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SENATE

{ REPORT  
104-186

**HEALTH CENTERS CONSOLIDATION ACT OF 1995**

DECEMBER 15, 1995.—Ordered to be printed

Mrs. KASSEBAUM, from the Committee on Labor and Human Resources, submitted the following

**REPORT**

[To accompany S. 1044]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1044) to amend title III of the Public Health Service Act to consolidate and reauthorize provisions relating to health centers, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

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**I. PURPOSE AND SUMMARY**

As reported by the Committee on Labor and Human Resources, S. 1044 consolidates, streamlines, and reauthorizes the four Federal health center programs under one authority, Section 330 of the Public Health Service Act. This authority will support the continued development and operation of local, community-based systems of health care to address the needs of medically underserved communities and vulnerable populations. The health center programs to be consolidated in this new authority include the:

Migrant Health Center program, authorized under Section 329 of the Public Health Service Act, which supports the provision of services to migrant and seasonal farmworkers and their families.

Community Health Center program, authorized under Section 330 of the Public Health Service Act, which supports the provision of services to medically underserved populations living in urban and rural underserved communities.

Health Care for the Homeless program, authorized under Section 340 of the Public Health Service Act, which supports the provision of services to homeless individuals and children in locations accessible to them.

Health Services for Residents of Public Housing program, authorized under Section 340A of the Public Health Service Act, which supports the provision of services to residents of public housing.

Under a new Section 330A of the Public Health Service Act, the bill also authorizes the "Rural Health Outreach, Network Development, and Telemedicine Grant Program." This program consolidates two rural health demonstration grant programs, the Rural Health Outreach program and the Rural Telemedicine grant program, and focuses the consolidated program on the development of coordinated, integrated health care delivery systems in rural areas.

## II. BACKGROUND AND NEED FOR THE LEGISLATION

In response to the large number of individuals living in medically underserved areas, as well as the growing number of special populations lacking access to preventive and primary health care services, Congress enacted the health center programs beginning in the 1960s. These programs were designed to empower communities to solve their own local access programs and to improve the health status of their underserved and vulnerable populations by building community-based primary care capacity and by offering case management, home visiting, outreach and other enabling services.

Currently, the health center programs support over 700 organizations and 2,200 service delivery sites, providing services to over 8 million underserved and uninsured people.

There are currently four federally funded health center programs.

**Migrant Health Center.**—The Migrant Health Center program was established by Congress in 1962 under the Migrant Health Act, Public Law 87-692, and authorized in its current form in 1975 by Public Law 94-63. Migrant Health Centers were created to provide a broad array of medical and support services to farmworkers employed on a seasonal basis and their families. In addition to primary and preventive health care, many of these centers provide transportation, outreach, dental, pharmaceutical, and environmental health services.

Currently, a network of 122 migrant health centers provides services to approximately 600,000 migrant and seasonal farmworkers and their families in over 390 service delivery sites.

**Community Health Centers.**—Community Health Centers were first funded by Congress in the mid-1960s as neighborhood health centers. By the early 1970s, about 100 neighborhood health centers

had been established under the Economic Opportunity act. These centers were designed to provide accessible, dignified personal health services to low-income families. Community and consumer participation in the organization and ongoing governance of the centers was and remains a central element of the program. Each center is required to have a governing board, a majority of the members of which are users of the center's services.

With the phase-out of the Office of Economic Opportunity in the early 1970s, the centers supported under this authority were transferred to the Public Health Service. While services were directed to the poor and near poor, the centers also provided access to a broader population who could pay all or part of the cost of their health care. The Community Health Center program, as authorized under section 330 of the Public Health Service Act, was established in 1975 by Public Law 94-63.

Over its nearly 30-year history, the Community Health Center program has developed into a highly successful, cost-effective and efficient health program. The program currently serves over 7 million medically underserved people in over 1,600 service delivery sites.

**Health Care for the Homeless.**—Established under the Stewart B. McKinney Homeless Assistance Act of 1987, P.L. 100-77, the Health Care for the Homeless program was developed by Congress to provide comprehensive, high quality, case-managed preventive and primary health care services—including substance abuse services and mental health referrals for homeless individuals—at locations accessible to them. In 1992, Title VI of the Stewart B. McKinney Homeless Assistance Act was amended to include section 340(s), which authorizes additional Federal funding to provide outreach and primary health services for homeless children.

The Health Care for the Homeless program has played a pivotal role in stimulating local collaboration and coordination of health and social services. A total of 119 organizations, including community health centers, public health departments, and other community-based health service providers, currently receive Health Care for the Homeless funding. Services are provided at nearly 500 delivery sites in both urban and rural areas.

The Health Care for the Homeless programs provide services to approximately 420,000 sick and untreated homeless people annually. While most of these are single adults, 4 out of every 10 people served are family members or run-away youth.

**Health Services for Residents of Public Housing.**—The Health Services for Residents of Public Housing program was established by Congress under the Disadvantaged Minority Health Improvement Act of 1990. This legislation focused on the disparity in health status of minority populations and placed emphasis on the development of delivery models that are comprehensive in nature and address the special health problems which affect families, especially pregnant women and children.

Services are provided at public housing complexes or at sites either adjacent to or immediately accessible to these complexes.

Currently, there are 22 organizations receiving funding under the section 340A authority. These centers provide comprehensive, high quality, case-managed, family based preventive and primary

health care services to approximately 25,000 public housing residents at 39 service delivery sites.

#### SUCCESS OF THE HEALTH CENTER PROGRAMS

The health center programs have developed and supported a significant number of highly successful, innovative preventive and primary health care delivery systems in our Nation's most needy inner-cities and underserved rural areas. In reviewing evaluations of the health center programs, the committee found that health centers have reduced infant mortality rates by 10 to 40 percent in underserved communities, improved the use of prenatal care, reduced the incidence of low birthweight and increased immunization rates. Health centers have also effectively addressed major public health concerns (e.g., violence prevention, teenage pregnancy) and have been actively involved with Academic Health Centers in providing community-based training of physicians, nurses, and other health professionals.

When examining studies of the quality of care received in health centers, the committee found that nationally, health centers have a 96 percent patient satisfaction rate and 97 percent of their patients would recommend the center to friends or family. A recent study in the *Journal of the American Medical Association* found that the care provided in health centers was equal to or better than that provided by other types of Medicaid providers when rated on 21 different quality measures.

In reviewing evaluations of the impact of health centers on the use of other services and on costs, the committee found that health centers lower costs otherwise borne publicly through Medicaid or State and local taxes. In California, health center patients had 33 percent lower total Medicaid costs and 27 percent lower hospital costs (controlling for maternity). In New York, health center patients had 22 to 30 percent lower total Medicaid costs and 41 percent lower inpatient costs; diabetics and asthmatics who were regular health center patients had 62 percent and 44 percent lower inpatient costs, respectively. In Maryland, health center patients had lower total Medicaid costs and fewer hospitalizations than patients who used hospital outpatient departments or emergency rooms.

#### REASONS FOR HEALTH CENTER SUCCESS

The committee recognizes that these programs have been successful because health centers offer high quality, prevention-oriented, case-managed, family focused primary care services that result in appropriate and cost-effective use of ambulatory, specialty and in-patient services. Primary care is offered for all life cycles, and a range of health and other social services is available on-site or through referrals. The range of services includes health promotion, disease prevention, screening and educational, outreach, and case management services which are often missing from the traditional delivery of medical services but which are particularly needed by high-risk populations because of their multiple health problems and the significant barriers to access to care that they face.

Health centers are also staffed with full-time primary care providers who are capable of providing culturally competent services

to diverse populations. Over 4,000 primary care physicians and an additional 1,750 nurse practitioners, physician assistants and nurse midwives are the core of the health centers nationally. Health centers have also been assisted greatly in attracting and retaining quality providers by the National Health Service Corps.

In addition, the health center programs have enabled underserved communities to design and develop their own local solutions to their problems of medical underservice. By supporting the development and operation of health centers at the community level, the health center programs have assured that centers are community-responsive and highly accessible. Residents and patients play an active role in centers' decision-making and planning. By working with local communities and State organizations to plan, develop and determine priorities for the allocation of resources, the health center programs have successfully funded new and expanded programs and services in those communities across the country that are most in need. One measure of the success of these community-based and governed centers is their ability to attract private-pay and privately insured individuals and families as well as those who are uninsured or covered by Medicaid. Patient payments and third-party insurance payments comprise, on average, 15 percent of health centers' revenues.

#### CONTINUED NEED FOR HEALTH CENTERS

Many Americans continue to lack access to basic preventive and primary care services. These individuals are disproportionately poor and minority, they lack adequate or do not have any health insurance, and they tend to be sicker patients who require more expensive treatment and care. The barriers to access to health care services include:

**Financial Barriers.**—Millions of people lack adequate insurance and/or cannot afford to pay for cost-effective preventive and primary care services. An estimated 43 million Americans (18.7 percent of the nonelderly population) will be without health insurance coverage for some period of time in 1995, 1 million more than in 1994. A significant proportion of these people also have incomes under 200 percent of poverty.

**Geographic and Capacity Barriers.**—Currently, a total of 71.9 million people live in areas designated by the Federal Government as medically underserved—37.7 million in urban areas (52 percent) and 34.2 million (48 percent) in rural areas. Of these, a total of 43.4 million lack access to primary care provider—22.2 million in urban areas and 21.2 million in rural areas.

Private practice in these underserved areas has not been economically viable because of low income and, in rural areas, low population density. Underserved rural and urban areas also tend to lack professional backup, facilities, equipment and organizational support. As a result, physicians have not "diffused" into shortage areas to the degree previously predicted, resulting in primary health care practitioner shortages.

**Transportation, Culture, and Language Barriers.**—Health Care facilities are often located in areas that are not easily accessible to underserved patients. To assure the timely, effective receipt of preventive as well as curative care, the availability of transportation

and outreach services is essential. Even where health services are physically accessible, communication and language problems between providers and patients, as well as provider insensitivity to cultural concerns, may impose barriers to care.

#### HEALTH CENTERS AND THE CHANGING HEALTH CARE ENVIRONMENT

A movement toward managed care is a dominant trend within the health care industry and the States in particular. From testimony presented to the committee at a May 4, 1995, hearing, the committee learned that health centers across the country are being affected by the rapid changes in the health care marketplace.

As a result, many health centers have had to make major adjustments in their management and strategic decision making. In order to assure that they can continue to serve underserved, high-risk patients, centers have had to negotiate with State Medicaid agencies and Health Maintenance Organizations (HMO's) to assure that they are included in both mandated and voluntary Medicaid managed care programs.

As they make the transition to managed care arrangements, health centers have needed and will continue to need assistance in several areas, including contract review, strategic planning, network development, rate setting, clinical management, marketing, and development of management information systems.

Health centers are also responding to managed care's penetration of Medicaid and private-sector markets by forming provider networks for the more efficient, cost-effective delivery of coordinated health care services. These networks take several forms. They may be horizontal linkages with other primary care providers or vertical linkages with primary care providers and other providers of care in a community, such as inpatient and specialty care providers, for example. Horizontally integrated networks may develop into vertically integrated networks, and individual centers may participate in more than one type of network.

According to the latest information available to the committee, there are 140 networks in the developmental stage and 7 which are now operating. These networks currently include several hundred participants in addition to health centers. Among the participants are nonfederally supported Federally Qualified Health Centers, Rural Health Clinics, local health departments, other primary care providers, specialty practice groups, academic medical centers, and hospitals.

At the present time, health centers make a significant contribution to managed care. As of December 1994, 25 percent of health centers were under contract with an HMO or State Medicaid agency to cover some of their patients. In 1994, a total of 566,000 health center patients were managed care enrollees.

As an increasing number of health centers have become involved in managed care, the committee has also learned that HMO's are increasingly recognizing the advantages of contracting with health center programs. Specifically, HMO's reported in a recent study by Lewin-VHI that health centers' cost performance is equal to or better than private providers in managed care networks. The HMO's also reported that these health centers were high-quality providers with a unique capability to provide enabling services to under-

served populations and noted that health centers were often the sole providers of health care services in geographically isolated or economically depressed areas.

### III. LEGISLATIVE HISTORY AND COMMITTEE ACTION

S. 1044 was introduced on July 17, 1995, by Senators Kassebaum, Kennedy, Jeffords, Pell, and Simon. The bill was referred to the Committee on Labor and Human Resources, which held a hearing to consider the legislation on May 4, 1995.

In the executive session of the Committee on Labor and Human Resources held on Thursday, July 20, 1995, S. 1044 was brought up for consideration. It was amended to increase the authorization level for the consolidated health center programs from \$756,000,000 to \$756,518,000. It was also amended to require that during a 3-year transitional period, migrant, homeless, and health services for residents of public housing programs would receive funding in relative proportion to the funding these programs received in fiscal year 1995. Under the amendment, in fiscal years 1997 and 1998, funding for these programs could vary by up to 10 percent relative to the funding the programs received in fiscal year 1996. The bill was then unanimously ordered reported.

### IV. COMMITTEE VIEWS

The committee finds that the health center programs have a strong history of providing a much-needed, cost-effective, high-quality "medical home" for millions of individuals who would otherwise lack access to comprehensive primary and preventive health care services. As the number of uninsured individuals and families continues to increase and as the Nation's health care system is undergoing significant changes, federally funded health center programs continue to merit strong Federal support to ensure that the most vulnerable individuals have access to high-quality, affordable, community-based primary and preventive health care services.

In developing the reauthorization of the health center programs under one new health center authority, the committee recognized that the migrant health center, community health center, health care for the homeless and health services for residents of public housing programs all share a number of important characteristics and requirements. All of the consolidated programs are community-based, organized systems of preventive and primary care delivery for medically underserved populations. Although some of these programs are targeted to specific populations, most are, in fact, jointly funded projects that assure access to the whole community, as well as its special underserved populations.

As a logical progression in the development of these programs, the committee feels it is now appropriate to consolidate these programs into one new health center authority. This consolidation maintains the commitment of Congress and the health centers to medically underserved and special underserved populations, but frees these programs from unnecessary and burdensome requirements. In particular, the proposed authority will:

Assure continued Federal support for health centers while consolidating the funding previously requested under separate

community health center, migrant health center, health care for the homeless, and public housing primary care authorities of the Public Health Service Act;

make grants more flexible, simpler, streamlined and less burdensome for communities receiving health center awards; and

reduce the number of grants and the Federal administrative costs associated with administering the program.

In proposing the consolidated health center authority, the committee recognizes the PHS's successful efforts in the past 2 years to develop and implement a single grant application for all health center applicants. Through this streamlining effort, the Public Health Service has been able to eliminate duplicative instructions, requirements, and applications for hundreds of health centers. In addition, the committee recognizes the Public Health Service's current efforts to develop a single, uniform data system to reduce and eliminate duplicative reporting and data requirements.

#### SPECIAL MEDICALLY UNDERSERVED POPULATIONS

The committee bill consolidates the health center authorities currently under Sections 329, 330, 340 and 340A of the Public Health Service Act. The committee wishes to clarify that the consolidation authorizes grants both to centers that serve all residents of a catchment area and to centers that serve one or more special medically underserved populations, i.e., migratory and seasonal agricultural workers, the homeless, and residents of public housing.

#### REQUIRED PRIMARY HEALTH SERVICES

The bill revises the current law list of required primary health services to streamline and update that list. It is the intent of the committee that health centers maintain the same services provided under the current health center programs. These services have proven to be highly effective in promoting and assuring the health of underserved populations.

The list of required primary health services also serves to highlight the critical role that enabling services such as outreach, transportation and translation as well as other services such as patient case management and patient education play in the delivery of primary health services to underserved populations. Such services are essential to health centers' efforts to reduce the barriers to care experienced by many of our Nation's underserved populations.

#### HOME VISITING SERVICES

The committee was encouraged to learn during our May 4 hearing that a number of health centers have initiated home visiting services by nurses and trained volunteers as part of their outreach, prevention, and infant mortality and morbidity reduction efforts. The committee notes that in its 1988 report to Congress, "Death Before Life: The Tragedy of Infant Mortality," the National Commission to Prevent Infant Mortality strongly recommended home visiting program as an effective strategy for reducing infant mortality and morbidity. The committee encourages health centers to con-

sider initiating or expanding home visiting services as part of their outreach, prevention, and infant mortality reduction programs.

#### DENTAL SERVICES

The committee notes that a 1993 report by the Oral Health Coordinating Committee of the U.S. Public Health Service found that the dental needs of low-income and minority population are increasing significantly. In response to this growing need, the committee has added pediatric dental screenings as a required primary health preventive service and encourages health centers, as resources are available, to initiate or expand dental care for the populations they serve.

#### NETWORKS, INCLUDING MANAGED CARE NETWORKS AND PLANS

The committee recognizes the need, in our nation's changing health care delivery system, for health centers to form or participate in networks with other health care providers and entities, including managed care networks and plans. The committee bill authorizes the Secretary to award grants to health centers for planning and developing such networks and plans.

The bill does not establish rigid criteria by which the Secretary would judge health centers' network development proposals. Given the significant diversity of circumstances in urban and rural communities, it is the committee's belief that no one type or model for a network arrangement be prescribed. The committee envisions a continuum of networks, from informal linkages of centers and other providers to fully integrated managed care networks. In addition, because of the challenges facing health centers in participating in networks with other providers and in retaining health care providers in underserved areas, the committee encourages the Secretary to review current policies, such as policies relating to the contracting of physicians, which may act as a barrier to health center participation in various integrated service networks.

The committee also wishes to note that applicants for health center planning grants would be required under this bill to include in their planning grant application proposed linkages between the center and other appropriate provider entities in their communities, such as local health departments, hospitals, and rural health clinics. The committee believes that such linkages are essential to the provision of coordinated care and to the avoidance of the costly duplication of health care services.

#### USE OF NONGRANT FUNDS

The committee is advised that a majority of health center funding is from sources other than the Federal grant, such as funding from State and local sources, patient fees, and third-party reimbursements. Under current policy, most of the restrictions and requirements which apply to the health centers' use of Federal funding, including Federal cost principles, also apply to the centers' use of their nongrant funding.

The committee understands that some of these restrictions and requirements impede health centers' ability to respond to changes in the needs and size of the population it serves and to compete

on an equal footing in an increasingly competitive and rapidly changing health care marketplace. Further, these restrictions sometimes conflict with requirements of other funding sources. Relieving centers from the requirements for prior Federal approval for things like equipment purchases and procurement and property standards will allow health centers to respond quickly to critical business opportunities in the competitive marketplace.

The committee has therefore included in the bill provisions to clarify that, although the level of nongrant funding available to a health center for an approved project would continue to be considered by the Secretary in computing the amount of the Federal grant, the restrictions that apply to a center's use of Federal grant funds under the Federal cost principles and the procurement and property standards would no longer apply to the center's use of nongrant funds. The bill also continues to require that nongrant funds be spent in a manner consistent with the objectives of the project or program and continues to require health centers to undergo an independent annual audit which includes a review of the entity's use of project-related nongrant funds.

#### SPECIAL CONSIDERATION FOR SPARSELY POPULATED RURAL AREAS

Recognizing that the delivery of health care services in sparsely populated rural areas poses unique challenges, the committee bill directs the Secretary to give special consideration to these challenges in evaluating "new start" grant applications from entities proposing to serve these areas. Sparsely populated rural areas, for example, are often characterized by significant shortages of health professionals and high percentages of elderly individuals in their populations, but they may not have high incidences of infant mortality or poverty.

The committee bill also provides the Secretary with the authority to waive statutory requirements relating to the full scope of required services and the governing board structure for new centers upon a showing of good cause by a particular health center serving a sparsely populated rural area. In providing the authority to waive the statutory requirement that centers provide the full scope of required health services, the committee recognizes that it may not be feasible or financially viable for health centers located in sparsely populated rural areas to offer the full range of required primary health services.

While the committee continues to believe that the requirement for consumer-directed governance of health centers is vital to the continued success of the health center programs, the committee recognizes that some programs which are being consolidated in the bill have not historically required community governance, and in certain instances, compliance with such requirements may not be realistic.

The committee wishes to underscore that it expects that requests for waivers will not be automatically granted, but rather will be evaluated carefully and limited to cases in which good cause has clearly been demonstrated.

RURAL HEALTH OUTREACH, NETWORK DEVELOPMENT, AND  
TELEMEDICINE GRANT PROGRAM

The committee believes, based on expert testimony given at the May 14, 1995, hearing, that the development of integrated health care provider networks is key to preserving and strengthening access to community-based health care services in rural areas. Provider networks offer a number of advantages: they can work to ensure that a continuum of health care services is available, reduce the duplication of services, produce savings in administrative and other costs through shared services and an enhanced ability to negotiate in the health care market place, and recruit and utilize health professionals more effectively and efficiently.

Accordingly, the committee bill consolidates and gives specific statutory authorization under a new section 330A of the Public Health Service Act to two current demonstration programs being administered by the Federal Office of Rural Health Policy, the Rural Health Outreach program and a rural telemedicine grant program.

It is the committee's intention that the consolidated program provide incentives and support to rural communities and the health care providers serving those communities to form local and regional integrated health care delivery systems and experiment with the potential of telemedicine to strengthen the quality and accessibility of care in rural areas.

The committee intends that these networks become self-sustaining and that the Secretary take into account the potential of the networks to become self-sustaining in evaluating grant applications. Under provisions of the bill, a network's eligibility to receive funding would be limited to 3 years.

The committee believes it is very important that the States be involved in assisting those communities which wish to develop networks to ensure that the grants will meet the priority health care needs of the State. The bill accordingly requires that grant applicants consult with the State office of rural health or other appropriate State entity in preparing and submitting the grant application.

V. COST ESTIMATE

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, December 7, 1995.*

Hon. NANCY LANDON KASSEBAUM,  
*Chairman, Committee on Labor and Human Resources,*  
*U.S. Senate, Washington, DC.*

DEAR MADAM CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1044, the Health Centers Consolidation Act of 1995, as ordered reported by the Senate Committee on Labor and Human Resources on July 20, 1995.

This bill would not affect direct spending or receipts and thus would not be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.  
Sincerely,

JUNE E. O'NEILL.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1044.
2. Bill title: Health Centers Consolidation Act of 1995.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on July 20, 1995.
4. Bill purpose: S. 1044 would reauthorize, consolidate, and streamline the four federal health center programs. It would also authorize funding of grants for a rural health services outreach program that is currently a demonstration program.
5. Estimated cost to the Federal Government: Most of the spending that would occur under S. 1044 would be subject to the availability of appropriated funds. For the purposes of this estimate, CBO assumes that all funds authorized by the bill for the 1996–2000 period will be appropriated. For fiscal year 1996, the additional costs represent funding above the levels provided in the continuing resolutions through December 15, 1995. Estimated outlays are based on historical spending patterns of existing programs administered by the Health Resources and Services Administration (HRSA).

The bill would authorize \$756.5 million for 1996 for federal health centers and such sums as necessary for 1997 through 2000. The rural health outreach grant program would be authorized at \$36 million in 1996 and such sums as necessary for 1997 through 2000. The following table summarizes the estimated authorizations and outlays that would result from S. 1044 under two different sets of assumptions. The first set of assumptions adjusts the estimated amounts for projected inflation after 1995. The second set of assumptions makes no allowance for projected inflation.

[By fiscal year, in millions of dollars]

	1995	1996	1997	1998	1999	2000
Spending under current law:						
Budget authority .....	790	185	.....	.....	.....	.....
Estimated outlays .....	769	497	163	20	0	0
With adjustment of inflation						
Proposed changes:						
Budget authority .....	.....	607	820	849	879	910
Estimated outlays .....	.....	291	643	811	860	891
Projected spending under S. 1044:						
Budget authority .....	790	793	820	849	879	910
Estimated outlays .....	769	789	805	831	860	891
Without adjustment for inflation						
Proposed changes:						
Budget authority .....	.....	607	793	793	793	793
Estimated outlays .....	.....	291	629	772	793	793
Projected spending under S. 1044:						
Budget authority .....	790	793	793	793	793	793
Estimated outlays .....	769	789	792	793	793	793

The costs of this bill fall within budget function 550.

6. Basis of the estimate: S. 1044 would consolidate the four existing Federal health center programs under a new authority. The programs that would be incorporated into this new authority are the Migrant Health Center program, the Community Health Center program, the Health Care for the Homeless program, and the Health Service for Residents of Public Housing program. The bill would also authorize funding for the rural health outreach demonstration program operated by the Office of Rural Health.

#### *Health Centers*

The bill would provide planning and operating grants to centers serving medically underserved populations; grants to reduce infant mortality; and grants to centers providing specialized services to migratory and seasonal agricultural workers, the homeless, and residents of public housing. Grantees, except those receiving funds to serve migrant and seasonal workers, the homeless and residents of public housing, would be required to serve all residents of their service area. By replacing categorical grant programs (for example, grants are made for services either to the homeless or to migrant and seasonal workers) with a single program and a single application process, the bill would allow grantees to redirect their grant funds to meet the changing health care needs of the communities they serve.

In combining the four Federal health center grant programs, the bill would retain the major features of each program. For example, many of the same medical services required by the current grant programs would be retained, although with some modifications. Required primary health services would include: medical services related to pediatrics, obstetrics, gynecology, and internal and family medicine; preventive health services; emergency medical services, referrals for medical and health services, including substance abuse and mental health services; case management; patient education; and outreach, transportation and translation services.

S. 1044 would also authorize health centers to provide additional health services beyond the required primary health services. These services could include environmental health services, such as sewage treatment or solid waste disposal. The bill would also require that centers receiving migratory and seasonal agricultural worker grants provide such occupation-related services as injury prevention programs and screening for and control of infectious diseases.

Finally, the bill would permit the Secretary of Health and Human Services to provide technical or nonfinancial assistance (for example, program management assistance) to public or nonprofit private entities to help them develop plans for, or operate as, health centers.

*Planning grants.*—This provision would provide funds for the planning and development of new health centers to treat the medically underserved. Funds could be used for the purchase and renovation of existing facilities or the construction of new facilities. Grantees would be required to demonstrate ties between the center and area hospitals, rural health clinics and health departments for the coordination and provision of cost-effective services. Eligible entities could also obtain planning grants for developing managed care networks to serve all or some of their patients, provided they

demonstrated that the provision of prepaid services would not diminish the quality of the care rendered.

*Operating grants.*—Operating grants would allow health centers to purchase and renovate existing facilities, build new facilities, repay loans on buildings, or provide training related to center management or the provision of the services required under S. 1044. The Secretary would determine the amount of operating grants, which could not exceed the difference between the costs of a center's operations in a given year and the total of operational funds that the center received from State and local governments and third-party reimbursements (including any fees and premiums that the center could reasonably be expected to receive during that year).

The bill would retain many of the requirements that grant recipients must meet under current law. For example, grantees must have payment arrangements with agencies administering State plans under titles XVIII and XIX of the Social Security Act, any public assistance programs, and private insurance plans. Centers must also prepare a schedule of discounts based on patients' ability to pay. Additionally, the centers must form governing boards to determine the general policies and operations of the centers. A majority of board members must represent the individuals served by the center.

*Infant mortality grants.*—This provision would consolidate the authority currently existing under the four Federal health center programs to fund programs to reduce infant mortality. The specifications of this provision are essentially the same as those in current law.

*Migratory and seasonal workers.*—S. 1044 would preserve most of the current requirements and features of grants for the provision of services to migrant and seasonal workers and their families. However, it would remove the requirement that centers receiving these grants serve areas where a minimum of 4,000 migrant and seasonal workers live for at least 2 months of a calendar year.

*Homeless populations.*—The bill would provide grants to centers serving the homeless and offering outreach and primary health services to homeless children and children determined to be at risk of homelessness. Grantees serving the homeless would also be required to provide substance abuse services, in addition to the health services required under the bill.

*Residents of public housing.*—Grants for the provision of health services to residents of public housing, and individuals living in areas immediately accessible to public housing, would be continued under S. 1044. Recipients would be required to use these funds to supplement other existing funding sources. The bill would also require that grantees consult with residents in preparing their applications and in planning and operating the program to be implemented with the grant.

S. 1044 would authorize \$756.5 million for fiscal year 1996 for these programs, the same amount of funding as in 1995. It would authorize such sums as necessary for 1997 through 2000. Adjusting for inflation, authorization amounts would rise to \$869 million in 2000.

The bill specifies that for 1996, the share of funds for services to migrant and seasonal workers, the homeless, and residents of public housing should be the same as for 1995. In 1997 through 2000, the bill would allow the proportion of funds available under each subsection to change by no more than 10 percent in each year.

*Rural Health Outreach, Network Development, and Telemedicine Grant Program*

S. 1044 would authorize funding for the rural health outreach demonstration program operated under the Office of Rural Health. Grants administered under this program could be used to broaden access to, reduce the cost and improve the quality of health care services in rural areas through the formation of integrated health care networks. Grant funds could be used to plan and establish integrated health care networks, and to fund the initial provision of services. According to the bill, the Secretary must ensure that at least 50 percent of the grant awarded would be used in a rural area or to provide services to residents of rural areas.

Grants could also be used to operate and evaluate telemedicine networks and to demonstrate whether these networks improve access to care in rural areas. Providers who were members of an existing or proposed telemedicine network, or consortiums of providers who were members of such networks would be eligible. These networks would have to include at least two rural health care facilities, and a multispecialty entity that provides 24-hour access to specialty care.

Funding of a network under this provision would not continue for more than 3 years. The bill would also require the Secretary to continue funding grants, contracts, and cooperative arrangements made under current law until the end of the grant period, or the term of the contract or cooperative agreement.

For the purposes of this provision, S. 1044 would authorize \$36 million for 1996 and such sums as necessary for 1997 through 2000. Accounting for anticipated inflation, estimated authorizations would increase to \$41 million in 2000.

7. Estimated cost to State and local governments: S. 1044 would have a minimal impact upon health centers operated by State or local governments, since such centers constitute less than 5 percent of the total number of health centers receiving grants under this program. The bill would also make some changes in how these centers, all voluntary participants in the program, are allowed to use their grant funds. In general, these changes would provide more flexibility to the centers.

8. Estimate comparison: None.

9. Previous estimate: None.

10. Estimate prepared by: Anne T. Hunt.

11. Estimate approved by: Paul Van de Water, Assistant Director for Budget Analysis.

## VI. REGULATORY IMPACT STATEMENT

The committee has determined that this legislation will decrease the regulatory burden and administrative costs of health centers, enabling them to devote more of their resources to patient care.

## VII. SECTION-BY-SECTION ANALYSIS

Section 1 of the bill entitles the act the “Health Centers Consolidation Act of 1995.”

Section 2 of the bill amends Subpart I of Part D of Title III of the Public Health Service Act to consolidate and reauthorize current law Sections 329, 330, 340, and 340A of the Public Health Service Act into a new “Section 330. Health Centers.”

**SEC. 330. HEALTH CENTERS.**

(a) **DEFINITION OF HEALTH CENTER.**—Section 330(a) defines “health center” as an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers and their families, the homeless, and residents of public housing. To qualify as a “health center,” an entity must provide primary health services and, as appropriate for a particular center, additional health services necessary for the adequate support of the required primary health services. These services must be provided to all residents in the area served by the center, unless the health center receives a grant only for the purpose of providing services to migratory and seasonal agriculture workers and their families, a homeless population, or residents of public housing.

(b) **DEFINITIONS.**—Subsection (b) of the bill provides definitions of “required primary health services,” “additional services,” and “medically underserved population.” The subsection streamlines and rewords the current statutory list of required primary health services, but maintains the same services.

The subsection also sets forth the considerations which must go into the Secretary of Health and Human Services’ determination of areas and populations experiencing shortages of personal health services. It requires the Secretary to consult with State and local officials and with organizations representing a majority of health centers in the States, such as State primary care associations, if any, in making these determinations, and permits the Secretary to designate medically underserved populations that may not meet certain criteria but that are recommended by the chief executive officer of a State.

The subsection specifies that upon the showing of good cause by a center receiving a grant only for the purpose of providing services to migratory and seasonal agricultural workers, the Secretary shall waive the requirement that the center provide all required primary health services and, as appropriate, approve the provision of certain required services only during certain periods of the year.

The subsection maintains the current law requirement that in designating medically underserved populations, the Secretary take into account State and local government officials’ comments and include factors indicative of the health status of a population, the ability of the population to pay for services and their accessibility to them, and the availability of health professionals. The subsection also maintains the requirement that the Secretary provide reasonable notice and opportunity to comment and consult with the chief executive officer of a State, local officials, and organizations, if any, representing a majority of the centers in a State before designating an area as medically underserved or terminating that designation.

Further, subsection (b) maintains the authority of the Secretary to designate as medically underserved, those populations which would not otherwise meet the criteria for such designation but which are recommended for designation by the chief executive officer and local officials of the State on the basis of unusual local conditions which are a barrier to access to or the availability of personal health services.

(c) PLANNING GRANTS.—Subsection (c) of the bill authorizes the Secretary to make grants to public and nonprofit private entities to plan and develop health centers which will serve medically underserved populations. The subsection adds a requirement that grant proposals include proposed linkages between the center and other appropriate provider entities, such as health departments, local hospitals, and rural health clinics, to provide better coordinated, higher quality, and more cost-effective health care services.

This subsection also authorizes a new type of planning grant for the planning and development of comprehensive service delivery networks and plans, which may include the provision of health services on a prepaid basis or through another managed care arrangement. Such grants are contingent upon a center's having received operating grants for at least 2 consecutive years preceding the year it applies for this type of planning grant or otherwise demonstrating to the Secretary that it has been providing primary care services for at least 2 consecutive years immediately preceding its application.

(d) OPERATING GRANTS.—Subsection (d) of the bill authorizes the Secretary to make grants for the costs of operation of public or private nonprofit health centers that provide health services to medically underserved populations. In addition, the subsection authorizes the Secretary to make grants, for a period not to exceed 2 years, for the costs of the operation of public and private nonprofit entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required of a health center in subsection (i)(3) of the bill

Under this subsection, the operating grant awarded by the Secretary may not exceed the amount by which the costs of operation of the center exceed the total of State, local, and other operational funds provided to the center and the fees, premiums, and third-party reimbursements which the center may reasonably be expected to receive for its operations.

The subsection permits the Secretary to make grant payments in advance or by way of reimbursement and in such installments as the Secretary may find necessary and allows the Secretary to make adjustments for overpayments and underpayments.

The subsection replaces the current law list of allowable uses of nongrant funds with the authority for grantees to use nongrant funds as permitted under this section and for other purposes that are not specifically prohibited under the section, if such use furthers the objectives of the project.

(e) INFANT MORTALITY GRANTS.—Subsection (e) maintains the current law authority of the Secretary to make grants to health centers for the purpose of assisting such centers in reducing the incidence of infant mortality and morbidity. The subsection also

maintains the requirement that in making grants, priority be given to health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.

(f) **MIGRATORY AND SEASONAL AGRICULTURAL WORKERS.**—Subsection (f) authorizes the Secretary to award grants for the planning and delivery of primary health care services to a special medically underserved population comprised of migratory and seasonal agricultural workers and their family members.

Consistent with Section 329 of the current Public Health Service Act, subsection (f) also authorizes the Secretary to enter into grants or contracts with public and private entities to address environmental concerns. Grants and contracts will be used to assist the States in implementing and enforcing acceptable environmental health standards, including standards for sanitation in migratory agricultural worker camps and standards for pesticide control. Grants and contracts may also be used to conduct projects and studies to assist the States and other entities in assessing problems related to camp and field sanitation, exposure to unsafe levels of agricultural chemicals, including pesticides, and other environmental hazards to which migratory agricultural workers and members of their families may be exposed.

Subsection (f) defines “migratory agricultural worker,” “seasonal agricultural workers,” and “agriculture,” consistent with the definitions in Section 329 of the current Public Health Service Act.

(g) **HOMELESS POPULATION.**—Consistent with Section 340 of the current Public Health Service Act, subsection (g) of this bill authorizes the Secretary to award grants for the planning and delivery of services to a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to homeless children and children at risk of homelessness.

Also consistent with Section 340 of the current Public Health Service Act, in addition to the required primary health services for all centers, an entity that receives a grant under subsection (g) is required to provide substance abuse services as a condition of the grant .

Subsection (g) of this bill replaces a matching requirement under current law with a requirement that grants awarded under the subsection must be used to supplement and not supplant the expenditures of the health center and the value of in-kind contributions for the delivery of services to the homeless population.

Subsection (g) defines “homeless individual,” “substance abuse,” and “substance abuse services” consistent with definition of these terms in Section 340 of the current Public Health Service Act.

(h) **RESIDENTS OF PUBLIC HOUSING.**—Consistent with Section 340A of the current Public Health Service Act, subsection (h) of this bill authorizes the Secretary to award grants for the planning and delivery of services to a special medically underserved population comprised of residents of public housing (as defined in Section 3(b)(1) of the United States Housing Act of 1937) and individual living in areas immediately accessible to such public housing.

Subsection (h) replaces a current law matching requirement as a condition of eligibility for a grant with a requirement that grant funds to be expended to supplement, not supplant, the expenditures of the health center and the value of in-kind contributions for the delivery of services to the population being served.

Subsection (h) maintains the current law requirement that applicants for grants must consult with residents of public housing in preparing applications for grants and must provide for ongoing consultation with residents regarding the planning and administration of the program.

(i) APPLICATIONS.—Subsection (i) of the bill sets forth general and specific requirements that health centers must meet in order to be eligible for a grant.

In most cases, before making grants to health centers the Secretary must determine that the applicant:

Will make required health services available and accessible;

Has an ongoing quality improvement system;

Will demonstrate its financial responsibility;

Has or will have a contractual arrangement with the State agency that administers the State Medicaid plan;

Has made and will continue to make every reasonable effort to secure payment for its costs of providing services to persons who are insured through public or private plans;

Has prepared a schedule of fees and has made and will continue to make every reasonable effort to secure payment;

Has established a governing board that meets at least once a month and of which individuals being served by the center comprise a majority. However, upon a showing of good cause, the Secretary is required to waive this requirement for centers receiving grants under subsections (f), (g), (h), and (o) of the bill;

Has developed an overall plan and budget that meets certain requirements and an effective procedure for compiling and reporting certain data to the Secretary;

Periodically reviews its catchment area to ensure that services are available and accessible;

Has developed a plan and made arrangements to meet the needs of individuals with limited English-speaking ability, if necessary; and

Has developed an ongoing referral relationship with one or more hospitals.

Subsection (i) maintains the current law requirement that in approving grant applications for new health center starts, the Secretary fund new rural and urban centers proportionally.

(j) TECHNICAL AND OTHER ASSISTANCE.—Subsection (j) maintains the Secretary's authority under current law to provide grants to public or private nonprofit entities to assist entities in developing plans for or operating as health centers and in meeting program requirements.

(k) AUTHORIZATION OF APPROPRIATIONS.—Subsection (k) authorizes appropriations of \$756,518,000 for fiscal year 1996 and such sums as may be necessary for each of fiscal years 1997 through 2000.

Subsection (k) prohibits the Secretary from expending more than 5 percent of the amounts appropriated for a fiscal year on grants to centers which do not meet certain governing board requirements. Centers funded under the authorities of subsections (g) or (h) are not included in the calculation of this limitation.

Subsection (k) stipulates that for fiscal year 1996, the amounts made available under each of subsections (f), (g), and (h) must be proportional, relative to the fiscal year 1996 appropriation, to the amounts appropriated in fiscal year 1995 under the authorities of sections 329, 340, and 340A. For fiscal years 1997 and 1998, the proportion of the amounts made available under each of subsections (f), (g), and (h) may vary as to the proportion of the amounts made available under each subsection for the previous fiscal year by no more than plus or minus 10 percent.

The Secretary is required to report annually to the appropriate committees of Congress on the distribution of funds provided to meet the health care needs of medically underserved populations, including migratory and seasonal agricultural workers, the homeless, and residents of public housing. The report must include an assessment of the relative health care access needs of the targeted populations and the rationale for any substantial changes in the distribution of funds.

(l) MEMORANDUM OF AGREEMENT.—Subsection (l) maintains the authority of the Secretary to enter into a memorandum of agreement with a State, which may include provisions permitting the State to (1) analyze the need for primary health services for medically underserved populations within the State; (2) assist in the planning and development of new health centers; (3) review and comment upon annual program plans and budgets of health centers; (4) provide technical assistance to health centers in the development of clinical practices and fiscal and administrative systems; and (5) share information and data relevant to the operation of new and existing health centers.

(m) RECORDS.—Subsection (m) maintains the requirement that each entity that receives an operating grant must establish and maintain necessary records and must make such records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives.

(n) DELEGATION OF AUTHORITY.—Subsection (n) maintains the authority of the Secretary to delegate authority to administer the programs authorized by this section to any office within the Public Health Service, except that the authority to enter into, modify, or issue approvals with respect to grants and contracts may be delegated only within the Health Resources and Services Administration (HRSA).

(o) SPECIAL CONSIDERATION.—Subsection (o) maintains the requirement that the Secretary give special consideration to the unique needs of sparsely populated rural areas, including priority in the awarding of grants for new health centers under subsections (c) and (d), and the granting of waivers as appropriate and permitted under (b) and (i), subsections relating to required primary health services and governing boards.

**SEC. 3. RURAL HEALTH OUTREACH, NETWORK DEVELOPMENT, AND  
TELEMEDICINE GRANT PROGRAM.**

Section 3 of the bill amends Subpart I of part D of title III of the Public Health Service Act to add a new section, 330A, entitled the "Rural Health Outreach, Network Development, and Telemedicine Grant Program."

(a) **ADMINISTRATION.**—Subsection (a) establishes that the rural health outreach demonstration grant program, currently funded under the general authority of Section 301 of the Public Health Service Act, will be administered by the Office of Rural Health Policy (of the Health Resources and Services Administration) in consultation with State rural health offices or other appropriate State governmental entities.

(b) **GRANTS.**—Subsection (b) authorizes the Secretary, acting through the Office of Rural Health Policy, to award grants to expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions.

(c) **ELIGIBLE NETWORKS.**—Outreach network—To be eligible to receive a grant, an entity must be a public or nonprofit private entity in a rural area, that is or represents a network or potential network that includes three or more health care providers or other entities that provide or support the delivery of health care services. The entity, in consultation with the State office of rural health or other appropriate State entity, must prepare and submit to the Secretary an application that meets the Secretary's requirements.

The application must include: a description of the activities which the applicant intends to carry out using amounts provided under the grant; a plan for continuing the project after Federal support is ended; a description of the manner in which the activities funded under the grant will meet the health care needs of underserved rural populations in the State; and a description of how the local community or region to be served by the network or proposed network will be involved in the development and ongoing operations of the network.

**For-profit entities**—This provision clarifies that an eligible network may include for-profit entities so long as the network grantee is a nonprofit entity.

**Telemedicine networks**—This provision establishes the eligibility to receive a grant under this section of an entity that is a health care provider and a member of an existing or proposed telemedicine network or of an entity that is a consortium of health care providers that are members of an existing or proposed telemedicine network.

An eligible telemedicine network must, at a minimum, be composed of a multispecialty entity that is located in an urban or rural area and can provide 24-hour a day access to a range of specialty care and at least two rural health care facilities, which may include rural hospitals, rural physician offices, rural health clinics, rural community health clinics, and rural nursing homes.

(d) **PREFERENCE.**—Subsection (d) requires the Secretary, in awarding grants, to give preference to applicant networks that include:

(1) a majority of the health care providers in the area or region to be served by the network;

(2) any federally qualified health centers, rural health clinics, and local public health departments in the area or region;

(3) outpatient mental health providers in the area or region;

or

(4) appropriate social service providers, such as agencies on aging, school systems, and providers under the women, infants, and children program, to improve access to and coordination of health care services.

(e) **USE OF FUNDS.**—Subsection (e) specifies that in general, the amounts provided under this section must be used for the planning and development of integrated self-sustaining health care networks and for the initial provision of services and that not less than 50 percent of the grant award must be expended in rural areas.

Subsection (e) further specifies that telemedicine networks may not use in excess of 40 percent of the grant amounts to purchase or lease and install equipment and in excess of 20 percent of grant amounts to pay for the indirect costs associated with carrying out the purposes of the grant.

Subsection (e) specifies that telemedicine networks may use grant funds to:

Demonstrate the use of telemedicine in facilitating the development of rural health care networks and for improving access to health care services for rural citizens;

Provide a baseline of information for a systematic evaluation of telemedicine systems serving rural areas;

Purchase or lease and install equipment; and

Operate and evaluate the telemedicine system.

This subsection prohibits entities receiving telemedicine network grants from using grant funds to build or acquire real property or purchase or install transmission equipment or for construction, except for minor renovations relating to the installation of equipment.

(f) **TERMS OF THE GRANT.**—Subsection (f) specifies that funding may not be provided to outreach or telemedicine network grantees for more than 3 years.

(g) **AUTHORIZATION OF APPROPRIATIONS.**—This subsection authorizes \$36,000,000 for fiscal year 1996 and such sums as may be necessary for each of fiscal years 1997 through 2000.

(h) **TRANSITION.**—This subsection requires the Secretary to continue funding for grants or contracts which were entered into prior to the establishment of section 330A until the term of the grant or contract expires, subject to the availability of appropriations.

#### **SEC. 4. TECHNICAL AND CONFORMING AMENDMENTS.**

This section makes technical and conforming amendments to the Public Health Service Act and the Social Security Act necessitated by the consolidation of the health center programs. It clarifies that whenever any reference is made in any provision of law, regulation, rule, record, or document to a community health center, migrant health center, public housing health center or homeless health center, such reference shall be considered a reference to a health center.

The Secretary is required, after consultation with the appropriate committees of Congress, to prepare and submit to Congress

a legislative proposal in the form of an implementing bill containing technical and conforming amendments to reflect the changes made by this act.

**SEC. 5. EFFECTIVE DATE.**

This section specifies an effective date of October 1, 1995 for the act and amendments made by it.

VIII. CHANGES IN EXISTING LAW

In compliance with rule XXVI, paragraph 12, of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

TITLE 42—UNITED STATES CODE

\* \* \* \* \*

PART D—PRIMARY HEALTH CARE

**[**SUBPART I—PRIMARY HEALTH CENTERS

**[**MIGRANT HEALTH

**[**SEC. 254b. (a) For purposes of this section:

**[**(1) The term “migrant health center” means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

**[**(A) primary health services,

**[**(B) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

**[**(C) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

**[**(D) environmental health services, including, as may be appropriate for particular centers (as determined by the centers), the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health,

**[**(E) as may be appropriate for particular centers (as determined by the centers), infections and parasitic disease screening and control,

**[**(F) as may be appropriate for particular centers, accident prevention programs, including prevention of excessive pesticide exposure,

**[**(G) information on the availability and proper use of health services and services which promote and facilitate optimal use of health services, including, if a substantial

number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals, and

[(H) patient case management services (including outreach, counseling, referral, and follow-up services), for migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, within the area it serves (referred to in this section as a “catchment area”) and individuals who have previously been migratory agricultural workers but can no longer meet the requirements of paragraph (2) of this subsection because of age or disability and members of their families within the area it serves.

[(2) The term “migratory agricultural worker” means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

[(3) The term “seasonal agricultural workers” means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

[(4) The term “agriculture” means farming in all its branches, including—

[(A) cultivation and tillage of the soil,

[(B) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land, and

[(C) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in subparagraphs (B).

[(5) The term “high impact area” means a health service area or other area which has not less than four thousand migratory agricultural workers and seasonal agricultural workers residing within its boundaries for more than two months in any calendar year. In computing the number of workers residing in an area, there shall be included as workers the members of the families of such workers.

[(6) The term “primary health services” means—

[(A) services of physicians and, where feasible, services of physicians’ assistants and nurse clinicians;

[(B) diagnostic laboratory and radiologic services;

[(C) preventive health services (including children’s eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, immunizations against vaccine-preventable diseases, screenings for elevated blood lead levels, and family planning services);

[(D) emergency medical services;

[(E) transportation services as required for adequate patient care;

[(F) preventive dental services; and

[(G) pharmaceutical services, as may be appropriate for particular centers.

[(7) The term "supplemental health services" means services which are not included as primary health services and which are—

[(A) hospital services;

[(B) home health services;

[(C) extended care facility services;

[(D) rehabilitative services (including physical therapy) and long-term physical medicine;

[(E) mental health services;

[(F) dental services;

[(G) vision services;

[(H) allied health services;

[(I) therapeutic radiologic services;

[(J) public health services (including, for the social and other nonmedical needs which affect health status, counseling, referral for assistance, and followup services);

[(K) ambulatory surgical services;

[(L) health education services (including nutrition education); and

[(M) other services appropriate to meet the health needs of the population served by the migrant health center involved.

[(b)(1) The Secretary shall assign to high impact areas and any other areas (where appropriate) priorities for the provision of assistance under this section to projects and programs in such areas. The highest priorities for such assistance shall be assigned to areas where the Secretary determines the greatest need exists.

[(2) No application for a grant under subsection (c) or (d) for a project in an area which has no migratory agricultural workers may be approved unless grants have been provided for all approved applications under such subsections for projects in areas with migratory agricultural workers.

[(c)(1)(A) The Secretary may, in accordance with the priorities assigned under subsection (b)(1), make grants to public and non-profit private entities for projects to plan and develop migrant health center which will serve migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, in high impact areas. A project for which a grant may be made under this subparagraph may include the cost of the acquisition, expansion, and modernization of existing buildings and construction of new buildings (including the costs of amortizing the principal of, and paying the interest on loans) and the costs of providing training related to the management of migrant health center programs, and shall include—

[(i) an assessment of the need that the workers (and the members of the families of such workers) proposed to be served by the migrant health center for which the project is undertaken have for primary health services, supplemental health services, and environmental health services;

[(ii) the design of a migrant health center program for such workers and the members of their families, based on such assessment;

[(iii) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

[(iv) initiation and encouragement of continuing community involvement in the development and operation of the project.

[(B) The Secretary may make grants to or enter into contracts with public and nonprofit private entities for projects to plan and develop programs in areas in which no migrant health center exists and in which not more than four thousand migratory agricultural workers and their families reside for more than two months—

[(i) for the provision of emergency care to migratory agricultural workers, seasonal agricultural workers, and the members of families of such migratory and seasonal workers;

[(ii) for the provision of primary care (as defined in regulations of the Secretary) for such workers and the members of their families;

[(iii) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations under clause (ii)) to such workers and the members of their families; or

[(iv) which otherwise improve the health of such workers and their families.

Any such program may include the acquisition, expansion, an modernization of existing buildings, construction of new buildings, and providing training related to the management of programs assisted under this subparagraph.

[(2) Not more than two grants may be made under paragraph (1)(A) for the same project, and if a grant or contract is made or entered into under paragraph (1)(A) for a project, no other grant or contract under that paragraph may be made or entered into for the project.

[(3) The amount of any grant made under paragraph (1) for any project shall be determined by the Secretary.

[(d)(1)(A)(i) The Secretary may, in accordance with priorities assigned under subsection (b)(1), make grants for the cost of operation of public and nonprofit private migrant health centers in high impact areas.

[(ii) If the Secretary makes a determination that an area is a high impact area, the Secretary may alter the determination only after providing to the grantee under subclause (i) for the area, and to other interested entities in the area, reasonable notice with respect to such determination and a reasonable opportunity to offer information with respect to such determination.

[(B) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects for the operation of programs in areas in which no migrant health center exists and in which not more than four thousand migratory agricultural workers and their families reside for more than two months—

[(i) for the provision of emergency care to migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers;

[(ii) for the provision of primary care (as defined in regulations of the Secretary) for such workers and the members of their families;

[(iii) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations under clause (ii)) to such workers and the members of their families; or

[(iv) which otherwise improve the health of such workers and the members of their families.

Any such program may include the acquisition, expansion, and modernization of existing buildings, construction of new buildings, and providing training related to the management of programs assisted under this subparagraph.

[(C) The Secretary may make grants to migrant health centers to enable the centers to plan and develop the provision of health services on a prepaid basis to some or to all of the individuals which the centers serve. Such a grant may only be made for such a center if—

[(i) the center has received grants under subparagraph (A) of this paragraph for at least two consecutive years preceding the year of the grant under this subparagraph;

[(ii) the governing board of the center (described in subsection (f)(3)(G)) requests, in a manner prescribed by the Secretary, that the center provide health services on a prepaid basis to some or to all of the population which the center serves; and

[(iii) the center provides assurances satisfactory to the Secretary that the provision of such services on a prepaid basis will not result in the diminution of health services provided by the center to the population the center served prior to grant under this subparagraph.

Any such grant may include the acquisition, expansion, and modernization of existing buildings, construction of new buildings, and providing training related to the management of the provision of health services on a prepaid basis.

[(2) The costs for which a grant may be made under paragraph (1)(A) may include the costs of acquiring, expanding, and modernizing existing buildings and constructing new buildings (including the costs of amortizing the principal of, and paying the interest on, loans); and the costs of repaying loans made by the Farmers Home Administration for buildings; and the costs for which a grant or contract may be made under paragraph (1) may include the costs of providing training related to the provision of primary health services, supplemental health services, and environmental health services, and to the management of migrant health center programs.

[(3) Not more than two grants may be made under paragraph (1)(C) for the same entity.

[(4)(A) The amount of any grant made in any fiscal year under subparagraph (A) of paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

[(i) State, local, and other operational funding, and

[(ii) the fees, premiums, and third party reimbursements,

which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a

grant for a center, if the application for the grant requests funds for a service described in subparagraph (D) or (E) of subsection (a)(1) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subparagraph (B), (F), (J), or (L) of subsection (a)(7), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding.

[(B) Payments under grants under subparagraph (A) of paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments, except that if in any fiscal year the sum of—

[(i) the total of the amounts described in clauses (i) and (ii) of subparagraph (A) of this paragraph received by a center in such fiscal year, and

[(ii) the amount of the grant to the center in such fiscal year, exceeded the costs of the center's operation in such fiscal year because the amount received by the center from fees, premiums, and third-party reimbursements was greater than expected, an adjustment in the amount of the grant to the center in the succeeding fiscal year shall be made in such a manner that the center shall be entitled to retain the additional amount of fees, premiums, and other third party reimbursements as the center will use (I) to expand and improve its services, (II) to increase the number of persons (eligible under subsection (a) to receive services from such a center) it is able to serve, (III) to construct, expand, and modernize its facilities, (IV) to improve the administration of its service programs, and (V) to establish the financial reserve required for the furnishing of services on a prepaid basis. Without the approval of the Secretary, not more than one-half of such retained sum may be used for construction and modernization of its facilities.

[(C) With respect to amounts described in clauses (i) and (ii) of subparagraph (A), the Secretary may not restrict expenditures of such amounts by any grantee under paragraph (1)(A) for—

[(i) repair or minor renovation of the physical plant;

[(ii) establishment of a financial reserve as required for the furnishing of services on a prepaid basis or as needed to cover unanticipated expenses;

[(iii) interest payments on short-term loans to cover cash shortfalls; or

[(iv) necessary salary requirements to remain competitive in hiring health care practitioners.

[(e) The Secretary may enter into contracts with public and private entities to—

[(1) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migrant labor camps and applicable Federal and State pesticide control standards; and

[(2) conduct projects and studies to assist the several States and entities which have received grants or contracts under this

section in the assessment of problems related to camp and field sanitation, pesticide hazards, and other environmental health hazards to which migratory agricultural workers, seasonal agricultural workers, and members of their families are exposed.

[(F)(1) No grant may be made under subsection (c) or (d) and no contract may be entered into under subsection (c)(1)(B), (d)(1)(B), or (e) unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant or contract which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary—

[(A) a description of the site of the building,

[(B) plans and specifications for its modernization, and

[(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a-276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 74 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

[(2) An application for a grant under subparagraph (A) of subsection (d)(1) for a migrant health center shall include—

[(A) a description of the need in the center's catchment area for each of the health services described in subparagraph (D) and (E) of subsection (a)(1) and in subparagraphs (B), (F), (J), and (L) of subsection (a)(7),

[(B) if the applicant determines that any such service is not needed, the basis for such determination, and

[(C) if the applicant does not request funds for any such service which the applicant determines is needed, the reason for not making such a request.

In considering an application for a grant under subparagraph (A) of subsection (d)(1), the Secretary may require as a condition to the approval of such application assurance that the applicant will provide any specified health service described in subsection (a) which the Secretary finds is needed to meet specific health needs of the area to be served by the applicant. Such a finding shall be made in writing and a copy shall be provided the applicant.

[(3) The Secretary may not approve an application for a grant under subsection (d)(1)(A) unless the Secretary determines that the entity for which the application is sub-

mitted is a migrant health center (within the meaning of subsection (a)(1)) and that—

[(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

[(B) the center will have organizational arrangements, established in accordance with regulations of the Secretary, for (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

[(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

[(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such arrangement;

[(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

[(F) the center (i) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

[(G) the center has established a governing board which (i) is composed of individuals, a majority of whom are being served by the center and who, as a

group, represent the individuals being served by the center, and (ii) selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center, and, except in the case of a public center (as defined in the second sentence of this paragraph), establishes general policies for the center; and if the application is for a second or subsequent grant for a public center, the governing body of the center has approved the application or if the governing body has not approved the application, the failure of the governing body to approve the application was unreasonable;

[(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require, and (V) expenditures made from any amount the center was permitted to retain under subsection (d)(4)(B);

[(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to residents of the area promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation; and

[(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

For purposes of subparagraph (G) and subsection (h)(4), the term "public center" means a migrant health center funded (or to be funded) through a grant under this section to a public agency.

[(4) In considering applications for grants and contracts under subsection (c) or (d)(1)(B), the Secretary shall give priority to applications submitted by community-based organizations which are representative of the populations to be served through the projects, programs, or centers to be assisted by such grants or contracts.

[(5) The Secretary, in making a grant under this section to a migrant health center for the provision of environmental health services described in subsection (a)(1)(D), may designate a portion of the grant to be expended for improvements to private property for which the written consent of the owner has been obtained and which are necessary to alleviate a hazard to the health of those residing on, or otherwise using, the property and of other persons in the center's catchment area. A center may make such an expenditure for an improvement under a grant only after the Secretary has specifically approved such expenditure and has determined that funds for the improvement are not available from any other source.

[(6) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 1 41 U.S.C. 5).

[(7) The Secretary may make a grant under subsection (c) or (d) for the construction of new buildings for a migrant health center or a migrant health program only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, or expanding existing buildings and that the entity to which the grant will be made has made reasonable efforts to secure from other source funds, in lieu of the grant, to construct such facilities.

[(g)(1) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any migrant health center or to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a migrant health center, and in meeting the requirements of subsection (f)(2).

[(2) The Secretary shall make available to each grant recipient under this section a list of available Federal and non-Federal resources to improve the environmental and nutritional status of individuals in the recipient's catchment area.

[(h)(1)(A) For the purposes of subsections (c) through (e), there are authorized to be appropriated \$48,500,000 for fiscal year 1989, such sums as may be necessary for fiscal years 1990 and 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994.

[(B) Of the amounts appropriated pursuant to subparagraph (A) for a fiscal year, the Secretary may obligate for grants and con-

tracts under subsection (c)(1) not more than 2 percent, for grants under subsection (d)(1)(C) not more than 5 percent, and for contracts under subsection (e) not more than 10 percent.

[(2)(A) For the purpose of carrying out subparagraph (B), there are authorized to be appropriated \$1,500,000 for fiscal year 1989, \$2,000,000 for fiscal year 1990, \$2,500,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994.

[(B) The Secretary may make grants to migrant health centers for the purpose of assisting such centers in—

[(i) providing comprehensive health care and support services for the reduction of (I) the incidence of infant mortality, and (II) morbidity among children who are less than 3 years of age; and

[(ii) developing and coordinating service and referral arrangements between migrant health centers and other entities for the health management of pregnant women and children described in clause (i).

[(C) In making grants under subparagraph (B), the Secretary shall give priority to migrant health centers providing services in any catchment area in which there is a substantial incidence of infant mortality or in which there is a significant increase in the incidence of infant mortality.

[(D) The Secretary may make a grant under subparagraph (B) only if the migrant health center involved agrees to expend the grant for the following activities with respect to the purpose described in such subparagraph:

[(i) Primary health services, including prenatal care.

[(ii) Community education, outreach, and case finding.

[(iii) Case management services.

[(iv) Client education, including parenting and child development education.

[(E) The purposes for which a migrant health center may expend a grant under subparagraph (B) include, with respect to the purpose described in such subparagraph, substance abuse screening, counseling and referral services, and other necessary nonmedical support services, including child care, translation services, and housing assistance.

[(F) The Secretary may make a grant under subparagraph (B) only if the migrant health center involved agrees that—

[(i) the center will coordinate the provision of services under the grant to each of the recipients of the services;

[(ii) such services will be continuous for each such recipient;

[(iii) the center will provide follow-up services for individuals who are referred by the center for services described in subparagraph (E); and

[(iv) the grant will be expended to supplement, and not supplant, the expenditures of the center for primary health services (including prenatal care) with respect to the purpose described in such subparagraph.

[(3) The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (f)(3)) the governing boards of which (as described in subsection (f)(3)(G)(ii)) do not establish general policies

for such centers, an amount which exceeds 5 per centum of the funds appropriated under this section for that fiscal year.

[(i) The Secretary may delegate the authority to administer the programs authorized by this section to any office within the Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the central office of the Health Resources and Services Administration.

#### [COMMUNITY HEALTH CENTERS

[SEC. 254c. (a) For purposes of this section, the term "community health center" means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

[(1) primary health services,

[(2) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

[(3) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

[(4) environmental health services, including, as may be appropriate for particular centers (as determined by the centers), the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health,

[(5) information on the availability and proper use of health services and services which promote and facilitate optimal use of health services, including, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals, and

[(6) patient case management services (including outreach, counseling, referral, and follow-up services),

for all residents of the area it serves (referred to in this section as a "catchment area").

[(b) For purposes of this section:

[(1) The term "primary health services" means—

[(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

[(B) diagnostic laboratory and radiologic services;

[(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, immunizations against vaccine-preventable diseases, screenings for elevated blood lead levels, and family planning services);

[(D) emergency medical services;

[(E) transportation services as required for adequate patient care;

[(F) preventive dental services; and

[(G) pharmaceutical services, as may be appropriate for particular centers.

[(2) The term “supplemental health services” means services which are not included as primary health services and which are—

[(A) hospital services;

[(B) home health services;

[(C) extended care facility services;

[(D) rehabilitative services (including physical therapy) and long-term physical medicine;

[(E) mental health services;

[(F) dental services;

[(G) vision services;

[(H) allied health services;

[(I) therapeutic radiologic services;

[(J) public health services (including, for the social and other nonmedical needs which affect health status, counseling, referral for assistance, and followup services);

[(K) ambulatory surgical services;

[(L) health education services (including nutrition education); and

[(M) other services appropriate to meet the health needs of the medically underserved population served by the community health center involved.

[(3) The term “medically underserved population” means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

[(4) In carrying out paragraph (3), the Secretary shall by regulation prescribe criteria for determining the specific shortages of personal health services of an area or population group. Such criteria shall—

[(A) take into account comments received by the Secretary from the chief executive officer of a State and local officials in a State; and;

[(B) include infant mortality in an area or population group, other factors indicative of the health status of a population group or residents of an area, the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group.

The Secretary may modify the criteria established in regulations issued under this paragraph only after affording public notice and an opportunity for comment on any such proposed modifications.

[(5) The Secretary may not designate a medically underserved population in a State or terminate the designation of such a population unless, prior to such designation or termination, the Secretary provides reasonable notice and opportunity for comment and consults with—

[(A) the chief executive officer of such State;;

[(B) local officials in such State; and

[(C) the State organization, if any, which represents a majority of community health centers in such State.

[(6) The Secretary may designate a medically underserved population that does not meet the criteria established under paragraph (4) if the chief executive officer of the State in which such population is located and local officials of such State recommend the designation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services.

[(c)(1) The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition expansion, and modernization of existing buildings and construction of new buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

[(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

[(B) the design of a community health center program for such population based on such assessment;

[(C) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

[(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

[(2) Not more than two grants may be made under this subsection for the same project.

[(3) The amount of any grant made under this subsection for any project shall be determined by the Secretary.

[(d)(1)(A) The Secretary may make grants for the costs of operation of public and nonprofit private community health centers which serve medically underserved populations.

[(B) The Secretary may make grants for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which he is unable to make each of the determinations required by subsection (e)(3).

[(C) The Secretary may make grants to community health centers to enable the centers to plan and develop the provision of health services on a prepaid basis to some or to all of the individuals which the centers serve. Such a grant may only be made for such a center if—

[(i) the center has received grants under subparagraph (A) of this paragraph for at least two consecutive years preceding the year of the grant under this subparagraph;

[(ii) the governing board of the center (described in subsection (e)(3)(G)) requests, in a manner prescribed by the Secretary, that the center provide health services on a prepaid basis to some or to all of the population which the center serves; and

[(iii) the center provides assurances satisfactory to the Secretary that the provision of such services on a prepaid basis will not result in the diminution of health services provided by the center to the population the center served prior to the grant under this subparagraph.

Any such grant may include the acquisition, expansion, and modernization of existing buildings, construction of new buildings, and providing training related to management on the provision of health services on a prepaid basis.

[(2) The costs for which a grant may be made under paragraph (1)(A) or (1)(B) may include the costs of acquiring, expanding, and modernizing existing buildings and constructing new buildings (including the costs of amortizing the principal of, and paying interest on, loans), the costs of repaying loans made by the Farmers Home Administration for buildings, and the costs of providing training related to the provision of primary health services, supplemental health services and environmental health services, and to the management of community health center programs.

[(3) Not more than two grants may be made under paragraph (1)(B) or (1)(C) for the same entity.

[(4)(A) The amount of any grant made in any fiscal year under paragraph (1) (other than subparagraph (C)) to a community health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

[(i) State, local, and other operational funding, and

[(ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year. In determining the amount of such a grant for a center, if the application for the grant requests funds for a service described in subsection (a)(4) (other than to the extent the funds would be used for the improvement of private property) or a supplemental health service described in subparagraph (B), (F), (L) or (M) of subsection (b)(2), the Secretary shall include, in an amount determined by the Secretary and to the extent funds are available under appropriation Acts, funds for such service unless the Secretary makes a written finding that such service is not needed and provides the applicant with a copy of such finding.

[(B) Payments under grants under subparagraph (A) or (B) of paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments, except that if in any fiscal year the sum of—

[(i) the total of the amounts described in clauses (i) and (ii) of subparagraph (A) received by a center in such fiscal year, and

[(ii) the amount of the grant to the center in such fiscal year, exceeded the costs of the center's operation in such fiscal year because the amount received by the center from fees, premiums, and third-party reimbursements was greater than expected, an adjustment in the amount of the grant to the center in the succeeding fiscal year shall be made in such a manner that the center shall be entitled to retain the additional amount of fees, premiums, and

other third party reimbursements as the center will use (I) to expand and improve its services, (II) to increase the number of persons (eligible to receive services from such a center) it is able to serve, (III) to construct, expand, and modernize its facilities, (IV) to improve the administration of its service programs, and (V) to establish the financial reserve required for the furnishing of services on a prepaid basis. Without the approval of the Secretary, not more than one-half of such retained sum may be used for construction and modernization of its facilities.

[(C) With respect to amounts described in clauses (i) and (ii) of subparagraph (A), the Secretary may not restrict expenditures of such amounts by any grantee under paragraph (1) for—

[(i) repair or minor renovation of the physical plant;

[(ii) establishment of a financial reserve as required for the furnishing of services on a prepaid basis or as needed to cover unanticipated expenses;

[(iii) interest payments on short-term loans to cover cash shortfalls; or

[(iv) necessary salary requirements to remain competitive in hiring health care practitioners.

[(e)(1) No grant may be made under subsection (c) or (d) unless an application therefor is submitted to, and approved by, the Secretary. Such an applicant shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary—

[(A) a description of the site of the building,

[(B) plans and specifications for its modernization, and

[(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a to 276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 FR 3176, 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

[(2) An application for a grant under subparagraph (A) of (B) of subsection (d)(1) for a community health center shall include—

[(A) a description of the need in the center's catchment area for each of the health services described in subsection (a)(4) and in subparagraphs (B), (F), (L), and (M) of subsection (b)(2),

[(B) if the applicant determines that any such service is not needed, the basis for such determination, and

[(C) if the applicant does not require funds for any such service which the applicant determines is needed, the reason for not making such a request.

Such an application shall also include a demonstration by the applicant that the area or a population group to be served by the applicant has a shortage of personal health services and that the cen-

ter will be located so that it will provide services to the greatest number of persons residing in such area or included in such population group. Such a demonstration shall be made on the basis of the criteria prescribed by the Secretary under subsection (b)(3) or on any other criteria which the Secretary may prescribe to determine if the area or population group to be served by the applicant has a shortage of personal health service. In considering an application for a grant under subparagraph (A) or (B) of subsection (d)(1), the Secretary may require as a condition to the approval of such applicant assurance that the applicant will provide any specified health services described in subsection (a) or (b) which the Secretary finds is needed to meet specific health needs of the area to be served by the applicant. Such a finding shall be made in writing and a copy shall be provided by the applicant.

[(3) Except as provided in subsection (d)(1)(B), the Secretary may not approve an application for a grant under paragraph (1)(A) or (1)(B) of subsection (d) unless the Secretary determines that the entity for which the application is submitted is a community health center (within the meaning of subsection (a)) and that—

[(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

[(B) the center will have organizational arrangements, established in accordance with regulations prescribed by the Secretary, or (i) an ongoing quality assurance program (including utilization and peer systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

[(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

[(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort enter into such an arrangement;

[(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

[(F) the center (i) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for

services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

[(G) the center has established a governing board which (i) except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act, is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, and (ii) meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center, and, except in the case of a governing board of a public center (as defined in the second sentence of this paragraph), establishes general policies for the center; and if the application is for a second or subsequent grant for a public center, the governing body has approved the application or if the governing body has not approved the application, the failure of the governing body to approve the application was unreasonable;

[(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require, and (V) expenditures made from any amount the center was permitted to retain under subsection (d)(4)(B);

[(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;

[(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and

(ii) identified an individual on its staff who is fluent in both that language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences; and

[(K) the center, in accordance with regulations prescribed by the Secretary, has developed an ongoing referral relationship with one or more hospitals.

For purposes of subparagraph (G) and subsection (g)(4), the term “public center” means a community health center funded (or to be funded) through a grant under this section to a public agency.

[(4) The Secretary shall approve applications for grants under paragraph (1)(A) or (1)(B) of subsection (d) for community health centers which—

[(A) have not received a previous grant under such paragraph, or

[(B) have applied for such a grant to expand their services, in such a manner that the ratio of the medical underserved populations in rural areas which may be expected to use the services provided by such centers to the medical underserved populations in urban areas which may be expected to use the services provided by such centers is not less than two or three or greater than three to two.

[(5) The Secretary, in making a grant under this section to a community health center for the provision of environmental health services described in subsection (a)(4), may designate a portion of the grant to be expended for improvements to private property for which the written consent of the owner has been obtained and which are necessary to alleviate a hazard to the health of those residing on, or otherwise using, the property and of other persons in the center’s catchment area. A center may make such an expenditure for an improvement under a grant only after the Secretary has specifically approved such expenditure and has determined that funds for the improvement are not available from any other source.

[(6) The Secretary may make a grant under subsection (c) or (d) for the construction of new buildings for a community health center only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, or expanding existing buildings and that the entity to which the grant will be made has made reasonable efforts to secure from other sources funds, in lieu of the grant, to construct such facilities.

[(f)(1) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a community health center, and in meeting requirements of subsection (e)(2).

[(2) The Secretary shall make available to each grant recipient under this section a list of available Federal and non-Federal resources to improve the environmental and nutritional status of individuals in the recipient’s catchment area.

[(g)(1)(A) For the purpose of payments under grants under this section, there are authorized to be appropriated \$440,000,000 for

fiscal year 1989, such sums as may be necessary for fiscal years 1990 and 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994.

[(B) The Secretary may not in any fiscal year—

[(i) expend for grants to serve medically underserved populations designated under subsection (b)(6) an amount which exceeds 5 percent of the funds appropriated under paragraph (1) for that fiscal year; and

[(ii) expend for grants under subsection (d)(1)(C) an amount which exceeds 5 percent of the funds appropriated under paragraph (1) for that fiscal year.

[(2)(A) For the purpose of carrying out subparagraph (B), there are authorized to be appropriated \$25,000,000 for fiscal year 1989, \$30,000,000 for fiscal year 1990, \$35,000,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 through 1994.

[(B) The Secretary may make grants to community health centers for the purpose of assisting such centers in—

[(i) providing comprehensive health care and support services for the reduction of (I) the incidence of infant mortality, and (II) morbidity among children who are less than 3 years of age; and

[(ii) developing and coordinating service and referral arrangements between community health centers and other entities for the health management of pregnant women and children described in clause (i).

[(C) In making grants under subparagraph (B), the Secretary shall give priority to community health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.

[(D) The Secretary may make a grant under subparagraph (B) only if the community health center involved agrees to expend the grant for the following activities with respect to the purpose described in such subparagraph:

[(i) Primary health services, including prenatal care.

[(ii) Community education, outreach, and case finding.

[(iii) Case management services.

[(iv) Client education, including parenting and child development education.

[(E) The purposes for which a community health center may expend a grant under subparagraph (B) include, with respect to the purpose described in such subparagraph, substance abuse screening, counseling and referral services, and other necessary nonmedical support services, including child care, translation services, and housing assistance.

[(F) The Secretary may make a grant under subparagraph (B) only if the community health center involved agrees that—

[(i) the center will coordinate the provision of services under the grant to each of the recipients of the services;

[(ii) such services will be continuous for each such recipient;

[(iii) the center will provide follow-up services for individuals who are referred by the center for services described in subparagraph (E); and

[(iv) the grant will be expended to supplement, and not supplant, the expenditures of the center for primary health services (including prenatal care) with respect to the purpose described in such subparagraph.

[(3) The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (e)(3)) the governing boards of which (as described in subsection (e)(3)(G)(ii)) do not establish general policies for such centers, an amount which exceeds 5 per centum of the funds appropriated under this section for that fiscal year.

[(h) In carrying out this section, the Secretary may enter into a memorandum of agreement with a State. Such memorandum may include, where appropriate, provisions permitting such State to—

[(1) analyze the need for primary health services for medically underserved populations within such State;

[(2) assist in the planning and development of new community health centers;

[(3) review and comment upon annual program plans and budgets of community health centers, including comments upon allocations of health care resources in the State;

[(4) assist community health centers in the development of clinical practices and fiscal and administrative systems through a technical assistance plan which is responsive to the requests of community health centers; and

[(5) share information and data relevant to the operation of new and existing community health centers.

[(i)(1) Each entity which receives a grant under subsection (d) shall provide for an independent annual financial audit of any books, accounts, financial records, files, and other papers and property which relate to the disposition or use of the funds received under such grant and such other funds received by or allocated to the project for which such grant was made. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received, each such audit shall be conducted in accordance with generally accepted accounting principles. Each audit shall evaluate—

[(A) the entity's implementation of the guidelines established by the Secretary respecting cost accounting,

[(B) the processes used by the entity to meet the financial and program reporting requirements of the Secretary, and

[(C) the billing and collection procedures of the entity and the relation of the procedures to its fee schedule and schedule of discounts and to the availability of health insurance and public programs to pay for the health services it provides

A report of each such audit shall be filed with the Secretary at such time and in such manner as the Secretary may require.

[(2) Each entity which receives a grant under subsection (d) shall establish and maintain such records as the Secretary shall by regulation require to facilitate the audit required by paragraph (1). The Secretary may specify by regulation the form and manner in which such records shall be established and maintained.

[(3) Each entity which is required to establish and maintain records or to provide for and audit under this subsection shall make such books, documents, papers, and records available to the

Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying or mechanical reproduction on or off the premises of such entity upon a reasonable request therefor. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.

[(4) The Secretary may, under appropriate circumstances, waive the application of all or part of the requirements of this subsection to a community health center.

[(j) The Secretary may delegate the authority to administer the programs authorized by this section to any office within the Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the central office of the Health Resources and Services Administration.

[(k) In making grants under this section, the Secretary shall give special consideration to the unique needs of frontier areas.]

#### *Subpart I—Health Centers*

#### **SEC. 330. HEALTH CENTERS.**

##### *(a) DEFINITION OF HEALTH CENTER.—*

*(1) IN GENERAL.—For purposes of this section, the term “health center” means an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements—*

*(A) required primary health services (as defined in subsection (b)(1); and*

*(B) as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2) necessary for the adequate support of the primary health services required under subparagraph (A);*  
*for all residents of the area served by the center (hereafter referred to in this section as the “catchment area”).*

*(2) LIMITATION.—The requirement in paragraph (1) to provide services for all residents within a catchment area shall not apply in the case of a health center receiving a grant only under subsection (f), (g), or (h).*

##### *(b) DEFINITIONS.—For purposes of this section:*

##### *(1) REQUIRED PRIMARY HEALTH SERVICES.—*

*(A) IN GENERAL.—The term “required primary health services” means—*

*(i) basic health services which, for purposes of this section, shall consist of—*

*(I) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;*

*(II) diagnostic laboratory and radiologic services;*

- (III) *preventive health services, including—*
- (aa) *prenatal and perinatal services;*
  - (bb) *screening for breast and cervical cancer;*
  - (cc) *well-child services;*
  - (dd) *immunizations against vaccine-preventable diseases;*
  - (ee) *screenings for elevated blood lead levels, communicable diseases, and cholesterol;*
  - (ff) *pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;*
  - (gg) *voluntary family planning services; and*
  - (hh) *preventive dental services;*

(IV) *emergency medical services; and*

(V) *pharmaceutical services as may be appropriate for particular centers;*

(ii) *referrals to providers of medical services and other health-related services (including substance abuse and mental health services);*

(iii) *patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational, or other related services;*

(iv) *services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and*

(v) *education of patients and the general population served by the health center regarding the availability and proper use of health services.*

(B) *EXCEPTION.—With respect to a health center that receives a grant only under subsection (f), the Secretary, upon a showing of good cause, shall—*

(i) *waive the requirements that the center provide all required primary health services under this paragraph; and*

(ii) *approve, as appropriate, the provision of certain required primary health services only during certain periods of the year.*

(2) *ADDITIONAL HEALTH SERVICES.—The term “additional health services” means services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the health center involved. Such term may include—*

(A) *environmental health services, including—*

(i) *the detection and alleviation of unhealthful conditions associated with water supply;*

(ii) *sewage treatment;*

- (iii) solid waste disposal;
- (iv) rodent and parasitic infestation;
- (v) field sanitation;
- (vi) housing; and
- (vii) other environmental factors related to health;

and

(B) in the case of health centers receiving grants under subsection (f), special occupation-related health services for migratory and seasonal agricultural workers, including—

- (i) screening for and control of infectious diseases, including parasitic diseases; and
- (ii) injury prevention programs, including prevention of exposure to unsafe levels of agricultural chemicals including pesticides.

(3) Medically underserved populations.—

(A) *IN GENERAL.*—The term ‘medically underserved population’ means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

(B) *CRITERIA.*—In carrying out subparagraph (A), the Secretary shall prescribe criteria for determining the specific shortages of personal health services of an area or population group. Such criteria shall—

- (i) take into account comments received by the Secretary from the chief executive officer of a State and local officials in a State; and
- (ii) include factors indicative of the health status of a population group or residents of an area, the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group.

(C) *LIMITATION.*—The Secretary may not designate a medically underserved population in a State or terminate the designation of such a population unless, prior to such designation or termination, the Secretary provides reasonable notice and opportunity for comment and consults with—

- (i) the chief executive officer of such State;
- (ii) local officials in such State; and
- (iii) the organization, if any, which represents a majority of health centers in such State.

(D) *PERMISSIBLE DESIGNATION.*—The Secretary may designate a medically underserved population that does not meet the criteria established under subparagraph (B) if the chief executive officer of the State in which such population is located and local officials of such State recommend the designation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services.

(c) *PLANNING GRANTS.*—

(1) *IN GENERAL.*—

(A) *CENTERS.*—The Secretary may make grants to public and nonprofit private entities for projects to plan and develop health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition, expansion, and modernization of existing buildings and construction of new buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

(i) an assessment of the need that the population proposed to be served by the health center for which the project is undertaken has for required primary health services and additional health services;

(ii) the design of a health center program for such population based on such assessment;

(iii) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project;

(iv) initiation and encouragement of continuing community involvement in the development and operation of the project; and

(v) proposed linkages between the center and other appropriate provider entities, such as health departments, local hospitals, and rural health clinics, to provide better coordinated, higher quality, and more cost-effective health care services.

(B) *COMPREHENSIVE SERVICE DELIVERY NETWORKS AND PLANS.*—The Secretary may make grants to help centers that receive assistance under this section to enable the centers to plan and develop a network or plan for the provision of health services, which may include the provision of health services on a prepaid basis or through another managed care arrangement, to some or to all of the individuals which the centers serve. Such a grant may only be made for such a center if—

(i) the center has received grants under subsection (d)(1)(A) for at least 2 consecutive years preceding the year of the grant under this subparagraph or has otherwise demonstrated, as required by the Secretary, that such center has been providing primary care services for at least the 2 consecutive years immediately preceding such year; and

(ii) the center provides assurances satisfactory to the Secretary that the provision of such services on a prepaid basis, or under another managed care arrangement, will not result in the diminution of the level or quality of health services provided to the medically underserved population served prior to the grant under this subparagraph.

Any such grant may include the acquisition and lease, expansion, and modernization of existing buildings, construction of new buildings, acquisition or lease of equipment which may include data and information systems, and providing training and technical assistance related to the pro-

vision of health services on a prepaid basis or under another managed care arrangement, and for other purposes that promote the development of managed care networks and plans.

(2) *LIMITATION.*—Not more than two grants may be made under this subsection for the same project, except that upon a showing of good cause, the Secretary may make additional grant awards.

(d) *OPERATING GRANTS.*—

(1) *AUTHORITY.*—

(A) *IN GENERAL.*—The Secretary may make grants for the costs of the operation of public and nonprofit private health centers that provide health services to medically underserved populations.

(B) *ENTITIES THAT FAIL TO MEET CERTAIN REQUIREMENTS.*—The Secretary may make grants, for a period of not to exceed 2-years, for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by subsection (i)(3).

(2) *USE OF FUNDS.*—The costs for which a grant may be made under subparagraph (A) or (B) of paragraph (1) may include the costs of acquiring, expanding, and modernizing existing buildings and constructing new buildings (including the costs of amortizing the principal of, and paying interest on, loans), the costs of repaying loans for buildings, and the costs of providing training related to the provision of required primary health services and additional health services and to the management of health center programs.

(3) *LIMITATION.*—Not more than two grants may be made under subparagraph (B) of paragraph (1) for the same entity.

(4) *AMOUNT.*—

(A) *IN GENERAL.*—The amount of any grant made in any fiscal year under paragraph (1) to a health center shall be determined by the Secretary, but may not exceed the amount by which the costs of operation of the center in such fiscal year exceed the total of—

(i) State, local, and other operational funding provided to the center; and

(ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year.

(B) *PAYMENTS.*—Payments under grants under subparagraph (A) and (B) of paragraph (1) shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary and adjustments may be made for overpayments or underpayments.

(C) *USE OF NONGRANT FUNDS.*—Nongrant funds described in clauses (i) and (ii) of subparagraph (A), including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohib-

- ited under this section if such use furthers the objectives of the project.
- (e) *INFANT MORTALITY GRANTS.*—
- (1) *IN GENERAL.*—The Secretary may make grants to health centers for the purpose of assisting such centers in—
- (A) providing comprehensive health care and support services for the reduction of—
- (i) the incidence of infant mortality; and
- (ii) morbidity among children who are less than 3 years of age; and
- (B) developing and coordinating service and referral arrangements between health centers and other entities for the health management of pregnant women and children described in subparagraph (A).
- (2) *PRIORITY.*—In making grants under this subsection the Secretary shall give priority to health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.
- (3) *REQUIREMENTS.*—The Secretary may make a grant under this subsection only if the health center involved agrees that—
- (A) the center will coordinate the provision of services under the grant to each of the recipients of the services;
- (B) such services will be continuous for each such recipient;
- (C) the center will provide follow-up services for individuals who are referred by the center for services described in paragraph (1);
- (D) the grant will be expended to supplement, and not supplant, the expenditures of the center for primary health services (including prenatal care) with respect to the purpose described in this subsection; and
- (E) the center will coordinate the provision of services with other maternal and child health providers operating in the catchment area.
- (f) *MIGRATORY AND SEASONAL AGRICULTURAL WORKERS.*—
- (1) *IN GENERAL.*—The Secretary may award grants for the purposes described in subsections (c), (d), and (e) for the planning and delivery of services to a special medically underserved population comprised of—
- (A) migratory agricultural workers, seasonal agricultural workers, and members of the families of such migratory and seasonal agricultural workers who are within a designated catchment area; and
- (B) individuals who have previously been migratory agricultural workers but who no longer meet the requirements of subparagraph (A) of paragraph (4) because of age or disability and members of the families of such individuals who are within such catchment area.
- (2) *ENVIRONMENTAL CONCERNS.*—The Secretary may enter into grants or contracts under this subsection with public and private entities to—

(A) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migratory agricultural worker labor camps, and applicable Federal and State pesticide control standards; and

(B) conduct projects and studies to assist the several States and entities which have received grants or contracts under this section in the assessment of problems related to camp and field sanitation, exposure to unsafe levels of agricultural chemicals including pesticides, and other environmental health hazards to which migratory agricultural workers and members of their families are exposed.

(3) DEFINITIONS.—For purposes of this subsection:

(A) MIGRATORY AGRICULTURAL WORKER.—The term “migratory agricultural worker” means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.

(B) SEASONAL AGRICULTURAL WORKER.—The term “seasonal agricultural worker” means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

(C) AGRICULTURE.—The term “agriculture” means farming in all its branches, including—

(i) cultivation and tillage of the soil;

(ii) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and

(iii) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in clause (ii).

(g) HOMELESS POPULATION.—

(1) IN GENERAL.—The Secretary may award grants for the purposes described in subsections (c); (d), and (e) for the planning and delivery of services to a special medically underserved population comprised of homeless individuals, including grants for innovative programs that provide outreach and comprehensive primary health services to homeless children and children at risk of homelessness.

(2) REQUIRED SERVICES.—In addition to required primary health services (as defined in subsection (b)(1)), an entity that receives a grant under this subsection shall be required to provide substance abuse services as a condition of such grant.

(3) SUPPLEMENT NOT SUPPLANT REQUIREMENT.—A grant awarded under this subsection shall be expended to supplement, and not supplant, the expenditures of the health center and the value of in kind contributions for the delivery of services to the population described in paragraph (1).

(4) DEFINITIONS.—for purposes of this section:

(A) *HOMELESS INDIVIDUAL.*—The term “homeless individual” means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

(B) *SUBSTANCE ABUSE.*—The term “substance abuse” has the same meaning given such term in section 534(4).

(C) *SUBSTANCE ABUSE SERVICES.*—The term “substance abuse services” includes detoxification and residential treatment for substance abuse provided in settings other than hospitals.

(h) *RESIDENTS OF PUBLIC HOUSING.*—

(1) *IN GENERAL.*—The Secretary may award grants for the purposes described in subsections (c), (d), and (e) for the planning and delivery of services to a special medically underserved population comprised of residents of public housing (such term, for purposes of this subsection, shall have the same meaning given such term in section 3(b)(1) of the United States Housing Act of 1937) and individuals living in areas immediately accessible to such public housing.

(2) *SUPPLEMENT NOT SUPPLANT.*—A grant awarded under this subsection shall be expended to supplement, and not supplant, the expenditures of the health center and the value of in kind contributions for the delivery of services to the population described in paragraph (1).

(3) *CONSULTATION WITH RESIDENTS.*—The Secretary may not make a grant under paragraph (1) unless, with respect to the residents of the public housing involved, the applicant for the grant—

(A) has consulted with the residents in the preparation of the application for the grant; and

(B) agrees to provide for ongoing consultation with the residents regarding the planning and administration of the program carried out with the grant.

(i) *APPLICATIONS.*—

(1) *SUBMISSION.*—No grant may be made under this section unless an applicant therefore is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe.

(2) *DESCRIPTION OF NEED.*—An application for a grant under subparagraph (A) of (B) of subsection (d)(1) for a health center shall include—

(A) a description of the need for health services in the catchment area of the center;

(B) a demonstration by the applicant that the area or the population group to be served by the applicant has a shortage of personal health services; and

(C) a demonstration that the center will be located so that it will provide services to the greatest number of individuals residing in the catchment area or included in such population group.

*Such a demonstration shall be made on the basis of the criteria prescribed by the Secretary under subsection (b)(3) or on any other criteria which the Secretary may prescribe to determine if the area or population group to be served by the applicant has a shortage of personal health services. In considering an application for a grant under subparagraph (A) or (B) of subsection (d)(1), the Secretary may require as a condition to the approval of such application an assurance that the applicant will provide any health service defined under paragraphs (1) and (2) of subsection (b) that the Secretary finds is needed to meet specific health needs of the area to be served by the applicant. Such a finding shall be made in writing and a copy shall be provided to the applicant.*

*(3) REQUIREMENTS.—Except as provided in subsection (d)(1)(B), the Secretary may not approve an application for a grant under subparagraph (A) or (B) of subsection (d)(1) unless the Secretary determines that the entity for which the application is submitted is a health center (within the meaning of subsection (a)) and that—*

*(A) the required primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity;*

*(B) the center will have an ongoing quality improvement system that includes clinical services and management, and that maintains the confidentiality of patient records;*

*(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;*

*(D) THE CENTER—*

*(i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan; or*

*(ii) has made or will make every reasonable effort to enter into such an arrangement;*

*(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;*

*(F) THE CENTER—*

*(i) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a cor-*

*responding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay;*

*(ii) has made and will continue to make every reasonable effort—*

*(I) to secure from patients payment for services in accordance with such schedules; and*

*(II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount; and*

*(iii) has submitted to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph;*

*(G) the center has established a governing board which except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act—*

*(i) is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center;*

*(ii) meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center, and, except in the case of a governing board of a public center (as defined in the second sentence of this paragraph), establishes general policies for the center; and*

*(iii) in the case of an application for a second or subsequent grant for a public center, has approved the application or if the governing body has not approved the application, the failure of the governing body to approve the application was unreasonable;*

*except that, upon a showing of good cause the Secretary shall waive all or part of the requirements of this subparagraph in the case of a health center that receives a grant pursuant to subsection (f), (g), (h), or (o);*

*(H) the center has developed—*

*(i) an overall plan and budget that meets the requirements of the Secretary; and*

*(ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to—*

*(I) the costs of its operations;*

*(II) the patterns of use of its services;*

*(III) the availability, accessibility, and acceptability of its services; and*

*(IV) such other matters relating to operations of the applicant as the Secretary may require;*

*(I) the center will review periodically its catchment area to—*

(i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;

(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation;

(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has—

(i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals; and

(ii) identified an individual on its staff who is fluent in both that language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences; and

(K) the center, has developed an ongoing referral relationship with one or more hospitals.

For purposes of subparagraph (G), the term "public center" means a health center funded (or to be funded) through a grant under this section to a public agency.

(4) APPROVAL OF NEW OR EXPANDED SERVICE APPLICATIONS.—The Secretary shall approve applications for grants under subparagraph (A) or (B) of subsection (d)(1) for health centers which—

(A) have not received a previous grant under such subsection; or

(B) have applied for such a grant to expand their services;

in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by such centers to the medically underserved populations in urban areas which may be expected to use the services provided by such centers is not less than two to three or greater than three to two.

(5) NEW CONSTRUCTION.—The Secretary may make a grant under subsection (c) or (d) for the construction of new buildings for a health center only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, or expanding existing buildings and that the entity to which the grant will be made has made reasonable efforts to secure from other sources funds, in lieu of the grant, to construct such facilities.

(j) *TECHNICAL AND OTHER ASSISTANCE.*—The Secretary may provide (either through the Department of Health and Human Services or by grant or contract) all necessary technical and other non-financial assistance (including fiscal and program management assistance and training in such management) to any public or private nonprofit entity to assist entities in developing plans for, or operating as, health centers, and in meeting the requirements of subsection (i)(2).

(k) *AUTHORIZATION OF APPROPRIATIONS.*—

(1) *IN GENERAL.*—For the purpose of carrying out this section there are authorized to be appropriated \$756,518,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 2000.

(2) *SPECIAL PROVISIONS.*—

(A) *PUBLIC CENTERS.*—The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (i)(3)) the governing boards of which (as described in subsection (i)(3)(G)(ii) do not establish general policies for such centers, an amount which exceeds 5 percent of the amounts appropriated under this section for that fiscal year. For purposes of applying the preceding sentence, the term 'public centers' shall not include health centers that receive grants pursuant to subsection (g) or (h).

(B) *DISTRIBUTION OF GRANTS.*—

(i) *FISCAL YEAR 1996.*—For fiscal year 1996, the Secretary, in awarding grants under this section shall ensure that the amounts made available under each of subsections (f), (g), and (h) in such fiscal year bears the same relationship to the total amount appropriated for such fiscal year under paragraph (1) as the amounts appropriated for fiscal year 1995 under each of sections 329, 340, and 340A (as such sections existed one day prior to the date of enactment of this section) bears to the total amount appropriated under sections 329, 330, 340, and 340A (as such sections existed one day prior to the date of enactment of this section) for such fiscal year.

(ii) *FISCAL YEARS 1997 AND 1998.*—For each of the fiscal years 1997 and 1998, the Secretary, in awarding grants under this section shall ensure that the proportion of the amounts made available under each of subsections (f), (g), and (h) is equal to the proportion of amounts made available under each such subsection for the previous fiscal year, as such amounts relate to the total amounts appropriated for the previous fiscal year involved, increased or decreased by not more than 10 percent.

(3) *FUNDING REPORT.*—The Secretary shall annually prepare and submit to the appropriate committees of Congress a report concerning the distribution of funds under this section that are provided to meet the health care needs of medically underserved populations, including the homeless, residents of public housing, and migratory and seasonal agricultural workers, and the

*appropriateness of the delivery systems involved in responding to the needs of the particular populations. Such report shall include an assessment of the relative health care access needs of the targeted populations and the rationale for any substantial changes in the distribution of funds.*

*(l) MEMORANDUM OF AGREEMENT.—In carrying out this section, the Secretary may enter into a memorandum of agreement with a State. Such memorandum may include, where appropriate, provisions permitting such State to—*

*(1) analyze the need for primary health services for medically underserved populations within such State;*

*(2) assist in the planning and development of new health centers;*

*(3) review and comment upon annual program plans and budgets of health centers, including comments upon allocations of health care resources in the State;*

*(4) assist health centers in the development of clinical practices and fiscal and administrative systems through a technical assistance plan which is responsive to the requests of health centers; and*

*(5) share information and data relevant to the operation of new and existing health centers.*

*(m) RECORDS.—*

*(1) IN GENERAL.—Each entity which receives a grant under subsection (d) shall establish and maintain such records as the Secretary shall require.*

*(2) AVAILABILITY.—Each entity which is required to establish and maintain records under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying or mechanical reproduction on or off the premises of such entity upon a reasonable request therefore. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.*

*(n) DELEGATION OF AUTHORITY.—The Secretary may delegate the authority to administer the programs authorized by this section to any office within the Service, except that the authority to enter into, modify, or issue approvals with respect to grants or contracts may be delegated only within the Health Resources and Services Administration.*

*(o) SPECIAL CONSIDERATION.—In making grants under this section, the Secretary shall give special consideration to the unique needs of sparsely populated rural areas, including priority in the awarding of grants for new health centers under subsections (c) and (d), and the granting of waivers as appropriate and permitted under subsections (b)(1)(B)(i) and (i)(3)(G).*

**SEC. 330A. RURAL HEALTH OUTREACH, NETWORK DEVELOPMENT, AND TELEMEDICINE GRANT PROGRAM.**

*(a) ADMINISTRATION.—The rural health services outreach demonstration grant program established under section 301 shall be administered by the Office of Rural Health Policy (of the Health Re-*

sources and Services Administration), in consultation with State rural health offices or other appropriate State governmental entities.

(b) *GRANTS.*—Under the program referred to in subsection (a), the Secretary, acting through the Director of the Office of Rural Health Policy, may award grants to expand access to, coordinate, restrain the cost of, and improve the quality of essential health care services, including preventive and emergency services, through the development of integrated health care delivery systems or networks in rural areas and regions.

(c) *ELIGIBLE NETWORKS.*—

(1) *OUTREACH NETWORKS.*—To be eligible to receive a grant under this section, an entity shall—

(A) be a rural public or nonprofit private entity that is or represents a network or potential network that includes three or more health care providers or other entities that provide or support the delivery of health care services; and

(B) in consultation with the State office of rural health or other appropriate State entity, prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(i) a description of the activities which the applicant intends to carry out using amounts provided under the grant;

(ii) a plan for continuing the project after Federal support is ended;

(iii) a description of the manner in which the activities funded under the grant will meet health care needs of underserved rural populations within the State; and

(iv) a description of how the local community or region to be served by the network or proposed network will be involved in the development and ongoing operations of the network.

(2) *FOR-PROFIT ENTITIES.*—An eligible network may include for-profit entities so long as the network grantee is a nonprofit entity.

(3) *TELEMEDICINE NETWORKS.*—

(A) *IN GENERAL.*—An entity that is a health care provider and a member of an existing or proposed telemedicine network, or an entity that is a consortium of health care providers that are members of an existing or proposed telemedicine network shall be eligible for a grant under this section.

(B) *REQUIREMENT.*—A telemedicine network referred to in subparagraph (A) shall, at a minimum, be composed of—

(i) a multispecialty entity that is located in an urban or rural area, which can provide 24-hour a day access to a range of specialty care; and

(ii) at least two rural health care facilities, which may include rural hospitals, rural physician offices, rural health clinics, rural community health clinics, and rural nursing homes.

(d) *PREFERENCE.*—In awarding grants under this section, the Secretary shall give preference to applicant networks that include—

- (1) a majority of the health care providers serving in the area or region to be served by the network;
  - (2) any federally qualified health centers, rural health clinics, and local public health departments serving in the area or region;
  - (3) outpatient mental health providers serving in the area or region; or
  - (4) appropriate social service providers, such as agencies on aging, school systems, and providers under the women, infants, and children program, to improve access to and coordination of health care services.
- (e) *USE OF FUNDS.*—
- (1) *IN GENERAL.*—Amounts provided under grants awarded under this section shall be used—
    - (A) for the planning and development of integrated self-sustaining health care networks; and
    - (B) for the initial provision of services.
  - (2) *EXPENDITURES IN RURAL AREAS.*—
    - (A) *IN GENERAL.*—In awarding a grant under this section, the Secretary shall ensure that not less than 50 percent of the grant award is expended in a rural area or to provide services to residents of rural areas.
    - (B) *TELEMEDICINE NETWORKS.*—An entity described in subsection (c)(3) may not use in excess of—
      - (i) 40 percent of the amounts provided under a grant under this section to carry out activities under paragraph (3)(A)(iii); and
      - (ii) 20 percent of the amounts provided under a grant under this section to pay for the indirect costs associated with carrying out the purposes of such grant.
  - (3) *TELEMEDICINE NETWORKS.*—
    - (A) *IN GENERAL.*—An entity described in subsection (c)(3), may use amounts provided under a grant under this section to—
      - (i) demonstrate the use of telemedicine in facilitating the development of rural health care networks and for improving access to health care services for rural citizens;
      - (ii) provide a baseline of information for a systematic evaluation of telemedicine systems serving rural areas;
      - (iii) purchase or lease and install equipment; and
      - (iv) operate the telemedicine system and evaluate the telemedicine system.
    - (B) *LIMITATIONS.*—An entity described in subsection (c)(3), may not use amounts provided under a grant under this section—
      - (i) to build or acquire real property;
      - (ii) purchase or install transmission equipment (such as laying cable or telephone lines, microwave towers, satellite dishes, amplifiers, and digital switching equipment); or
      - (iii) for construction, except that such funds may be expended for minor renovations relating to the installation of equipment;

(f) *TERM OF GRANTS.*—Funding may not be provided to a network under this section for in excess of a 3-year period.

(g) *AUTHORIZATION OF APPROPRIATIONS.*—For the purpose of carrying out this section there are authorized to be appropriated \$36,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 2000.

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(g) \* \* \*

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(4) An entity described in this paragraph is a public or non-profit private entity receiving Federal funds [under any of the following grant programs:

(A) Section 329 (relating to grants for migrant health centers).

(B) Section 330 (relating to grants for community health centers).

(C) Section 340 (relating to grants for health services for the homeless).

(D) Section 340A (relating to grants for health services for residents of public housing).] *under section 330.*

\* \* \* \* \*

SEC. 256c. \* \* \*

\* \* \* \* \*

(2) *RELEVANT ENTITIES.*—The entities referred to in paragraph (1) are entities that provide immunizations against vaccine-preventable diseases [under the programs established in sections 329, 330, 340, and 340A.] *with assistance provided under section 330.*

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TITLE 42—UNITED STATES CODE

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**[Subpart V—Health Services for the Homeless**

**[SEC. 256. GRANT PROGRAM FOR CERTAIN HEALTH SERVICES FOR THE HOMELESS.—**

**[(a) ESTABLISHMENT.—**

**[(1) The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make grants for the purpose of enabling grantees, directly or through contracts, to provide for the delivery of health services to homeless individuals.**

**[(2) In carrying out the program established in paragraph (1), the Administrator shall consult with the Director of the**

National Institute on Alcohol Abuse and Alcoholism and with the Director of the National Institute of Mental Health.

[(b) MINIMUM QUALIFICATIONS OF GRANTEES.—(1) Subject to paragraph (2), the Secretary may not make a grant under subsection (a) to an applicant unless—

[(A) the applicant is a public or nonprofit private entity;

[(B) the applicant has the capacity to effectively administer a grant under subsection (a); and

[(C) in the case of any health service that is covered in the State plan approved under title XIX of the Social Security Act for the State involved—

[(i) the applicant for the grant will provide the health service directly, and the applicant has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

[(ii) the applicant for the grant will enter into an agreement with an organization under which the organization will provide the health service, and the organization has entered into such a participation agreement and is qualified to receive such payments.

[(2)(A) In the case of an organization making an agreement under paragraph (1)(C)(ii) regarding the provision of health services under subsection (a), the requirement established in such paragraph regarding a participation agreement shall be waived by the Secretary if the organization does not, in providing health care services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement under any insurance policy or under any Federal or State health benefits program.

[(B) A determination by the Secretary of whether an organization referred to in subparagraph (A) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the organization accepts voluntary donations regarding the provision of services to the public.

[(c) PREFERENCES IN MAKING GRANTS.—The Secretary shall, in making grants under subsection (a), give preference to qualified applicants that—

[(1)(A) are experienced in the direct delivery of primary health services to homeless individuals or medically underserved populations; or

[(B) are experienced in the treatment of substance abuse in homeless individuals of medically underserved populations; and

[(2) agree to provide for health services to homeless individuals through both public entities and private organizations.

[(d) REQUIREMENT OF SUBMISSION OF APPLICATION CONTAINING CERTAIN AGREEMENTS.—(1) The Secretary may not make a grant under subsection (a) to an applicant unless the applicant has submitted to the Secretary an application for the grant containing agreements in accordance with—

[(A) subsection (e)(1)(A)(ii), relating to the provision of matching funds;

[(B) subsection (f), relating to the provision of certain health services;

[(C) subsection (i), relating to restrictions on the use of funds;

[(D) subsection (j), relating to a limitation on charges for services;

[(E) subsection (k), relating to the administration of grants; and

[(F) subsection (l), relating to a limitation on administrative expenses.

[(2) An application required in paragraph (1) shall, with respect to agreements required to be contained in the application, provide assurances of compliance satisfactory to the Secretary and shall otherwise be in such form, be made in such manner, and contain such information in addition to information required in paragraph (1) as the Secretary determines to be necessary to carry out this section.

[(e) REQUIREMENT OF PROVISION OF MATCHING FUNDS.—(1)(A) The Secretary may not make a grant under subsection (a) to an applicant—

[(i) in an amount exceeding 75 percent of the costs of providing health services for the first fiscal year of payments under the grant and 66<sup>2</sup>/<sub>3</sub> percent of the costs of providing such services for any subsequent fiscal year of payments under the grant; and

[(ii) unless the applicant agrees that the applicant will make available, directly or through donations to the applicant, non-Federal contributions toward such costs in an amount equal to not less than \$1 (in cash or in kind under subparagraph (B)) for each \$3 of Federal funds provided for the first fiscal year of payments under the grant and not less than \$1 (in cash or in kind under such subparagraph) for each \$2 of Federal funds provided for any subsequent fiscal year of payments under the grant.

[(B)(i) Non-Federal contributions required in subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

[(ii) Such determination may not include any cash or in-kind contributions that, prior to February 26, 1987, were made available by any public or private entity for the purpose of assisting homeless individuals (including assistance other than the provision of health services).

[(2) The Secretary may waive the requirement established in paragraph (1)(A) if the applicant involved is a nonprofit private entity and the Secretary determines that it is not feasible for the applicant to comply with such requirement.

[(f) REQUIREMENT OF PROVISION OF CERTAIN HEALTH SERVICES.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant agrees that the applicant will, directly or through contract—

[(1) provide health services at locations accessible to homeless individuals;

[(2) provide to homeless individuals, at all hours, emergency health services;

[(3) refer homeless individuals as appropriate to medical facilities for necessary hospital services;

[(4) refer for mental health services homeless individuals who are mentally ill to entities that provide such services, unless the applicant will provide such services pursuant to subsection (g);

[(5) provide outreach services to inform homeless individuals of the availability of health services; and

[(6) aid homeless individuals in establishing eligibility for assistance, and in obtaining services, under entitlement programs.

[(g) OPTIONAL PROVISION OF CERTAIN SERVICES.—A grantee under subsection (a) may expend amounts received pursuant to such subsection for the purpose of providing to homeless individuals mental health services, dental services (including dentures), services with respect to vision, and podiatry services.

[(h) TEMPORARY CONTINUED PROVISION OF SERVICES TO CERTAIN FORMER HOMELESS INDIVIDUALS.—If any grantee under subsection (a) has provided services described in subsection (f) or (g) to a homeless individual, any such grantee may, notwithstanding that the individual is no longer homeless as a result of becoming a resident in permanent housing, expend the grant to continue to provide such services to the individual for not more than 12 months.

[(i) RESTRICTIONS ON USE OF GRANT FUNDS.—(1) The Secretary may not except as provided in paragraph (2) make a grant under subsection (a) to an applicant unless the applicant agrees that amount received pursuant to such subsection will not, directly or through contract, be expended—

[(A) for any purpose other than the purposes described in subsections (a) and (g);

[(B) to provide inpatient services, except with respect to residential treatment for substance abuse provided in settings other than hospitals;

[(C) to make cash payments to intended recipients of health services or mental health services; or

[(D) to purchase or improve real property (other than minor remodeling of existing improvements to real property) or to purchase major medical equipment.

[(2) If the Secretary finds that the purpose described in subsection (a) cannot otherwise be carried out, the Secretary may, with respect to an otherwise qualified applicant, waive the restriction established in paragraph (1)(D).

[(j) LIMITATION ON CHARGES FOR SERVICES.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant agrees that, whether health services are provided directly or through contract—

[(1) health services under the grant will be provided without regard to ability to pay the health services; and

[(2) if a charge is imposed for the delivery of health services, such charge—

[(A) will be made according to a schedule of charges that is made available to the public;

[(B) will not be imposed on any homeless individual with an income less than the official poverty level; and

[(C) will be adjusted to reflect the income and resources of the homeless individual involved.

[(k) REQUIREMENTS WITH RESPECT TO ADMINISTRATION.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant—

[(1) agrees to establish such procedures for fiscal control and fund accounting as may be necessary to ensure proper disbursement and accounting with respect to the grant;

[(2) agrees to establish an ongoing program of quality assurance with respect to the health services provided under the grant;

[(3) agrees to ensure the confidentiality of records maintained on homeless individuals receiving health services under the grant;

[(4) with respect to providing health services to any population of homeless individuals a substantial portion of which has a limited ability to speak the English language—

[(A) has developed and has the ability to carry out a reasonable plan to provide health services under the grant through individuals who are able to communicate with the population involved in the language and cultural context that is most appropriate; and

[(B) has designated at least one individual, fluent in both English and the appropriate language, to assist in carrying out the plan; and

[(5) agrees to submit to the Secretary an annual report that describes the utilization and costs of health services provided under the grant and that provides such other information as the Secretary determines to be appropriate.

[(l) LIMITATION ON ADMINISTRATIVE EXPENSES OF GRANTEE.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant agrees that the applicant will not expend more than 10 percent of amounts received pursuant to such subsection for the purpose of administering the grant.

[(m) USE OF GRANT FUNDS FOR REFERRALS TO CERTAIN ADVOCACY SYSTEMS.—A grantee under subsection (a) may, with respect to title I of the Protection and Advocacy for Mentally Ill Individuals Act of 1986, expend amounts received under subsection (a) for the purpose of referring homeless individuals who are chronically mentally ill, and who are eligible under such Act, to systems that provide advocacy services under such Act.

[(n) USE OF SELF-HELP ORGANIZATIONS.—Any grantee under subsection (a) may provide health services through contracts with nonprofit self-help organizations that—

[(1) are established and managed by current and former recipients of mental health services, or substance abuse services, who have been homeless individuals; and

[(2) with respect to the provision of health services described in subsection (b)(3), are organizations qualified under subparagraph (B) of such subsection.

[(o) TECHNICAL ASSISTANCE.—(1) The Secretary may, without charge to any grantee under subsection (a), provide technical as-

sistance to any such grantee with respect to the planning, development, and operation of programs to carry out the purpose described in such subsection. The Secretary may provide such technical assistance directly, through contract, or through grants.

[(2) Of the amounts appropriated pursuant to subsection (q)(1) for a fiscal year, the Secretary may expend not more than \$2,000,000 for the purpose of carrying out paragraph (1).

[(p) ANNUAL REPORTS BY SECRETARY.—Not later than January 10 of each year, the Secretary shall submit to the Congress a report describing the utilization and costs of health services provided under subsection (a) during the immediate preceding fiscal year.

[(q) FUNDING.—(1) There are authorized to be appropriated to carry out this section \$70,000,000 for fiscal year 1991, \$80,000,000 for fiscal year 1992, and such sums as may be necessary for each of the fiscal years 1993 and 1994.

[(2) Amounts received by a grantee pursuant to subsection (a) remaining unobligated at the end of the fiscal year in which the amounts were received shall remain available to the grantee during the succeeding fiscal year for the purpose described in such subsection.

[(r) DEFINITIONS.—For purposes of this section:

[(1) The term “health services” means primary health services and substance abuse services.

[(2) The term “homeless individual” means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

[(3) The term “medically underserved population” has the meaning given such term in section 330(b)(3).

[(4) The term “official poverty level” means the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

[(5) The term “organization” includes individuals, corporations, partnerships, companies, and associations.

[(6) The term “primary health services” has the meaning given such term in section 330(b)(1).

[(7) The term “substance abuse” has the meaning given such term in section 536(4). So in original. Probably should be “section 534(4)”. See the amendments made by section 511 of Public Law 101-645 (104 Stat. 4726).

[(8) The term “substance abuse services” includes detoxification and residential treatment for substance abuse provided in settings other than hospitals.

[(s) GRANTS REGARDING OUTREACH AND PRIMARY HEALTH SERVICES FOR HOMELESS CHILDREN.—

[(1) The Secretary may make grants to entities specified in paragraph (2) for the purpose of enabling the entities, directly or through contracts, to carry out demonstration programs—

[(A) to provide comprehensive primary health services to homeless children and to children at imminent risk of

homelessness, including such services provided through mobile medical units;

[(B) to provide referrals for the provision of appropriate health services, social services, and education services to children receiving services under subparagraph (A) (including referrals regarding hospitals, the programs of sections 329 and 330, the program of the Head Start Act (and other programs providing education services), and programs regarding the prevention and treatment of child abuse); and

[(C) to provide outreach services to identify children who are homeless and to inform the parents (or other guardians) of the children of the availability of services from the grantees and from the entities or programs specified in subparagraph (B).

[(2) The entities referred to in paragraph (1) are—

[(A) grantees under subsection (a), and other public and nonprofit private entities (other than children's hospitals) that provide primary health services, and substance abuse services, to a substantial number of homeless individuals; and

[(B) public and nonprofit private children's hospitals that provide primary health services to a substantial number of individuals.

[(3)(A) The Secretary may not make a grant under paragraph (1) to a hospital unless the hospital agrees, with respect to the costs of providing services under such paragraph, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than \$1 for each \$1 of Federal funds provided in the grant.

[(B) Non-Federal contributions required in subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

[(4) The Secretary may not make a grant under paragraph (1) unless the applicant for the grant agrees that subsections (b)(3), (h), (i), and (j) will apply to the grant to the same extent and in the same manner as such subsections apply to any grant under subsection (a). For purposes of subsection (i)(1)(D) (including as applied to this subsection by the preceding sentence), mobile medical units shall be considered to be major medical equipment.

[(5) The Secretary may not make a grant under paragraph (1) unless the applicant for the grant agrees to collect such data as the Secretary determines to be necessary for assessing the efficacy of services provided under paragraph (1) to homeless children.

[(6) The Secretary may not make a grant under paragraph (1) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and infor-

mation as the Secretary determines to be necessary to carry out this subsection.

[(7) In making grants under paragraph (1), the Secretary shall take into account the needs of homeless children in rural areas.

[(8) For the purpose of carrying out this subsection, there is authorized to be appropriated \$5,000,000 for each of the fiscal years 1991 through 1993.

[(t) INFANT MORTALITY AND MORBIDITY.—

[(1) IN GENERAL.—The Secretary may make grants to grantees under subsection (a) for the purpose of assisting such grantees in—

[(A) providing comprehensive health care and support services for the reduction of (i) the incidence of infant mortality, and (ii) morbidity among children who are less than 3 years of age; and

[(B) developing and coordinating service and referral arrangements between such grantees and other entities for the health management of pregnant women and children described in subparagraph (A).

[(2) REQUIRED ACTIVITIES.—The Secretary may make a grant under paragraph (1) only if the applicant involved agrees to expend the grant for the following activities with respect to the purpose described in such paragraph:

[(A) Primary health services, including prenatal care.

[(B) Community education, outreach, and case finding.

[(C) Case management services.

[(D) Client education, including parenting and child development education.

[(3) CERTAIN AUTHORIZED ACTIVITIES.—The purposes for which a grant under paragraph (1) may be expended include, with respect to the purpose described in such paragraph, substance abuse screening, counseling and referral services, and other necessary nonmedical support services, including child care, translation services, and housing assistance.

[(4) CERTAIN REQUIREMENTS REGARDING PROVISION OF SERVICES.—The Secretary may make a grant under paragraph (1) only if the applicant involved agrees that—

[(A) the applicant will coordinate the provision of services under the grant to each of the recipients of the services:

[(B) such services will be continuous for each such recipient;

[(C) the applicant will provide follow-up services for individuals who are referred by the applicant for services described in paragraph (3); and

[(D) the grant will be expended to supplement, and not supplant, the expenditures of the applicant for primary health services (including prenatal care) with respect to the purpose described in paragraph (1).

[(5) APPLICATION FOR GRANT.—The Secretary may make a grant under paragraph (1) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements,

assurances, and information as the Secretary determines to be necessary to carry out this subsection.

[(6) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1993 and 1994.

**[Subpart VI—Health Services for Residents of Public Housing**

**[HEALTH SERVICES FOR RESIDENTS OF PUBLIC HOUSING**

**[SEC. 256a. (a) ESTABLISHMENT.—**

[(1) The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make grants for the purpose of enabling grantees, directly or through contracts, to provide to residents of public housing, subject to subsections (e) and (f)—

[(A) primary health services, including health screenings; and

[(B) health counseling and education services.

[(2) The Secretary may not make a grant under paragraph (1) unless the applicant for the grant agrees to expend the grant to carry out each of subparagraphs (A) and (B) of such paragraph.

[(3) In carrying out the program established in paragraph (1), the Administrator shall consult with the Director of the Centers for Disease Control.

**[(b) MINIMUM QUALIFICATIONS OF GRANTEEES.—**

[(1) Subject to paragraph (2), the Secretary may not make a grant under subsection (a) to an applicant unless—

[(A) the applicant is a public or nonprofit private entity;

[(B) the applicant has the capacity to effectively administer a grant under subsection (a); and

[(C) in the case of any service under this section that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State in which the service will be provided—

[(i) the applicant for the grant will provide the service directly, and the applicant has entered into a participation agreement under the State plan and is qualified to receive payments under such plan; or

[(ii) the applicant for the grant will enter into an agreement with a public or nonprofit private organization under which the organization will provide the service, and the organization has entered into such a participation agreement and is qualified to receive such payments.

[(2)(A) In the case of an organization making an agreement pursuant to paragraph (1)(C)(ii) regarding the provision of services under subsection (a), the requirement established in such paragraph regarding a participation agreement shall be waived by the Secretary if the organization does not, in providing services, impose a charge or accept reimbursement available from any third-party payor, including reimbursement

under any insurance policy or under any Federal or State health benefits program.

[(B) A determination by the Secretary of whether an organization referred to in subparagraph (A) meets the criteria for a waiver under such subparagraph shall be made without regard to whether the organization accepts voluntary donations regarding the provision of services to the public.

[(c) PREFERENCES IN MAKING GRANTS.—The Secretary shall, in making grants under subsection (a), give preference to qualified applicants that—

[(1) are resident management corporations under section 20 of the United States Housing Act of 1937; or

[(2) are receiving funds under section 330 or 340.

[(d) REQUIREMENT OF MATCHING FUNDS FROM PUBLIC GRANTEES.—

[(1) In the case of a public entity applying for a grant under subsection (a), the Secretary may not make such a grant unless the public entity agrees that, with respect to the costs to be incurred by such entity in carrying out the purpose described in such subsection, the entity will make available non-Federal contributions in cash toward such costs in an amount equal to not less than \$1 for each \$1 of Federal funds provided in the grant.

[(2) In determining the amount of non-Federal contributions in cash that a public entity has provided pursuant to paragraph (1), the Secretary may not include any amounts provided to the public entity by the Federal Government.

[(e) REQUIREMENTS REGARDING SERVICES.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant agrees that the applicant will, directly or through contract—

[(1) provide services under this section on the premises of public housing projects or at other locations immediately accessible to residents of public housing;

[(2) refer such residents, as appropriate, to qualified facilities and practitioners for necessary follow-up services;

[(3) provide outreach services to inform such residents of the availability of such services; and

[(4) aid such residents in establishing eligibility for assistance, and in obtaining services, under Federal, State, and local programs providing health services, mental health services, or social services.

[(f) OPTIONAL PROVISION OF CERTAIN SERVICES.—

[(1) A grantee under subsection (a) may expend the grant—

[(A) to train residents of public housing to provide health screenings and to provide educational services; and

[(B) to provide health services to individuals who are not residents of public housing.

[(2) The Secretary may not make a grant under subsection (a) unless the applicant for the grant agrees that if, pursuant to paragraph (1)(B), the applicant provides health services to individuals who are not residents of public housing, the health services will be provided to such individuals under the same terms and conditions as such services are provided to residents

of public housing (including all terms and conditions in effect pursuant to this section).

[(g) CONSULTATION WITH RESIDENTS.—The Secretary may not make a grant under subsection (a) unless, with respect to the residents of the public housing involved, the applicant for the grant—

[(1) has consulted with the residents in the preparation of the application for the grant; and

[(2) agrees to provide for ongoing consultation with the residents regarding the planning and administration of the program carried out with the grant.

[(h) RESTRICTIONS ON USE OF GRANT FUNDS.—

[(1) The Secretary may not, except as provided in paragraph (2), make a grant under subsection (a) to an applicant unless the applicant agrees that amounts received pursuant to such subsection will not, directly or through contract, be expended—

[(A) for any purpose other than the purposes authorized in this section;

[(B) to provide inpatient services;

[(C) to make cash payments to intended recipients of services under this section; or

[(D) to purchase or improve real property (other than minor remodeling of existing improvements to real property) or to purchase major medical equipment or motor vehicles.

[(2) If the Secretary finds that the purpose described in subsection (a) cannot otherwise be carried out, the Secretary may, with respect to an otherwise qualified applicant, waive the restriction established in paragraph (1)(D).

[(i) LIMITATION ON CHARGES FOR SERVICES.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant agrees that, whether the services are provided directly or through contract—

[(1) services under the grant will be provided without regard to ability to pay for the services; and

[(2) if a charge is imposed for the delivery of the services, such charge—

[(A) will be made according to a schedule of charges that is made available to the public;

[(B) will not be imposed on any resident of public housing with an income less than the official poverty level; and

[(C) will be adjusted to reflect the income and resources of the resident of public housing involved.

[(j) REQUIREMENTS REGARDING ADMINISTRATION.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant—

[(1) agrees to establish such procedures for fiscal control and fund accounting as may be necessary to ensure proper disbursement and accounting with respect to the grant;

[(2) agrees to establish an ongoing program of quality assurance with respect to the services provided under the grant;

[(3) agrees to ensure the confidentiality of records maintained on residents of public housing that are receiving such services;

[(4) with respect to providing services to any population of such residents a substantial portion of which has a limited ability to speak the English language—

[(A) has developed and has the ability to carry out a reasonable plan to provide services under the grant through individuals who are able to communicate with the population involved in the language and cultural context that is most appropriate; and

[(B) has designated at least one individual, fluent in both English and the appropriate language, to assist in carrying out the plan; and

[(5) agrees to submit to the Secretary an annual report that describes the utilization and costs of services provided under the grant and that provides such other information as the Secretary determines to be appropriate.

[(k) LIMITATION ON ADMINISTRATIVE EXPENSES OF GRANTEE.—The Secretary may not make a grant under subsection (a) to an applicant unless the applicant agrees that the applicant will not expend more than 10 percent of amounts received pursuant to such subsection for the purpose of administering the grant.

[(l) REQUIREMENT OF APPLICATION.—The Secretary may not provide financial assistance under subsection (a) unless—

[(1) an application for the assistance is submitted to the Secretary;

[(2) with respect to carrying out the purpose for which the assistance is to be provided, the application provides assurances of compliance satisfactory to the Secretary; and

[(3) the application otherwise is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

[(m) TECHNICAL ASSISTANCE.—

[(1) The Secretary may provide technical assistance to applicants and grantees under subsection (a) regarding the planning, development, and operation of programs to carry out the purpose described in such subsection. The Secretary may provide such technical assistance directly, through contracts, or through grants.

[(2) Any technical assistance provided by the Secretary under paragraph (1) shall be provided without charge to applicants and grantees under subsection (a).

[(3) Of the amounts appropriated pursuant to subsection (p)(1) for a fiscal year, the Secretary may expend not more than \$2,000,000 for the purpose of carrying out paragraph (1).

[(n) ANNUAL REPORTS BY SECRETARY.—Not later than January 10 of each year, the Secretary shall submit to the Congress a report describing the utilization and costs of services provided under this section during the immediately preceding fiscal year.

[(o) DEFINITIONS.—For purposes of this section:

[(1) The term “official poverty level” means the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

[(2) The term “organization” includes individuals, corporations, partnerships, companies, and associations.

[(3) The term “primary health services” has the meaning given such term in section 330(b)(1).

[(4) The term “public housing” has the meaning given such term in section 3(b)(1) of the United States Housing Act of 1937.

[(p) FUNDING.—

[(1) For the purpose of carrying out this section, there are authorized to be appropriated \$35,000,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 and 1993.

[(2) Amounts received by a grantee pursuant to subsection (a) remaining unobligated at the end of the fiscal year in which the amounts were received shall remain available to the grantee during the succeeding fiscal year for the purpose described in such subsection.

[(q) INFANT MORTALITY AND MORBIDITY.—

[(1) IN GENERAL.—The Secretary may make grants to grantees under subsection (a) for the purpose of assisting such grantees in—

[(A) providing comprehensive health care and support services for the reduction of (i) the incidence of infant mortality, and (ii) morbidity among children who are less than 3 years of age; and

[(B) developing and coordinating service and referral arrangements between such grantees and other entities for the health management of pregnant women and children described in subparagraph (A).

[(2) REQUIRED ACTIVITIES.—The Secretary may make a grant under paragraph (1) only if the applicant involved agrees to expend the grant for the following activities with respect to the purpose described in such paragraph:

[(A) Primary health services, including prenatal care.

[(B) Community education, outreach, and case finding.

[(C) Case management services.

[(D) Client education, including parenting and child development education.

[(3) CERTAIN AUTHORIZED ACTIVITIES.—The purposes for which a grant under paragraph (f) may be expended include, with respect to the purpose described in such paragraph, substance abuse screening, counseling and referral services, and other necessary nonmedical support services, including child care, translation services, and housing assistance.

[(4) Certain requirements regarding provision of services.—The Secretary may make a grant under paragraph (1) only if the applicant involved agrees that—

[(A) the applicant will coordinate the provision of services under the grant to each of the recipients of the services;

[(B) such services will be continuous for each such recipient;

[(C) the applicant will provide follow-up services for individuals who are referred by the applicant for services described in paragraph (3); and

[(D) the grant will be expended to supplement, and not supplant, the expenditures of the applicant for primary health services (including prenatal care) with respect to the purpose described in paragraph (1).

[(5) APPLICATION FOR GRANT.—The Secretary may make a grant under paragraph (1) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subsection.

[(6) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1993 and 1994.]

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SOCIAL SECURITY ACT

TITLE 42—UNITED STATES CODE

\* \* \* \* \*  
SEC. 1395x \* \* \*

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(aa) \* \* \*

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(4) \* \* \*

\* \* \* \* \*  
(A) \* \* \*

(i) is receiving a grant under [section 329, 330, or 340] *section 330 (other than subsection (h))* of the Public Health Service Act, or

(ii)(I) \* \* \*

(II) meets the requirements to receive a grant under [section 329, 330, or 340] *section 330 (other than subsection (h))* of such Act, or

\* \* \* \* \*  
SEC. 1396d. \* \* \*

\* \* \* \* \*  
(2) \* \* \*

\* \* \* \* \*  
(B) \* \* \*

(i) is receiving a grant under section [329, 330, 340, or 340A] *section 330* of the Public Health Service Act.

(ii) \* \* \*

(II) meets the requirements to receive a grant under section [329, 330, 340, or 340A] *Section 330* of such Act.

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