental Health Services Administration.

''(E) The Bureau of Labor Statistics of the Department of Labor.

''(F) The National Institute on Minority Health and Health Disparities.

''(G) The Agency for Healthcare Research and Quality.

''(H) The Institute of Medicine Study Committee for the 2004 workforce diversity report.

''(I) The Indian Health Service.

''(J) The Department of Education.

''(K) Minority-serving academic institutions.

"(L) Consumer organizations.

"(M) Health professional associations, including those that represent underrepresented minority populations.

"(N) Researchers in the area of health workforce.

"(O) Health workforce accreditation entities.

"(P) Private (including nonprofit) foundations that have sponsored workforce diversity initiatives.

"(Q) Local and State health departments.

"(R) Representatives of community members to be included on admissions committees for health profession schools pursuant to subsection (c)(9).

"(S) National community-based organizations that serve as a national intermediary to their urban affiliate members and have demonstrated capacity to train health care professionals.

"(T) The Veterans Health Administration.

"(U) Other entities determined appropriate by the Secretary.

''(2) The grantee shall ensure that, in addition to the representatives under paragraph (1), the working group has not less than 5 health professions students representing various health profession fields and levels of training.

''(c) ACTIVITIES.—The working group established under subsection (a) shall convene at least twice each year to complete the following activities:

''(1) Review public and private health workforce diversity initiatives.

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

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

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

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

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

''(7) Develop guidelines to train health professionals to care for a diverse population.

''(8) Develop a workforce data collection or tracking system to identify where racial and ethnic minority health professionals practice.

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

''(10) Help with monitoring and implementation of standards for diversity, equity, and inclusion.

''(11) Other activities determined appropriate by the Secretary.

''(d) ANNUAL REPORT.—Not later than 1 year after the establishment of the working group under subsection (a), and annually thereafter, the working group shall prepare and make available to the general public for comment, an annual report on the activities of the working group. Such report shall include the recommendations of the working group for improving health workforce diversity.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

"SEC. 3412. TECHNICAL CLEARINGHOUSE FOR HEALTH WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Deputy Assistant Secretary for Minority Health, and in collaboration with the Bureau of Health Workforce within the Health Resources and Services Administration and the National Institute on Minority Health and Health Disparities, shall establish a technical clearinghouse on health workforce diversity within the Office of Minority Health and coordinate current and future clearinghouses related to health workforce diversity.

''(b) INFORMATION AND SERVICES.—The clearinghouse established under subsection (a) shall offer the following information and services:

''(1) Information on the importance of health workforce diversity.

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

''(3) Model health workforce diversity practices and programs, including integrated models of care.

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

''(5) Retainment policies that promote completion of health profession degrees for underserved populations.

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

''(7) Foundation and other large organizational initiatives relating to health workforce diversity.

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

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

''SEC. 3413. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY, EQUITY, AND INCLUSION.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and the Centers for Disease Control and

Prevention, shall award grants to eligible entities that demonstrate a commitment to health workforce diversity.

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

''(1) be an educational institution or entity that historically produces or trains meaningful numbers of underrepresented minority health professionals, including—

''(A) part B institutions, as defined in section 322 of the Higher Education Act of 1965;

''(B) Hispanic-serving health professions schools;

''(C) Hispanic-serving institutions, as defined in section 502 of such Act;

''(D) Tribal colleges or universities, as defined in section 316 of such Act;

''(E) Asian American and Native American Pacific Islander-serving institutions, as defined in section 371(c) of such Act;

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

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

"(H) institutions, including national and regional community-based organizations with demonstrated commitment to a diversified workforce—

"(i) located in communities with predominantly underrepresented minority populations;

"(ii) with whom partnerships have been formed for the purpose of increasing workforce diversity; and

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

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

"(c) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to expand existing workforce diversity programs, implement new workforce diversity programs, or evaluate existing or new workforce diversity programs, including with respect to mental health care professions. Such programs shall enhance di-

versity by considering minority status as part of an individualized consideration of qualifications. Possible activities may include—

''(1) educational outreach programs relating to opportunities in the health professions;

''(2) scholarship, fellowship, grant, loan repayment, and loan cancellation programs;

''(3) postbaccalaureate programs;

''(4) academic enrichment programs, particularly targeting those who would not be competitive for health professions schools;

''(5) supporting workforce diversity in kindergarten through 12th grade and other health pipeline programs;

''(6) mentoring programs;

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

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

''(9) leadership training.

''(d) REPORTS.—Not later than 1 year after receiving a grant under this section, and annually for the term of the grant, a grantee shall submit to the Secretary a report

that summarizes and evaluates all activities conducted under the grant.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

''SEC. 3414. CAREER DEVELOPMENT FOR SCIENTISTS AND RESEARCHERS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Health Resources and Services Administration, shall award grants that expand existing opportunities for scientists and researchers and promote the inclusion of underrepresented minorities in the health professions.

''(b) RESEARCH FUNDING.—The head of each agency listed in subsection (a) shall establish or expand existing programs to provide research funding to scientists and researchers in training. Under such programs, the head of each such entity shall give priority in allocating research funding to support health research in traditionally underserved communities, including underrepresented minority

communities, and research classified as community or participatory.

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

''(d) STUDENT LOAN REIMBURSEMENT.—The Secretary shall establish a student loan reimbursement program to provide student loan reimbursement assistance to researchers who focus on racial and ethnic disparities in health. The Secretary shall promulgate regulations to define the scope and procedures for the program under this subsection.

''(e) STUDENT LOAN CANCELLATION.—The Secretary shall establish a student loan cancellation program to provide student loan cancellation assistance to researchers who focus on racial and ethnic disparities in health. Students participating in the program shall make a minimum 5-year commitment to work at an accredited health profession school. The Secretary shall promulgate additional regulations to define the scope and procedures for the program under this subsection.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2021 through 2025.

"SEC. 3415. CAREER SUPPORT FOR NONRESEARCH HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Assistant Secretary for Mental Health and Substance Use, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare & Medicaid Services, shall establish a program to award grants to eligible individuals for career support in nonresearch-related health and wellness professions.

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

''(1) be a student in a health professions school, a graduate of such a school who is working in a health profession, an individual working in a health or wellness profession (including mental and behavioral health), or a faculty member of such a school; and

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

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

''(1) support the individual's health activities or projects that involve underserved communities, including racial and ethnic minority communities;

''(2) support health-related career advancement activities;

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

''(4) to establish and promote leadership training programs to decrease health disparities and to increase cultural competence with the goal of increasing diversity in leadership positions.

''(d) DEFINITION.—In this section, the term 'career in nonresearch-related health and wellness professions' means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, psychology,

social work, psychiatry, other mental and behavioral health, allied health, community health, social work, or other fields determined appropriate by the Secretary, other than in a position that involves research.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.

''SEC. 3416. RESEARCH ON THE EFFECT OF WORKFORCE DIVERSITY ON QUALITY.

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

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

''(1) be a clinical, public health, or health services research entity or other entity determined appropriate by the Director; and

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

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support research that investigates the effect of health workforce diversity on—

''(1) language access;

''(2) cultural competence;

''(3) patient satisfaction;

''(4) timeliness of care;

''(5) safety of care;

''(6) effectiveness of care;

''(7) efficiency of care;

''(8) patient outcomes;

''(9) community engagement;

''(10) resource allocation;

''(11) organizational structure;

''(12) compliance of care; or

''(13) other topics determined appropriate by the Director.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give individualized consideration to all relevant aspects of the applicant's background. Consideration of prior research experience involving the health of underserved communities shall be such a factor.

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

such sums as may be necessary for each of fiscal years 2021 through 2025.

"SEC. 3417. HEALTH DISPARITIES EDUCATION PROGRAM.

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

"(b) ACTIVITIES.—The Secretary, through the education program established under subsection (a), shall, through the use of public awareness and outreach campaigns targeting the general public and the medical community at large—

"(1) disseminate scientific evidence for the existence and extent of racial and ethnic disparities in health care, including disparities that are not otherwise attributable to known factors such as access to

care, patient preferences, or appropriateness of intervention, as described in the 2002 Institute of Medicine Report entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', as well as the impact of disparities related to age, disability status, socioeconomic status, sex, gender identity, and sexual orientation on racial and ethnic minorities;

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

''(3) disseminate information about the impact of linguistic and cultural barriers on health care quality and the obligation of health providers who receive Federal financial assistance to ensure that individuals with limited English proficiency have access to language access services;

''(4) disseminate information about the importance and legality of racial, ethnic, disability status, socioeconomic status, sex, gender identity, and sexual orientation, and primary language data collection, analysis, and reporting;

''(5) design and implement specific educational initiatives to health care providers relating to health and health care disparities;

''(6) assess the impact of the programs established under this section in raising awareness of health and health care disparities and providing information on available resources; and

''(7) design and implement specific educational initiatives to educate the health care workforce relating to unconscious bias.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2025.''.

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.

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

"SEC. 742. HISPANIC-SERVING INSTITUTIONS, HISTORICALLY BLACK COLLEGES AND UNIVERSITIES, ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTIONS, AND TRIBAL COLLEGES.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Secretary of Education, shall award grants to Hispanic-serving institutions, Historically Black Colleges and Universities, Asian American and Native American Pacific Islander-serving institutions, Tribal Colleges or Universities, regional community-based organizations, and national minority medical associations, for counseling, mentoring and providing information on financial assistance to prepare underrepresented minority individuals to enroll in and graduate from health professional schools and to increase services for underrepresented minority students including—

''(1) mentoring with underrepresented health professionals; and

''(2) providing financial assistance information for continued education and applications to health professional schools.

''(b) DEFINITIONS.—In this section:

''(1) ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTION.—The

term 'Asian American and Native American Pacific Islander-serving institution' has the meaning given such term in section 320(b) of the Higher Education Act of 1965.

''(2) HISPANIC-SERVING INSTITUTION.—The term 'Hispanic-serving institution' means an entity that—

''(A) is a school or program for which there is a definition under 799B;

''(B) has an enrollment of full-time equivalent students that is made up of at least 9 percent Hispanic students;

''(C) has been effective in carrying out programs to recruit Hispanic individuals to enroll in and graduate from the school;

''(D) has been effective in recruiting and retaining Hispanic faculty members;

''(E) has a significant number of graduates who are providing health services to medically underserved populations or to individuals in health professional shortage areas; and

''(F) is a Hispanic Center of Excellence in Health Professions Education designated under section 736(d)(2) of the Public Health Service Act (42 U.S.C. 293(d)(2)).

"(3) HISTORICALLY BLACK COLLEGES AND UNIVERSITY.—The term 'historically black college and university' has the meaning given the term 'part B institution' as defined in section 322 of the Higher Education Act of 1965.

"(4) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given such term in section 316(b) of the Higher Education Act of 1965.

"(c) CERTAIN LOAN REPAYMENT PROGRAMS.—In carrying out the National Health Service Corps Loan Repayment Program established under subpart III of part D of title III and the loan repayment program under section 317F, the Secretary shall ensure, notwithstanding such subpart or section, that loan repayments of not less than $50,000 per year per person are awarded for repayment of loans incurred for enrollment or participation of underrepresented minority individuals in health professional schools and other health programs described in this section.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2021 through 2026.".

SEC. 1204. LOAN REPAYMENT PROGRAM OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317F(c)(1) of the Public Health Service Act (42 U.S.C. 247b–7(c)(1)) is amended—

(1) by striking ''and'' after ''1994,''; and

(2) by inserting before the period at the end the following: '', $750,000 for fiscal year 2020, and such sums as may be necessary for each of the fiscal years 2021 through 2025''.

SEC. 1205. STUDY AND REPORT ON STRATEGIES FOR INCREASING DIVERSITY.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on strategies for increasing the diversity of the health professional workforce. Such study shall include an analysis of strategies for increasing the number of health professionals from rural, lower income, and underrepresented minority communities, including which strategies are most effective for achieving such goal.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 1206. AMENDMENTS TO THE PANDEMIC EBT ACT.

Section 1101 of the Families First Coronavirus Response Act (Public Law 116–127) is amended—

(1) in subsection (a)—

(A) by striking ''fiscal year 2020'' and inserting ''fiscal years 2020 and 2021'';

(B) by striking ''during which the school would otherwise be in session''; and

(C) by inserting ''until the school reopens'' after ''assistance'';

(2) in subsection (b)—

(A) by inserting ''and State agency plans for child care covered children in accordance with subsection (i)'' after ''with eligible children'';

(B) by inserting '', a plan to enroll children who become eligible children during a public health emergency designation'' before '', and issuances'';

(C) by striking ''in an amount not less than the value of meals at the free rate over the course of 5 school days'' and inserting ''in accordance with subsection (h)(1)''; and

(D) by inserting ''and for each child care covered child in the household'' before the period at the end;

(3) in subsection (c), by inserting ''or child care center'' after ''school'';

(4) by amending subsection (e) to read as follows:

''(e) RELEASE OF INFORMATION.—Notwithstanding any other provision of law, the Secretary of Agriculture may authorize—

''(1) State educational agencies and school food authorities administering a school lunch program under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) to release to appropriate officials administering the supplemental nutrition assistance program such information as may be necessary to carry out this section with respect to eligible children; and

''(2) State agencies administering a child and adult care food program under section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766) to release to appropriate officials administering the supplemental nutrition assistance program such information as may be necessary to carry out this section with respect to child care covered children.'';

(5) by amending subsection (g) to read as follows:

"(g) AVAILABILITY OF COMMODITIES.—

"(1) IN GENERAL.—Subject to paragraph (2), during fiscal year 2020, the Secretary of Agriculture may purchase commodities for emergency distribution in any area of the United States during a public health emergency designation.

"(2) PURCHASES.—Funds made available to carry out this subsection on or after the date of the enactment of the Child Nutrition and Related Programs Recovery Act may only be used to purchase commodities for emergency distribution—

"(A) under commodity distribution programs and child nutrition programs that were established and administered by the Food and Nutrition Service on or before the day before the date of the enactment of the Families First Coronavirus Response Act (Public Law 116–127);

"(B) to Tribal organizations (as defined in section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012)), that are not administering the food distribution program established under section 4(b) of the Food and Nutrition Act of 2008 (7 U.S.C. 2013(b)); or

"(C) to emergency feeding organizations that are eligible recipient agencies (as such terms are defined in section 201A of the Emergency Food Assistance Act of 1983 (7 U.S.C. 7501)).";

(6) by redesignating subsections (h) and (i) as subsections (l) and (m);

(7) by inserting after subsection (g) the following:

"(h) AMOUNT OF BENEFITS.—

"(1) IN GENERAL.—A household shall receive benefits under this section in an amount equal to 1 breakfast and 1 lunch at the free rate for each eligible child or child care covered child in such household for each day.

"(2) TREATMENT OF NEWLY ELIGIBLE CHILDREN.—In the case of a child who becomes an eligible child during a public health emergency designation, the Secretary and State agency shall—

"(A) if such child becomes an eligible child during school year 2019–2020, treat such child as if such child was an eligible child as of the date the school in which the child is enrolled closed; and

''(B) if such child becomes an eligible child after school year 2019–2020, treat such child as an eligible child as of the first day of the month in which such child becomes so eligible.

''(i) CHILD CARE COVERED CHILD ASSISTANCE.—

''(1) IN GENERAL.—During fiscal years 2020 and 2021, in any case in which a child care center is closed for at least 5 consecutive days during a public health emergency designation, each household containing at least 1 member who is a child care covered child attending the child care center shall be eligible until the schools in the State in which such child care center is located reopen, as determined by the Secretary, to receive assistance pursuant to—

''(A) a State agency plan approved under subsection (b) that includes—

''(i) an application by the State agency seeking to participate in the program under this subsection; and

''(ii) a State agency plan for temporary emergency standards of eligibility and levels of benefits under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) for households with child care covered children; or

''(B) an addendum application described in paragraph (2).

''(2) ADDENDUM APPLICATION.—In the case of a State agency that submits a plan to the Secretary of Agriculture under subsection (b) that does not include an application or plan described in clauses (i) and (ii) of paragraph (1)(A), such State agency may apply to participate in the program under this subsection by submitting to the Secretary of Agriculture an addendum application for approval that includes a State agency plan described in such clause (ii).

''(3) REQUIREMENTS FOR PARTICIPATION.—A State agency may not participate in the program under this subsection if—

''(A) the State agency plan submitted by such State agency under subsection (b) with respect to eligible children is not approved by the Secretary under such subsection; or

''(B) the State agency plan submitted by such State agency under subsection (b) or this subsection with respect to child care covered children is not approved by the Secretary under either such subsection.

''(4) AUTOMATIC ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall deem a child who is less than 6 years of age to be a child care covered child eligible to receive assistance under this subsection if—

''(i) the household with such child attests that such child is a child care covered child;

''(ii) such child resides in a household that includes an eligible child;

''(iii) such child receives cash assistance benefits under the temporary assistance for needy families program under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.);

''(iv) such child receives assistance under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9857 et seq.);

''(v) such child is—

''(I) enrolled as a participant in a Head Start program authorized under the Head Start Act (42 U.S.C. 9831 et seq.);

"(II) a foster child whose care and placement is the responsibility of an agency that administers a State plan under part B or E of title IV of the Social Security Act (42 U.S.C. 621 et seq.);

"(III) a foster child who a court has placed with a caretaker household; or

"(IV) a homeless child or youth (as defined in section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)));

"(vi) such child participates in the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786);

"(vii) through the use of information obtained by the State agency for the purpose of participating in the supplemental nutrition assistance program under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), the State agency elects to treat as a child care covered child each

child less than 6 years of age who is a member of a household that receives supplemental nutrition assistance program benefits under such Act; or

''(viii) the State in which such child resides determines that such child is a child care covered child, using State data approved by the Secretary.

''(B) ACCEPTANCE OF ANY FORM OF AUTOMATIC ENROLLMENT.—

''(i) ONE CATEGORY.—For purposes of deeming a child to be a child care covered child under subparagraph (A), a State agency may not be required to show that a child meets more than one requirement specified in clauses (i) through (viii) of such subparagraph.

''(ii) DEEMING REQUIREMENT.—If a State agency submits to the Secretary information that a child meets any one of the requirements specified in clauses (i) through (viii) of subparagraph (A), the Secretary shall deem such child a child care covered child under such subparagraph.

''(j) EXCLUSIONS.—The provisions of section 16 of the Food and Nutrition Act of 2008 (7 U.S.C. 2025) relating to quality control shall not apply with respect to assistance provided under this section.

''(k) FEASIBILITY ANALYSIS.—

''(1) IN GENERAL.—Not later than 30 days after the date of the enactment of the Child Nutrition and Related Programs Recovery Act, the Secretary shall submit to the Education and Labor Committee and the Agriculture Committee of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate a report on—

''(A) the feasibility of implementing the program for eligible children under this section using an EBT system in Puerto Rico, the Commonwealth of the Northern Mariana Islands, and American Samoa similar to the manner in which the supplemental nutrition assistance program under the Food and Nutrition Act of 2008 is operated in the States, including an analysis of—

''(i) the current nutrition assistance program issuance infrastructure;

''(ii) the availability of—

"(I) an EBT system, including the ability for authorized retailers to accept EBT cards; and

"(II) EBT cards;

"(iii) the ability to limit purchases using nutrition assistance program benefits to food for home consumption; and

"(iv) the availability of reliable data necessary for the implementation of such program under this section for eligible children and child care covered children, including the names of such children and the mailing addresses of their households; and

"(B) the feasibility of implementing the program for child care covered children under subsection (i) in Puerto Rico, the Commonwealth of the Northern Mariana Islands, and American Samoa, including with respect to such program each analysis specified in clauses (i) through (iv) of subparagraph (A).

"(2) CONTINGENT AVAILABILITY OF PARTICIPATION.—Beginning 30 days after the date of the enactment of the Child Nutrition and Related Programs Recovery Act, Puerto Rico, the Common-

wealth of the Northern Mariana Islands, and American Samoa may each—

"(A) submit a plan under subsection (b), unless the Secretary makes a finding, based on the analysis provided under paragraph (1)(A), that the implementation of the program for eligible children under this section is not feasible in such territories; and

"(B) submit a plan under subsection (i), unless the Secretary makes a finding, based on the analysis provided under paragraph (1)(B), that the implementation of the program for child care covered children under subsection (i) is not feasible in such territories.

"(3) TREATMENT OF PLANS SUBMITTED BY TERRITORIES.—Notwithstanding any other provision of law, with respect to a plan submitted pursuant to this subsection by Puerto Rico, the Commonwealth of the Northern Mariana Islands, or American Samoa under subsection (b) or subsection (i), the Secretary shall treat such plan in the same manner as a plan submitted by a State agency under such subsection, including with respect to the terms of funding provided under subsection (m).";

(8) in subsection (l), as redesigned by paragraph (7)—

(A) by redesignating paragraph (1) as paragraph (3);

(B) by redesignating paragraphs (2) and (3) as paragraphs (5) and (6), respectively;

(C) by inserting before paragraph (3) (as so redesignated) the following:

''(1) The term 'child care center' means an organization described in subparagraph (A) or (B) of section 17(a)(2) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766(a)(2)) and a family or group day care home.

''(2) The term 'child care covered child' means a child served under section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766) who, if not for the closure of the child care center attended by the child during a public health emergency designation and due to concerns about a COVID–19 outbreak, would receive meals under such section at the child care center.''; and

(D) by inserting after paragraph (3) (as so redesignated) the following:

''(4) The term 'free rate' means—

''(A) with respect to a breakfast, the rate of a free breakfast under the school breakfast program under section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773); and

''(B) with respect to a lunch, the rate of a free lunch under the school lunch program under the Richard B. Russell National School Lunch Act (42 U.S.C. 1771 et seq.).''; and

(9) in subsection (m), as redesignated by paragraph (7), by inserting ''(including all administrative expenses)'' after ''this section''.

TITLE XIII—PUBLIC HEALTH ASSISTANCE TO TRIBES

SEC. 1301. APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE.

HEROES Act Division A, Title V—Department of Health & Human Services—Indian Health Service—The $2.1 billion in COVID–19 response funding for the Indian Health Service.

SEC. 1302. IMPROVING STATE, LOCAL, AND TRIBAL PUBLIC HEALTH SECURITY.

Section 319C–1 of the Public Health Service Act (42 U.S.C. 247d–3a) is amended—

(1) in the section heading, by striking ''**AND LOCAL**'' and inserting ''**, LOCAL, AND TRIBAL**'';

(2) in subsection (b)—

(A) in paragraph (1)—

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

(ii) in subparagraph (C), by striking ''and'' at the end and inserting ''or''; and

(iii) by adding at the end the following:

''(D) be an Indian Tribe, Tribal organization, or a consortium of Indian Tribes or Tribal organizations; and''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting '', as applicable'' after ''including'';

(ii) in subparagraph (A)(viii)—

(I) by inserting ''and Tribal'' after ''with State'';

(II) by striking ''(as defined in section 8101 of the Elementary and Secondary Education Act of 1965)'' and inserting ''and Tribal educational agencies (as defined in sections 8101 and 6132, respectively, of the Elemen-

tary and Secondary Education Act of 1965)''; and

(III) by inserting ''and Tribal'' after ''and State'';

(iii) in subparagraph (G), by striking ''and tribal'' and inserting ''Tribal, and urban Indian organization''; and

(iv) in subparagraph (H), by inserting '', Indian Tribes, and urban Indian organizations'' after ''public health'';

(3) in subsection (e), by inserting ''Indian Tribes, Tribal organizations, urban Indian organizations,'' after ''local emergency plans,'';

(4) in subsection (g)(1), by striking ''tribal officials'' and inserting ''Tribal officials'';

(5) in subsection (h)—

(A) in paragraph (1)(A)—

(i) by striking ''through 2023'' and inserting ''and 2020''; and

(ii) by inserting before the period ''; and $690,000,000 for each of fiscal years 2021 through 2023 for awards pursuant to paragraph (3) (subject to the authority of the Secretary to make awards pursuant to paragraphs (4) and (5)) and paragraph

(8), of which not less than $5,000,000 shall be reserved each fiscal year for awards under paragraph (8)'';

(B) in subsection (h)(2)(B), by striking ''tribal public'' and inserting ''Tribal public'';

(C) in the heading of paragraph (3), by inserting ''FOR STATES'' after ''AMOUNT''; and

(D) by adding at the end the following:

''(8) TRIBAL ELIGIBLE ENTITIES.—

''(A) DETERMINATION OF FUNDING AMOUNT.—

''(i) IN GENERAL.—The Secretary shall award at least 10 cooperative agreements under this section, in amounts not less than the minimum amount determined under clause (ii), to eligible entities described in subsection (b)(1)(D) that submits to the Secretary an application that meets the criteria of the Secretary for the receipt of such an award and that meets other reasonable implementation conditions established by the Secretary, in consultation with Indian Tribes, for such awards. If the Secretary receives more than 10 applications under this section from eligible

entities described in subsection (b)(1)(D) that meet the criteria and conditions described in the previous sentence, the Secretary, in consultation with Indian Tribes, may make additional awards under this section to such entities.

"(ii) MINIMUM AMOUNT.—In determining the minimum amount of an award pursuant to clause (i), the Secretary, in consultation with Indian Tribes, shall first determine an amount the Secretary considers appropriate for the eligible entity.

"(B) AVAILABLE UNTIL EXPENDED.—Amounts provided to a Tribal eligible entity under a cooperative agreement under this section for a fiscal year and remaining unobligated at the end of such year shall remain available to such entity during the entirety of the performance period, for the purposes for which said funds were provided.

"(C) NO MATCHING REQUIREMENT.—Subparagraphs (B), (C), and (D) of paragraph (1) shall not apply with respect to cooperative agreements awarded under this section to eligi-

ble entities described in subsection (b)(1)(D).''; and

(6) by adding at the end the following:

''(l) SPECIAL RULES RELATED TO TRIBAL ELIGIBLE ENTITIES.—

''(1) MODIFICATIONS.—After consultation with Indian Tribes, the Secretary may make necessary and appropriate modifications to the program under this section to facilitate the use of the cooperative agreement program by eligible entities described in subsection (b)(1)(D).

''(2) WAIVERS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary may waive or specify alternative requirements for any provision of this section (including regulations) that the Secretary administers in connection with this section if the Secretary finds that the waiver or alternative requirement is necessary for the effective delivery and administration of this program with respect to eligible entities described in subsection (b)(1)(D).

''(B) EXCEPTION.—The Secretary may not waive or specify alternative requirements under

subparagraph (A) relating to labor standards or the environment.

''(3) CONSULTATION.—The Secretary shall consult with Indian Tribes and Tribal organizations on the design of this program with respect to such Tribes and organizations to ensure the effectiveness of the program in enhancing the security of Indian Tribes with respect to public health emergencies.

''(4) REPORTING.—

''(A) IN GENERAL.—Not later than 2 years after the date of enactment of this subsection, and as an addendum to the biennial evaluations required under subsection (k), the Secretary, in coordination with the Director of the Indian Health Service, shall—

''(i) conduct a review of the implementation of this section with respect to eligible entities described in subsection (b)(1)(D), including any factors that may have limited its success; and

''(ii) submit a report describing the results of the review described in clause (i) to—

''(I) the Committee on Indian Affairs, the Committee on Health, Edu-

cation, Labor, and Pensions, and the Committee on Appropriations of the Senate; and

''(II) the Subcommittee for Indigenous Peoples of the United States of the Committee on Natural Resources, the Committee on Energy and Commerce, and the Committee on Appropriations of the House of Representatives.

''(B) ANALYSIS OF TRIBAL PUBLIC HEALTH EMERGENCY INFRASTRUCTURE LIMITATION.—The Secretary shall include in the initial report submitted under subparagraph (A) a description of any public health emergency infrastructure limitation encountered by eligible entities described in subsection (b)(1)(D).''.

SEC. 1303. PROVISION OF ITEMS TO INDIAN PROGRAMS AND FACILITIES.

(a) STRATEGIC NATIONAL STOCKPILE.—Section 319F–2(a)(3)(G) of the Public Health Service Act (42 U.S.C. 247d–6b(a)(3)(G)) is amended by inserting '', and, in the case that the Secretary deploys the stockpile under this subparagraph, ensure, in coordination with the applicable States and programs and facilities, that appropriate

drugs, vaccines and other biological products, medical devices, and other supplies are deployed by the Secretary directly to health programs or facilities operated by the Indian Health Service, an Indian Tribe, a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), or an inter-Tribal consortium (as defined in section 501 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5381)) or through an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act), while avoiding duplicative distributions to such programs or facilities'' before the semicolon.

(b) DISTRIBUTION OF QUALIFIED PANDEMIC OR EPIDEMIC PRODUCTS TO IHS FACILITIES.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by inserting after section 319F–4 the following:

''SEC. 319F–5. DISTRIBUTION OF QUALIFIED PANDEMIC OR EPIDEMIC PRODUCTS TO INDIAN PROGRAMS AND FACILITIES.

''In the case that the Secretary distributes qualified pandemic or epidemic products (as defined in section 319F–3(i)(7)) to States or other entities, the Secretary shall ensure, in coordination with the applicable States and programs and facilities, that, as appropriate, such

products are distributed directly to health programs or facilities operated by the Indian Health Service, an Indian Tribe, a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304)), or an inter-Tribal consortium (as defined in section 501 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5381)) or through an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act), while avoiding duplicative distributions to such programs or facilities.''.

SEC. 1304. HEALTH CARE ACCESS FOR URBAN NATIVE VETERANS.

Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) is amended—

(1) in subsection (a)(1), by inserting ''urban Indian organizations,'' before ''and tribal organizations''; and

(2) in subsection (c)—

(A) by inserting ''urban Indian organization,'' before ''or tribal organization''; and

(B) by inserting ''an urban Indian organization,'' before ''or a tribal organization''.

SEC. 1305. PROPER AND REIMBURSED CARE FOR NATIVE VETERANS.

Section 405(c) of the Indian Health Care Improvement Act (25 U.S.C. 1645(c)) is amended by inserting before the period at the end the following: ", regardless of whether such services are provided directly by the Service, an Indian tribe, or tribal organization, through contract health services, or through a contract for travel described in section 213(b)".

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