

1 (A) by striking “and” after “fiscal year
2 2003,”; and

3 (B) by inserting “, and such sums as may
4 be necessary for subsequent fiscal years
5 through the end of fiscal year 2019” before the
6 period at the end.

7 (4) SECTION 761.—Subsection (e)(1), as so re-
8 designated, of section 761 is amended by striking
9 “2002” and inserting “2019”.

10 **TITLE III—PREVENTION AND**
11 **WELLNESS**

12 **SEC. 2301. PREVENTION AND WELLNESS.**

13 (a) IN GENERAL.—The Public Health Service Act
14 (42 U.S.C. 201 et seq.) is amended by adding at the end
15 the following:

16 **“TITLE XXXI—PREVENTION AND**
17 **WELLNESS**

18 **“Subtitle A—Prevention and**
19 **Wellness Trust**

20 **“SEC. 3111. PREVENTION AND WELLNESS TRUST.**

21 “(a) DEPOSITS INTO TRUST.—There is established
22 a Prevention and Wellness Trust. There are authorized
23 to be appropriated to the Trust—

1 “(1) amounts described in section
2 2002(b)(2)(ii) of the America’s Affordable Health
3 Choices Act of 2009 for each fiscal year; and

4 “(2) in addition, out of any monies in the Pub-
5 lic Health Investment Fund—

6 “(A) for fiscal year 2010, \$2,400,000,000;

7 “(B) for fiscal year 2011, \$2,800,000,000;

8 “(C) for fiscal year 2012, \$3,100,000,000;

9 “(D) for fiscal year 2013, \$3,400,000,000;

10 “(E) for fiscal year 2014, \$3,500,000,000;

11 “(F) for fiscal year 2015, \$3,600,000,000;

12 “(G) for fiscal year 2016, \$3,700,000,000;

13 “(H) for fiscal year 2017, \$3,900,000,000;

14 “(I) for fiscal year 2018, \$4,300,000,000;

15 and

16 “(J) for fiscal year 2019, \$4,600,000,000.

17 “(b) AVAILABILITY OF FUNDS.—Amounts in the Pre-
18 vention and Wellness Trust shall be available, as provided
19 in advance in appropriation Acts, for carrying out this
20 title.

21 “(c) ALLOCATION.—Of the amounts authorized to be
22 appropriated in subsection (a)(2), there are authorized to
23 be appropriated—

1 “(1) for carrying out subtitle C (Prevention
2 Task Forces), \$35,000,000 for each of fiscal years
3 2010 through 2019;

4 “(2) for carrying out subtitle D (Prevention
5 and Wellness Research)—

6 “(A) for fiscal year 2010, \$100,000,000;

7 “(B) for fiscal year 2011, \$150,000,000;

8 “(C) for fiscal year 2012, \$200,000,000;

9 “(D) for fiscal year 2013, \$250,000,000;

10 “(E) for fiscal year 2014, \$300,000,000;

11 “(F) for fiscal year 2015, \$315,000,000;

12 “(G) for fiscal year 2016, \$331,000,000;

13 “(H) for fiscal year 2017, \$347,000,000;

14 “(I) for fiscal year 2018, \$364,000,000;

15 and

16 “(J) for fiscal year 2019, \$383,000,000.

17 “(3) for carrying out subtitle E (Delivery of
18 Community Preventive and Wellness Services)—

19 “(A) for fiscal year 2010, \$1,100,000,000;

20 “(B) for fiscal year 2011, \$1,300,000,000;

21 “(C) for fiscal year 2012, \$1,400,000,000;

22 “(D) for fiscal year 2013, \$1,600,000,000;

23 “(E) for fiscal year 2014, \$1,700,000,000;

24 “(F) for fiscal year 2015, \$1,800,000,000;

25 “(G) for fiscal year 2016, \$1,900,000,000;

1989

1 “(H) for fiscal year 2017, \$2,000,000,000;

2 “(I) for fiscal year 2018, \$2,100,000,000;

3 and

4 “(J) for fiscal year 2019, \$2,300,000,000.

5 “(4) for carrying out section 3161 (Core Public
6 Health Infrastructure and Activities for State and
7 Local Health Departments)—

8 “(A) for fiscal year 2010, \$800,000,000;

9 “(B) for fiscal year 2011, \$1,000,000,000;

10 “(C) for fiscal year 2012, \$1,100,000,000;

11 “(D) for fiscal year 2013, \$1,200,000,000;

12 “(E) for fiscal year 2014, \$1,300,000,000;

13 “(F) for fiscal year 2015, \$1,400,000,000;

14 “(G) for fiscal year 2016, \$1,500,000,000;

15 “(H) for fiscal year 2017, \$1,600,000,000;

16 “(I) for fiscal year 2018, \$1,800,000,000;

17 and

18 “(J) for fiscal year 2019, \$1,900,000,000;

19 and

20 “(5) for carrying out section 3162 (Core Public

21 Health Infrastructure and Activities for CDC),

22 \$400,000,000 for each of fiscal years 2010 through

23 2019.

1 **“Subtitle B—National Prevention**
2 **and Wellness Strategy**

3 **“SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRAT-**
4 **EGY.**

5 “(a) IN GENERAL.—The Secretary shall submit to
6 the Congress within one year after the date of the enact-
7 ment of this section, and at least every 2 years thereafter,
8 a national strategy that is designed to improve the Na-
9 tion’s health through evidence-based clinical and commu-
10 nity prevention and wellness activities (in this section re-
11 ferred to as ‘prevention and wellness activities’), including
12 core public health infrastructure improvement activities.

13 “(b) CONTENTS.—The strategy under subsection (a)
14 shall include each of the following:

15 “(1) Identification of specific national goals and
16 objectives in prevention and wellness activities that
17 take into account appropriate public health measures
18 and standards, including departmental measures and
19 standards (including Healthy People and National
20 Public Health Performance Standards).

21 “(2) Establishment of national priorities for
22 prevention and wellness, taking into account unmet
23 prevention and wellness needs.

24 “(3) Establishment of national priorities for re-
25 search on prevention and wellness, taking into ac-

1 count unanswered research questions on prevention
2 and wellness.

3 “(4) Identification of health disparities in pre-
4 vention and wellness.

5 “(5) A plan for addressing and implementing
6 paragraphs (1) through (4).

7 “(c) CONSULTATION.—In developing or revising the
8 strategy under subsection (a), the Secretary shall consult
9 with the following:

10 “(1) The heads of appropriate health agencies
11 and offices in the Department, including the Office
12 of the Surgeon General of the Public Health Service,
13 the Office of Minority Health, and the Office on
14 Women’s Health.

15 “(2) As appropriate, the heads of other Federal
16 departments and agencies whose programs have a
17 significant impact upon health (as determined by the
18 Secretary).

19 “(3) As appropriate, nonprofit and for-profit
20 entities.

21 “(4) The Association of State and Territorial
22 Health Officials and the National Association of
23 County and City Health Officials.

1 **“Subtitle C—Prevention Task**
2 **Forces**

3 **“SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERV-**
4 **ICES.**

5 “(a) IN GENERAL.—The Secretary, acting through
6 the Director of the Agency for Healthcare Research and
7 Quality, shall establish a permanent task force to be
8 known as the Task Force on Clinical Preventive Services
9 (in this section referred to as the ‘Task Force’).

10 “(b) RESPONSIBILITIES.—The Task Force shall—

11 “(1) identify clinical preventive services for re-
12 view;

13 “(2) review the scientific evidence related to the
14 benefits, effectiveness, appropriateness, and costs of
15 clinical preventive services identified under para-
16 graph (1) for the purpose of developing, updating,
17 publishing, and disseminating evidence-based rec-
18 ommendations on the use of such services;

19 “(3) as appropriate, take into account health
20 disparities in developing, updating, publishing, and
21 disseminating evidence-based recommendations on
22 the use of such services;

23 “(4) identify gaps in clinical preventive services
24 research and evaluation and recommend priority
25 areas for such research and evaluation;

1 “(5) as appropriate, consult with the clinical
2 prevention stakeholders board in accordance with
3 subsection (f);

4 “(6) as appropriate, consult with the Task
5 Force on Community Preventive Services established
6 under section 3132; and

7 “(7) as appropriate, in carrying out this sec-
8 tion, consider the national strategy under section
9 3121.

10 “(c) ROLE OF AGENCY.—The Secretary shall provide
11 ongoing administrative, research, and technical support
12 for the operations of the Task Force, including coordi-
13 nating and supporting the dissemination of the rec-
14 ommendations of the Task Force.

15 “(d) MEMBERSHIP.—

16 “(1) NUMBER; APPOINTMENT.—The Task
17 Force shall be composed of 30 members, appointed
18 by the Secretary.

19 “(2) TERMS.—

20 “(A) IN GENERAL.—The Secretary shall
21 appoint members of the Task Force for a term
22 of 6 years and may reappoint such members,
23 but the Secretary may not appoint any member
24 to serve more than a total of 12 years.

1 “(B) STAGGERED TERMS.—Notwith-
2 standing subparagraph (A), of the members
3 first appointed to serve on the Task Force after
4 the enactment of this title—

5 “(i) 10 shall be appointed for a term
6 of 2 years;

7 “(ii) 10 shall be appointed for a term
8 of 4 years; and

9 “(iii) 10 shall be appointed for a term
10 of 6 years.

11 “(3) QUALIFICATIONS.—Members of the Task
12 Force shall be appointed from among individuals
13 who possess expertise in at least one of the following
14 areas:

15 “(A) Health promotion and disease preven-
16 tion.

17 “(B) Evaluation of research and system-
18 atic evidence reviews.

19 “(C) Application of systematic evidence re-
20 views to clinical decisionmaking or health pol-
21 icy.

22 “(D) Clinical primary care in child and ad-
23 olescent health.

24 “(E) Clinical primary care in adult health,
25 including women’s health.

1 “(F) Clinical primary care in geriatrics.

2 “(G) Clinical counseling and behavioral
3 services for primary care patients.

4 “(4) REPRESENTATION.—In appointing mem-
5 bers of the Task Force, the Secretary shall ensure
6 that—

7 “(A) all areas of expertise described in
8 paragraph (3) are represented; and

9 “(B) the members of the Task Force in-
10 clude practitioners who, collectively, have sig-
11 nificant experience treating racially and eth-
12 nically diverse populations.

13 “(e) SUBGROUPS.—As appropriate to maximize effi-
14 ciency, the Task Force may delegate authority for con-
15 ducting reviews and making recommendations to sub-
16 groups consisting of Task Force members, subject to final
17 approval by the Task Force.

18 “(f) CLINICAL PREVENTION STAKEHOLDERS
19 BOARD.—

20 “(1) IN GENERAL.—The Task Force shall con-
21 vene a clinical prevention stakeholders board com-
22 posed of representatives of appropriate public and
23 private entities with an interest in clinical preventive
24 services to advise the Task Force on developing, up-
25 dating, publishing, and disseminating evidence-based

1 recommendations on the use of clinical preventive
2 services.

3 “(2) MEMBERSHIP.—The members of the clin-
4 ical prevention stakeholders board shall include rep-
5 resentatives of the following:

6 “(A) Health care consumers and patient
7 groups.

8 “(B) Providers of clinical preventive serv-
9 ices, including community-based providers.

10 “(C) Federal departments and agencies,
11 including—

12 “(i) appropriate health agencies and
13 offices in the Department, including the
14 Office of the Surgeon General of the Pub-
15 lic Health Service, the Office of Minority
16 Health, and the Office on Women’s
17 Health; and

18 “(ii) as appropriate, other Federal de-
19 partments and agencies whose programs
20 have a significant impact upon health (as
21 determined by the Secretary).

22 “(D) Private health care payors.

23 “(3) RESPONSIBILITIES.—In accordance with
24 subsection (b)(5), the clinical prevention stake-
25 holders board shall—

1 “(A) recommend clinical preventive serv-
2 ices for review by the Task Force;

3 “(B) suggest scientific evidence for consid-
4 eration by the Task Force related to reviews
5 undertaken by the Task Force;

6 “(C) provide feedback regarding draft rec-
7 ommendations by the Task Force; and

8 “(D) assist with efforts regarding dissemi-
9 nation of recommendations by the Director of
10 the Agency for Healthcare Research and Qual-
11 ity.

12 “(g) DISCLOSURE AND CONFLICTS OF INTEREST.—
13 Members of the Task Force or the clinical prevention
14 stakeholders board shall not be considered employees of
15 the Federal Government by reason of service on the Task
16 Force, except members of the Task Force shall be consid-
17 ered to be special Government employees within the mean-
18 ing of section 107 of the Ethics in Government Act of
19 1978 (5 U.S.C. App.) and section 208 of title 18, United
20 States Code, for the purposes of disclosure and manage-
21 ment of conflicts of interest under those sections.

22 “(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—
23 Members of the Task Force or the clinical prevention
24 stakeholders board shall not receive any pay for service
25 on the Task Force, but may receive travel expenses, in-

1 cluding a per diem, in accordance with applicable provi-
2 sions of subchapter I of chapter 57 of title 5, United
3 States Code.

4 “(i) APPLICATION OF FACA.—The Federal Advisory
5 Committee Act (5 U.S.C. App.) except for section 14 of
6 such Act shall apply to the Task Force to the extent that
7 the provisions of such Act do not conflict with the provi-
8 sions of this title.

9 “(j) REPORT.—The Secretary shall submit to the
10 Congress an annual report on the Task Force, including
11 with respect to gaps identified and recommendations made
12 under subsection (b)(4).

13 **“SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE**
14 **SERVICES.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Director of the Centers for Disease Control and Pre-
17 vention, shall establish a permanent task force to be
18 known as the Task Force on Community Preventive Serv-
19 ices (in this section referred to as the ‘Task Force’).

20 “(b) RESPONSIBILITIES.—The Task Force shall—

21 “(1) identify community preventive services for
22 review;

23 “(2) review the scientific evidence related to the
24 benefits, effectiveness, appropriateness, and costs of
25 community preventive services identified under para-

1 graph (1) for the purpose of developing, updating,
2 publishing, and disseminating evidence-based rec-
3 ommendations on the use of such services;

4 “(3) as appropriate, take into account health
5 disparities in developing, updating, publishing, and
6 disseminating evidence-based recommendations on
7 the use of such services;

8 “(4) identify gaps in community preventive
9 services research and evaluation and recommend pri-
10 ority areas for such research and evaluation;

11 “(5) as appropriate, consult with the commu-
12 nity prevention stakeholders board in accordance
13 with subsection (f);

14 “(6) as appropriate, consult with the Task
15 Force on Clinical Preventive Services established
16 under section 3131; and

17 “(7) as appropriate, in carrying out this sec-
18 tion, consider the national strategy under section
19 3121.

20 “(c) ROLE OF AGENCY.—The Secretary shall provide
21 ongoing administrative, research, and technical support
22 for the operations of the Task Force, including coordi-
23 nating and supporting the dissemination of the rec-
24 ommendations of the Task Force.

25 “(d) MEMBERSHIP.—

1 “(1) NUMBER; APPOINTMENT.—The Task
2 Force shall be composed of 30 members, appointed
3 by the Secretary.

4 “(2) TERMS.—

5 “(A) IN GENERAL.—The Secretary shall
6 appoint members of the Task Force for a term
7 of 6 years and may reappoint such members,
8 but the Secretary may not appoint any member
9 to serve more than a total of 12 years.

10 “(B) STAGGERED TERMS.—Notwith-
11 standing subparagraph (A), of the members
12 first appointed to serve on the Task Force after
13 the enactment of this section—

14 “(i) 10 shall be appointed for a term
15 of 2 years;

16 “(ii) 10 shall be appointed for a term
17 of 4 years; and

18 “(iii) 10 shall be appointed for a term
19 of 6 years.

20 “(3) QUALIFICATIONS.—Members of the Task
21 Force shall be appointed from among individuals
22 who possess expertise in at least one of the following
23 areas:

24 “(A) Public health.

1 “(B) Evaluation of research and system-
2 atic evidence reviews.

3 “(C) Disciplines relevant to community
4 preventive services, including health promotion;
5 disease prevention; chronic disease; worksite
6 health; qualitative and quantitative analysis;
7 and health economics, policy, law, and statis-
8 tics.

9 “(4) REPRESENTATION.—In appointing mem-
10 bers of the Task Force, the Secretary—

11 “(A) shall ensure that all areas of exper-
12 tise described in paragraph (3) are represented;

13 “(B) shall ensure that such members in-
14 clude sufficient representatives of each of—

15 “(i) State health officers;

16 “(ii) local health officers;

17 “(iii) health care practitioners; and

18 “(iv) public health practitioners; and

19 “(C) shall appoint individuals who, collec-
20 tively, have significant experience working with
21 racially and ethnically diverse populations.

22 “(e) SUBGROUPS.—As appropriate to maximize effi-
23 ciency, the Task Force may delegate authority for con-
24 ducting reviews and making recommendations to sub-

1 groups consisting of Task Force members, subject to final
2 approval by the Task Force.

3 “(f) COMMUNITY PREVENTION STAKEHOLDERS
4 BOARD.—

5 “(1) IN GENERAL.—The Task Force shall con-
6 vene a community prevention stakeholders board
7 composed of representatives of appropriate public
8 and private entities with an interest in community
9 preventive services to advise the Task Force on de-
10 veloping, updating, publishing, and disseminating
11 evidence-based recommendations on the use of com-
12 munity preventive services.

13 “(2) MEMBERSHIP.—The members of the com-
14 munity prevention stakeholders board shall include
15 representatives of the following:

16 “(A) Health care consumers and patient
17 groups.

18 “(B) Providers of community preventive
19 services, including community-based providers.

20 “(C) Federal departments and agencies,
21 including—

22 “(i) appropriate health agencies and
23 offices in the Department, including the
24 Office of the Surgeon General of the Pub-
25 lic Health Service, the Office of Minority

1 Health, and the Office on Women's
2 Health; and

3 “(ii) as appropriate, other Federal de-
4 partments and agencies whose programs
5 have a significant impact upon health (as
6 determined by the Secretary).

7 “(D) Private health care payors.

8 “(3) RESPONSIBILITIES.—In accordance with
9 subsection (b)(5), the community prevention stake-
10 holders board shall—

11 “(A) recommend community preventive
12 services for review by the Task Force;

13 “(B) suggest scientific evidence for consid-
14 eration by the Task Force related to reviews
15 undertaken by the Task Force;

16 “(C) provide feedback regarding draft rec-
17 ommendations by the Task Force; and

18 “(D) assist with efforts regarding dissemi-
19 nation of recommendations by the Director of
20 the Centers for Disease Control and Prevention.

21 “(g) DISCLOSURE AND CONFLICTS OF INTEREST.—
22 Members of the Task Force or the community prevention
23 stakeholders board shall not be considered employees of
24 the Federal Government by reason of service on the Task
25 Force, except members of the Task Force shall be consid-

1 ered to be special Government employees within the mean-
2 ing of section 107 of the Ethics in Government Act of
3 1978 (5 U.S.C. App.) and section 208 of title 18, United
4 States Code, for the purposes of disclosure and manage-
5 ment of conflicts of interest under those sections.

6 “(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—
7 Members of the Task Force or the community prevention
8 stakeholders board shall not receive any pay for service
9 on the Task Force, but may receive travel expenses, in-
10 cluding a per diem, in accordance with applicable provi-
11 sions of subchapter I of chapter 57 of title 5, United
12 States Code.

13 “(i) APPLICATION OF FACA.—The Federal Advisory
14 Committee Act (5 U.S.C. App.) except for section 14 of
15 such Act shall apply to the Task Force to the extent that
16 the provisions of such Act do not conflict with the provi-
17 sions of this title.

18 “(j) REPORT.—The Secretary shall submit to the
19 Congress an annual report on the Task Force, including
20 with respect to gaps identified and recommendations made
21 under subsection (b)(4).

1 **“Subtitle D—Prevention and**
2 **Wellness Research**

3 **“SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIV-**
4 **ITY COORDINATION.**

5 “In conducting or supporting research on prevention
6 and wellness, the Director of the Centers for Disease Con-
7 trol and Prevention, the Director of the National Insti-
8 tutes of Health, and the heads of other agencies within
9 the Department of Health and Human Services con-
10 ducting or supporting such research, shall take into con-
11 sideration the national strategy under section 3121 and
12 the recommendations of the Task Force on Clinical Pre-
13 ventive Services under section 3131 and the Task Force
14 on Community Preventive Services under section 3132.

15 **“SEC. 3142. COMMUNITY PREVENTION AND WELLNESS RE-**
16 **SEARCH GRANTS.**

17 “(a) IN GENERAL.—The Secretary, acting through
18 the Director of the Centers for Disease Control and Pre-
19 vention, shall conduct, or award grants to eligible entities
20 to conduct, research in priority areas identified by the Sec-
21 retary in the national strategy under section 3121 or by
22 the Task Force on Community Preventive Services as re-
23 quired by section 3132.

24 “(b) ELIGIBILITY.—To be eligible for a grant under
25 this section, an entity shall be—

1 “(1) a State, local, or tribal department of
2 health;

3 “(2) a public or private nonprofit entity; or

4 “(3) a consortium of 2 or more entities de-
5 scribed in paragraphs (1) and (2).

6 “(c) REPORT.—The Secretary shall submit to the
7 Congress an annual report on the program of research
8 under this section.

9 **“Subtitle E—Delivery of Commu-
10 nity Prevention and Wellness
11 Services**

12 **“SEC. 3151. COMMUNITY PREVENTION AND WELLNESS
13 SERVICES GRANTS.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Director of the Centers for Disease Control and Pre-
16 vention, shall establish a program for the delivery of com-
17 munity preventive and wellness services consisting of
18 awarding grants to eligible entities—

19 “(1) to provide evidence-based, community pre-
20 ventive and wellness services in priority areas identi-
21 fied by the Secretary in the national strategy under
22 section 3121; or

23 “(2) to plan such services.

24 “(b) ELIGIBILITY.—

1 “(1) DEFINITION.—To be eligible for a grant
2 under this section, an entity shall be—

3 “(A) a State, local, or tribal department of
4 health;

5 “(B) a public or private entity; or

6 “(C) a consortium of—

7 “(i) 2 or more entities described in
8 subparagraph (A) or (B); and

9 “(ii) a community partnership rep-
10 resenting a Health Empowerment Zone.

11 “(2) HEALTH EMPOWERMENT ZONE.—In this
12 subsection, the term ‘Health Empowerment Zone’
13 means an area—

14 “(A) in which multiple community preven-
15 tive and wellness services are implemented in
16 order to address one or more health disparities,
17 including those identified by the Secretary in
18 the national strategy under section 3121; and

19 “(B) which is represented by a community
20 partnership that demonstrates community sup-
21 port and coordination with State, local, or tribal
22 health departments and includes—

23 “(i) a broad cross section of stake-
24 holders;

25 “(ii) residents of the community; and

1 “(iii) representatives of entities that
2 have a history of working within and serv-
3 ing the community.

4 “(c) PREFERENCES.—In awarding grants under this
5 section, the Secretary shall give preference to entities
6 that—

7 “(1) will address one or more goals or objec-
8 tives identified by the Secretary in the national
9 strategy under section 3121;

10 “(2) will address significant health disparities,
11 including those identified by the Secretary in the na-
12 tional strategy under section 3121;

13 “(3) will address unmet community prevention
14 needs and avoids duplication of effort;

15 “(4) have been demonstrated to be effective in
16 communities comparable to the proposed target com-
17 munity;

18 “(5) will contribute to the evidence base for
19 community preventive and wellness services;

20 “(6) demonstrate that the community preven-
21 tive services to be funded will be sustainable; and

22 “(7) demonstrate coordination or collaboration
23 across governmental and nongovernmental partners.

24 “(d) HEALTH DISPARITIES.—Of the funds awarded
25 under this section for a fiscal year, the Secretary shall

1 award not less than 50 percent for planning or imple-
2 menting community preventive and wellness services
3 whose primary purpose is to achieve a measurable reduc-
4 tion in one or more health disparities, including those
5 identified by the Secretary in the national strategy under
6 section 3121.

7 “(e) EMPHASIS ON RECOMMENDED SERVICES.—For
8 fiscal year 2013 and subsequent fiscal years, the Secretary
9 shall award grants under this section only for planning
10 or implementing services recommended by the Task Force
11 on Community Preventive Services under section 3122 or
12 deemed effective based on a review of comparable rigor
13 (as determined by the Director of the Centers for Disease
14 Control and Prevention).

15 “(f) PROHIBITED USES OF FUNDS.—An entity that
16 receives a grant under this section may not use funds pro-
17 vided through the grant—

18 “(1) to build or acquire real property or for
19 construction; or

20 “(2) for services or planning to the extent that
21 payment has been made, or can reasonably be ex-
22 pected to be made—

23 “(A) under any insurance policy;

1 “(B) under any Federal or State health
2 benefits program (including titles XIX and XXI
3 of the Social Security Act); or

4 “(C) by an entity which provides health
5 services on a prepaid basis.

6 “(g) REPORT.—The Secretary shall submit to the
7 Congress an annual report on the program of grants
8 awarded under this section.

9 “(h) DEFINITIONS.—In this section, the term ‘evi-
10 dence-based’ means that methodologically sound research
11 has demonstrated a beneficial health effect, in the judg-
12 ment of the Director of the Centers for Disease Control
13 and Prevention.

14 **“Subtitle F—Core Public Health**
15 **Infrastructure**

16 **“SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE FOR**
17 **STATE, LOCAL, AND TRIBAL HEALTH DEPART-**
18 **MENTS.**

19 “(a) PROGRAM.—The Secretary, acting through the
20 Director of the Centers for Disease Control and Preven-
21 tion shall establish a core public health infrastructure pro-
22 gram consisting of awarding grants under subsection (b).

23 “(b) GRANTS.—

1 “(1) AWARD.—For the purpose of addressing
2 core public health infrastructure needs, the Sec-
3 retary—

4 “(A) shall award a grant to each State
5 health department; and

6 “(B) may award grants on a competitive
7 basis to State, local, or tribal health depart-
8 ments.

9 “(2) ALLOCATION.—Of the total amount of
10 funds awarded as grants under this subsection for a
11 fiscal year—

12 “(A) not less than 50 percent shall be for
13 grants to State health departments under para-
14 graph (1)(A); and

15 “(B) not less than 30 percent shall be for
16 grants to State, local, or tribal health depart-
17 ments under paragraph (1)(B).

18 “(c) USE OF FUNDS.—The Secretary may award a
19 grant to an entity under subsection (b)(1) only if the enti-
20 ty agrees to use the grant to address core public health
21 infrastructure needs, including those identified in the ac-
22 creditation process under subsection (g).

23 “(d) FORMULA GRANTS TO STATE HEALTH DEPART-
24 MENTS.—In making grants under subsection (b)(1)(A),

1 the Secretary shall award funds to each State health de-
2 partment in accordance with—

3 “(1) a formula based on population size; burden
4 of preventable disease and disability; and core public
5 health infrastructure gaps, including those identified
6 in the accreditation process under subsection (g);
7 and

8 “(2) application requirements established by the
9 Secretary, including a requirement that the State
10 submit a plan that demonstrates to the satisfaction
11 of the Secretary that the State’s health department
12 will—

13 “(A) address its highest priority core pub-
14 lic health infrastructure needs; and

15 “(B) as appropriate, allocate funds to local
16 health departments within the State.

17 “(e) COMPETITIVE GRANTS TO STATE, LOCAL, AND
18 TRIBAL HEALTH DEPARTMENTS.—In making grants
19 under subsection (b)(1)(B), the Secretary shall give pri-
20 ority to applicants demonstrating core public health infra-
21 structure needs identified in the accreditation process
22 under subsection (g).

23 “(f) MAINTENANCE OF EFFORT.—The Secretary
24 may award a grant to an entity under subsection (b) only

1 if the entity demonstrates to the satisfaction of the Sec-
2 retary that—

3 “(1) funds received through the grant will be
4 expended only to supplement, and not supplant, non-
5 Federal and Federal funds otherwise available to the
6 entity for the purpose of addressing core public
7 health infrastructure needs; and

8 “(2) with respect to activities for which the
9 grant is awarded, the entity will maintain expendi-
10 tures of non-Federal amounts for such activities at
11 a level not less than the level of such expenditures
12 maintained by the entity for the fiscal year pre-
13 ceding the fiscal year for which the entity receives
14 the grant.

15 “(g) ESTABLISHMENT OF A PUBLIC HEALTH AC-
16 CREDITATION PROGRAM.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Director of the Centers for Disease
19 Control and Prevention, shall—

20 “(A) develop, and periodically review and
21 update, standards for voluntary accreditation of
22 State, local, or tribal health departments and
23 public health laboratories for the purpose of ad-
24 vancing the quality and performance of such de-
25 partments and laboratories; and

1 “(b) REPORT.—The Secretary shall submit to the
2 Congress an annual report on the activities funded
3 through this section.

4 **“Subtitle G—General Provisions**

5 **“SEC. 3171. DEFINITIONS.**

6 “In this title:

7 “(1) The term ‘core public health infrastruc-
8 ture’ includes workforce capacity and competency;
9 laboratory systems; health information, health infor-
10 mation systems, and health information analysis;
11 communications; financing; other relevant compo-
12 nents of organizational capacity; and other related
13 activities.

14 “(2) The terms ‘Department’ and ‘depart-
15 mental’ refer to the Department of Health and
16 Human Services.

17 “(3) The term ‘health disparities’ includes
18 health and health care disparities and means popu-
19 lation-specific differences in the presence of disease,
20 health outcomes, or access to health care. For pur-
21 poses of the preceding sentence, a population may be
22 delineated by race, ethnicity, geographic setting, or
23 other population or subpopulation determined appro-
24 priate by the Secretary.

1 “(4) The term ‘tribal’ refers to an Indian tribe,
2 a Tribal organization, or an Urban Indian organiza-
3 tion, as such terms are defined in section 4 of the
4 Indian Health Care Improvement Act.”.

5 (b) TRANSITION PROVISIONS APPLICABLE TO TASK
6 FORCES.—

7 (1) FUNCTIONS, PERSONNEL, ASSETS, LIABIL-
8 ITIES, AND ADMINISTRATIVE ACTIONS.—All func-
9 tions, personnel, assets, and liabilities of, and ad-
10 ministrative actions applicable to, the Preventive
11 Services Task Force convened under section 915(a)
12 of the Public Health Service Act and the Task Force
13 on Community Preventive Services (as such section
14 and Task Forces were in existence on the day before
15 the date of the enactment of this Act) shall be trans-
16 ferred to the Task Force on Clinical Preventive
17 Services and the Task Force on Community Preven-
18 tive Services, respectively, established under sections
19 3121 and 3122 of the Public Health Service Act, as
20 added by subsection (a).

21 (2) RECOMMENDATIONS.—All recommendations
22 of the Preventive Services Task Force and the Task
23 Force on Community Preventive Services, as in ex-
24 istence on the day before the date of the enactment
25 of this Act, shall be considered to be recommenda-

1 tions of the Task Force on Clinical Preventive Serv-
2 ices and the Task Force on Community Preventive
3 Services, respectively, established under sections
4 3121 and 3122 of the Public Health Service Act, as
5 added by subsection (a).

6 (3) MEMBERS ALREADY SERVING.—

7 (A) INITIAL MEMBERS.—The Secretary of
8 Health and Human Services may select those
9 individuals already serving on the Preventive
10 Services Task Force and the Task Force on
11 Community Preventive Services, as in existence
12 on the day before the date of the enactment of
13 this Act, to be among the first members ap-
14 pointed to the Task Force on Clinical Preven-
15 tive Services and the Task Force on Commu-
16 nity Preventive Services, respectively, under sec-
17 tions 3121 and 3122 of the Public Health Serv-
18 ice Act, as added by subsection (a).

19 (B) CALCULATION OF TOTAL SERVICE.—In
20 calculating the total years of service of a mem-
21 ber of a task force for purposes of section
22 3131(d)(2)(A) or 3132(d)(2)(A) of the Public
23 Health Service Act, as added by subsection (a),
24 the Secretary of Health and Human Services
25 shall not include any period of service by the

1 member on the Preventive Services Task Force
2 or the Task Force on Community Preventive
3 Services, respectively, as in existence on the day
4 before the date of the enactment of this Act.

5 (c) PERIOD BEFORE COMPLETION OF NATIONAL
6 STRATEGY.—Pending completion of the national strategy
7 under section 3121 of the Public Health Service Act, as
8 added by subsection (a), the Secretary of Health and
9 Human Services, acting through the relevant agency head,
10 may make a judgment about how the strategy will address
11 an issue and rely on such judgment in carrying out any
12 provision of subtitle C, D, E, or F of title XXXI of such
13 Act, as added by subsection (a), that requires the Sec-
14 retary—

15 (1) to take into consideration such strategy;

16 (2) to conduct or support research or provide
17 services in priority areas identified in such strategy;
18 or

19 (3) to take any other action in reliance on such
20 strategy.

21 (d) CONFORMING AMENDMENTS.—

22 (1) Paragraph (61) of section 3(b) of the In-
23 dian Health Care Improvement Act (25 U.S.C.
24 1602) is amended by striking “United States Pre-

1 ventive Services Task Force” and inserting “Task
2 Force on Clinical Preventive Services”.

3 (2) Section 126 of the Medicare, Medicaid, and
4 SCHIP Benefits Improvement and Protection Act of
5 2000 (Appendix F of Public Law 106–554) is
6 amended by striking “United States Preventive
7 Services Task Force” each place it appears and in-
8 serting “Task Force on Clinical Preventive Serv-
9 ices”.

10 (3) Paragraph (7) of section 317D of the Pub-
11 lic Health Service Act (42 U.S.C. 247b–5) is amend-
12 ed by striking “United States Preventive Services
13 Task Force” each place it appears and inserting
14 “Task Force on Clinical Preventive Services”.

15 (4) Section 915 of the Public Health Service
16 Act (42 U.S.C. 299b–4) is amended by striking sub-
17 section (a).

18 (5) Subsections (s)(2)(AA)(iii)(II), (xx)(1), and
19 (ddd)(1)(B) of section 1861 of the Social Security
20 Act (42 U.S.C. 1395x) are amended by striking
21 “United States Preventive Services Task Force”
22 each place it appears and inserting “Task Force on
23 Clinical Preventive Services”.

1 **TITLE IV—QUALITY AND**
2 **SURVEILLANCE**

3 **SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE**
4 **DELIVERY OF HEALTH CARE.**

5 (a) **IN GENERAL.**—Title IX of the Public Health
6 Service Act (42 U.S.C. 299 et seq.) is amended—

7 (1) by redesignating part D as part E;

8 (2) by redesignating sections 931 through 938
9 as sections 941 through 948, respectively;

10 (3) in section 938(1), by striking “931” and in-
11 sserting “941”; and

12 (4) by inserting after part C the following:

13 **“PART D—IMPLEMENTATION OF BEST**
14 **PRACTICES IN THE DELIVERY OF HEALTH CARE**
15 **“SEC. 931. CENTER FOR QUALITY IMPROVEMENT.**

16 “(a) **IN GENERAL.**—There is established the Center
17 for Quality Improvement (referred to in this part as the
18 ‘Center’), to be headed by the Director.

19 “(b) **PRIORITIZATION.**—

20 “(1) **IN GENERAL.**—The Director shall
21 prioritize areas for the identification, development,
22 evaluation, and implementation of best practices (in-
23 cluding innovative methodologies and strategies) for
24 quality improvement activities in the delivery of