

representation emphasizes the historical significance of the American census and the way our government views and governs itself today. Jefferson's significant contributions to the early American census include his alerting the Nation to the importance of accuracy in census taking and his recognition of the need to fully represent newly acquired territories in the census.

Historically, census taking was a negative thing. It was used for raising taxes for the militia. Thomas Jefferson, as Secretary of State, oversaw the first census in history, which was positive, which gave the people more than it took away by empowering those counted with a voice in their government.

As we have heard in recent weeks, the 2010 census has some very serious challenges. Although much work remains to be done to ensure its successful implementation, naming this building for Thomas Jefferson underscores this Congress' commitment to getting it right and making sure that every citizen is counted.

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A fair and accurate census, putting political power in the hands of the people, is a uniquely American invention. Let us honor our Founding Fathers' legacy by celebrating Thomas Jefferson, the father of the modern census.

Mr. OBERSTAR. Madam Speaker, I rise in support of H.R. 5599, a bill to designate the Federal building located at 4600 Silver Hill Road in Suitland, Maryland, as the "Thomas Jefferson Census Bureau Headquarters Building".

The United States census is a count of the Nation's population, conducted every 10 years. The results are used for various purposes, including allocation of congressional seats and impacting Government program funding for States and localities. The U.S. Census Bureau is responsible for conducting the census and serves "as the leading source of quality data about the Nation's people and economy," according to its mission.

The census is our Nation's longest continuous scientific project. In 1790, while Secretary of State, Thomas Jefferson conducted the first official count of the Nation's population. Census Day was August 2, 1790. The national census has several colonial predecessors with eight of the original 13 colonies having conducted their own census.

President Jefferson not only was one of our Founding Fathers and the third President of the United States, but he was also an early demographer.

Therefore, it is fitting and proper that we designate this Federal building as the "Thomas Jefferson Census Bureau Headquarters Building".

I urge my colleagues to join me in supporting H.R. 5599.

Mr. KUHLMAN. Madam Speaker, I yield back the balance of my time and encourage my colleagues to vote in support of this resolution.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I have no further requests for time, and I move the passage of this resolution.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) that the House suspend the rules and pass the bill, H.R. 5599.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

#### HEALTH CENTERS RENEWAL ACT OF 2008

Mr. GENE GREEN of Texas. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 1343) to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1343

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

#### SECTION 1. SHORT TITLE.

*This Act may be cited as the "Health Centers Renewal Act of 2008".*

#### SEC. 2. ADDITIONAL AUTHORIZATIONS OF APPROPRIATIONS FOR HEALTH CENTERS PROGRAM.

*Section 330(r)(1) of the Public Health Service Act (42 U.S.C. 254b(r)(1)) is amended to read as follows:*

*"(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—*

*"(A) for fiscal year 2008, \$2,213,020,000;*

*"(B) for fiscal year 2009, \$2,451,394,400;*

*"(C) for fiscal year 2010, \$2,757,818,700;*

*"(D) for fiscal year 2011, \$3,116,335,131; and*

*"(E) for fiscal year 2012, \$3,537,040,374."*

#### SEC. 3. RECOGNITION OF HIGH POVERTY AREAS.

*(a) IN GENERAL.—Section 330(c) of the Public Health Service Act (42 U.S.C. 254b(c)) is amended by adding at the end the following new paragraph:*

*"(3) RECOGNITION OF HIGH POVERTY AREAS.—*

*"(A) IN GENERAL.—In making grants under this subsection, the Secretary may recognize the unique needs of high poverty areas.*

*"(B) HIGH POVERTY AREA DEFINED.—For purposes of subparagraph (A), the term 'high poverty area' means a catchment area which is established in a manner that is consistent with the factors in subsection (k)(3)(J), and the poverty rate of which is greater than the national average poverty rate as determined by the Bureau of the Census."*

*(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to grants made on or after January 1, 2009.*

#### SEC. 4. LIABILITY PROTECTIONS FOR HEALTH CENTER VOLUNTEER PRACTITIONERS.

*(a) IN GENERAL.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended—*

*(1) in subsection (g)(1)(A)—*

*(A) in the first sentence, by striking "or employee" and inserting "employee, or (subject to subsection (k)(4)) volunteer practitioner"; and*

*(B) in the second sentence, by inserting "and subsection (k)(4)" after "subject to paragraph (5)"; and*

*(2) in each of subsections (g), (i), (j), (k), (l), and (m)—*

*(A) by striking the term "employee, or contractor" each place such term appears and inserting "employee, volunteer practitioner, or contractor";*

*(B) by striking the term "employee, and contractor" each place such term appears and inserting "employee, volunteer practitioner, and contractor";*

*(C) by striking the term "employee, or any contractor" each place such term appears and inserting "employee, volunteer practitioner, or contractor"; and*

*(D) by striking the term "employees, or contractors" each place such term appears and inserting "employees, volunteer practitioners, or contractors".*

*(b) APPLICABILITY; DEFINITION.—Section 224(k) of the Public Health Service Act (42 U.S.C. 233(k)) is amended by adding at the end the following paragraph:*

*"(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.*

*"(B) For purposes of subsections (g) through (m), the term 'volunteer practitioner' means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:*

*"(i) In the State involved, the practitioner is a licensed physician, a licensed clinical psychologist, or other licensed or certified health care practitioner.*

*"(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.*

*"(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payors (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program)."*

#### SEC. 5. LIABILITY PROTECTIONS FOR HEALTH CENTER PRACTITIONERS PROVIDING SERVICES IN EMERGENCY AREAS.

*Section 224(g) of the Public Health Service Act (42 U.S.C. 233(g)) is amended—*

*(1) in paragraph (1)(B)(ii), by striking "subparagraph (C)" and inserting "subparagraph (C) and paragraph (6)"; and*

*(2) by adding at the end the following paragraph:*

*"(6)(A) Subject to subparagraph (C), paragraph (1)(B)(ii) applies to health services provided to individuals who are not patients of the entity involved if, as determined under criteria issued by the Secretary, the following conditions are met:*

*"(i) The services are provided by a contractor, volunteer practitioner (as defined in subsection (k)(4)(B)), or employee of the entity who is a physician or other licensed or certified health care practitioner and who is otherwise deemed to be an employee for purposes of paragraph (1)(A) when providing services with respect to the entity.*

*"(ii) The services are provided in an emergency area (as defined in subparagraph (D)), with respect to a public health emergency or major disaster described in subparagraph (D), and during the period for which such emergency or disaster is determined or declared, respectively.*

*"(iii) The services of the contractor, volunteer practitioner, or employee (referred to in this paragraph as the 'out-of-area practitioner') are provided under an arrangement with—*

*"(I) an entity that is deemed to be an employee for purposes of paragraph (1)(A) and that serves the emergency area involved (referred to in this paragraph as an 'emergency-area entity'); or*

“(II) a Federal agency that has responsibilities regarding the provision of health services in such area during the emergency.

“(iv) The purposes of the arrangement are—

“(I) to coordinate, to the extent practicable, the provision of health services in the emergency area by the out-of-area practitioner with the provision of services by the emergency-area entity, or by the Federal agency, as the case may be;

“(II) to identify a location in the emergency area to which such practitioner should report for purposes of providing health services, and to identify an individual or individuals in the area to whom the practitioner should report for such purposes; and

“(III) to verify the identity of the practitioner and that the practitioner is licensed or certified by one or more of the States.

“(v) With respect to the licensure or certification of health care practitioners, the provision of services by the out-of-area practitioner in the emergency area is not a violation of the law of the State in which the area is located.

“(B) In issuing criteria under subparagraph (A), the Secretary shall take into account the need to rapidly enter into arrangements under such subparagraph in order to provide health services in emergency areas promptly after the emergency begins.

“(C) Subparagraph (A) applies with respect to an act or omission of an out-of-area practitioner only to the extent that the practitioner is not immune from liability for such act or omission under the Volunteer Protection Act of 1997.

“(D) For purposes of this paragraph, the term ‘emergency area’ means a geographic area for which—

“(i) the Secretary has made a determination under section 319 that a public health emergency exists; or

“(ii) a presidential declaration of major disaster has been issued under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act.”

**SEC. 6. DEMONSTRATION PROJECT FOR INTEGRATED HEALTH SYSTEMS TO EXPAND ACCESS TO PRIMARY AND PREVENTIVE SERVICES FOR THE MEDICALLY UNDERSERVED.**

Part D of title III of the Public Health Service Act (42 U.S.C. 259b et seq.) is amended by adding at the end the following new subpart:

**“Subpart XI—Demonstration Project for Integrated Health Systems to Expand Access to Primary and Preventive Services for the Medically Underserved**

**“SEC. 340H. DEMONSTRATION PROJECT FOR INTEGRATED HEALTH SYSTEMS TO EXPAND ACCESS TO PRIMARY AND PREVENTIVE CARE FOR THE MEDICALLY UNDERSERVED.**

“(a) ESTABLISHMENT OF DEMONSTRATION.—

“(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a demonstration project (hereafter in this section referred to as the ‘demonstration’) under which up to 30 qualifying integrated health systems receive grants for the costs of their operations to expand access to primary and preventive services for the medically underserved.

“(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing grants to be made or used for the costs of specialty care or hospital care furnished by an integrated health system.

“(b) APPLICATION.—Any integrated health system desiring to participate in the demonstration shall submit an application in such manner, at such time, and containing such information as the Secretary may require.

“(c) CRITERIA FOR SELECTION.—In selecting integrated health systems to participate in the demonstration (hereafter in this section referred to as ‘participating integrated health systems’), the Secretary shall ensure representation of integrated health systems that are located in a variety of States (including the District of Colum-

bia and the territories and possessions of the United States) and locations within States, including rural areas, inner-city areas, and frontier areas.

“(d) DURATION.—Subject to the availability of appropriations, the demonstration shall be conducted (and operating grants be made to each participating integrated health system) for a period of 3 years.

“(e) REPORTS.—

“(1) IN GENERAL.—The Secretary shall submit to the appropriate committees of the Congress interim and final reports with respect to the demonstration, with an interim report being submitted not later than 3 months after the demonstration has been in operation for 24 months and a final report being submitted not later than 3 months after the close of the demonstration.

“(2) CONTENT.—Such reports shall evaluate the effectiveness of the demonstration in providing greater access to primary and preventive care for medically underserved populations, and how the coordinated approach offered by integrated health systems contributes to improved patient outcomes.

“(f) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There is authorized to be appropriated \$25,000,000 for each of the fiscal years 2009, 2010, and 2011 to carry out this section.

“(2) CONSTRUCTION.—Nothing in this section shall be construed as requiring or authorizing a reduction in the amounts appropriated for grants to health centers under section 330 for the fiscal years referred to in paragraph (1).

“(g) DEFINITIONS.—For purposes of this section:

“(1) FRONTIER AREA.—The term ‘frontier area’ has the meaning given to such term in regulations promulgated pursuant to section 330I(r).

“(2) INTEGRATED HEALTH SYSTEM.—The term ‘integrated health system’ means a health system that—

“(A) has a demonstrated capacity and commitment to provide a full range of primary care, specialty care, and hospital care in both inpatient and outpatient settings; and

“(B) is organized to provide such care in a coordinated fashion.

“(3) QUALIFYING INTEGRATED HEALTH SYSTEM.—

“(A) IN GENERAL.—The term ‘qualifying integrated health system’ means a public or private nonprofit entity that is an integrated health system that meets the requirements of subparagraph (B) and serves a medically underserved population (either through the staff and supporting resources of the integrated health system or through contracts or cooperative arrangements) by providing—

“(i) required primary and preventive health and related services (as defined in paragraph (4)); and

“(ii) as may be appropriate for a population served by a particular integrated health system, integrative health services (as defined in paragraph (5)) that are necessary for the adequate support of the required primary and preventive health and related services and that improve care coordination.

“(B) OTHER REQUIREMENTS.—The requirements of this subparagraph are that the integrated health system—

“(i) will make the required primary and preventive health and related services of the integrated health system available and accessible in the service area of the integrated health system promptly, as appropriate, and in a manner which assures continuity;

“(ii) will demonstrate financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

“(iii) provides or will provide services to individuals who are eligible for medical assistance under title XIX of the Social Security Act or for assistance under title XXI of such Act;

“(iv) 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;

“(v) will assure that no patient will be denied health care services due to an individual’s inability to pay for such services;

“(vi) will assure that any fees or payments required by the system for such services will be reduced or waived to enable the system to fulfill the assurance described in clause (v);

“(vii) provides assurances that any grant funds will be expended to supplement, and not supplant, the expenditures of the integrated health system for primary and preventive health services for the medically underserved; and

“(viii) submits to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph.

“(C) TREATMENT OF CERTAIN ENTITIES.—The term ‘qualifying integrated health system’ may include a nurse-managed health clinic if such clinic meets the requirements of subparagraphs (A) and (B) (except those requirements that have been waived under paragraph (4)(B)).

“(4) REQUIRED PRIMARY AND PREVENTIVE HEALTH AND RELATED SERVICES.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘required primary and preventive health and related services’ means basic health services consisting of—

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

“(ii) diagnostic laboratory services and radiologic services;

“(iii) preventive health services, including prenatal and perinatal care; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; and voluntary family planning services;

“(iv) emergency medical services; and

“(v) pharmaceutical services, behavioral, mental health, and substance abuse services, preventive dental services, and recuperative care, as may be appropriate.

“(B) EXCEPTION.—In the case of an integrated health system serving a targeted population, the Secretary shall, upon a showing of good cause, waive the requirement that the integrated health system provide each required primary and preventive health and related service under this paragraph if the Secretary determines one or more such services are inappropriate or unnecessary for such population.

“(5) INTEGRATIVE HEALTH SERVICES.—The term ‘integrative health services’ means services that are not included as required primary and preventive health and related services and are associated with achieving the greater integration of a health care delivery system to improve patient care coordination so that the system either directly provides or ensures the provision of a broad range of culturally competent services. Integrative health services include but are not limited to the following:

“(A) Outreach activities.

“(B) Case management and patient navigation services.

“(C) Chronic care management.

“(D) Transportation to health care facilities.

“(E) Development of provider networks and other innovative models to engage local physicians and other providers to serve the medically underserved within a community.

“(F) Recruitment, training, and compensation of necessary personnel.

“(G) Acquisition of technology for the purpose of coordinating care.

“(H) Improvements to provider communication, including implementation of shared information systems or shared clinical systems.

“(I) Determination of eligibility for Federal, State, and local programs that provide, or financially support the provision of, medical, social, housing, educational, or other related services.

“(J) Development of prevention and disease management tools and processes.

“(K) Translation services.

“(L) Development and implementation of evaluation measures and processes to assess patient outcomes.

“(M) Integration of primary care and mental health services.

“(N) Carrying out other activities that may be appropriate to a community and that would increase access by the uninsured to health care, such as access initiatives for which private entities provide non-Federal contributions to supplement the Federal funds provided through the grants for the initiatives.

“(6) SPECIALTY CARE.—The term ‘specialty care’ means care that is provided through a referral and by a physician or nonphysician practitioner, such as surgical consultative services, radiology services requiring the immediate presence of a physician, audiology, optometric services, cardiology services, magnetic resonance imaging (MRI) services, computerized axial tomography (CAT) scans, nuclear medicine studies, and ambulatory surgical services.

“(7) NURSE-MANAGED HEALTH CLINIC.—The term ‘nurse-managed health clinic’ means a nurse-practice arrangement, managed by advanced practice nurses, that provides care for underserved and vulnerable populations and is associated with a school, college, or department of nursing or an independent nonprofit health or social services agency.”

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. GENE GREEN) and the gentleman from Georgia (Mr. DEAL) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

#### GENERAL LEAVE

Mr. GENE GREEN of Texas. Madam Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. GENE GREEN of Texas. Madam Speaker, I yield myself as much time as I may consume.

Madam Speaker, I rise today in support of H.R. 1343, the Health Centers Renewal Act of 2008.

The health centers program was first enacted 40 years ago. Today, health centers are located in 6,000 sites in all 50 States serving as the medical home and family physician to 17 million people nationally.

Over the years, the health centers program has gained tremendous support from Democrats, Republicans, the Congress and the President. We don't all agree on much, but there is no doubt that the health centers program has been a great success.

The overwhelming support for the health centers program may be attributed to the impact health centers have made on the health and well-being of

our country's most vulnerable populations.

Federally qualified health centers are local, nonprofit or public entity, community-owned health care provider serving low-income and medically underserved areas as designated by the Federal Government.

Health centers provide comprehensive primary and preventive health care, with services available to all community residents where they are located, regardless of the patients' ability to pay.

Community health centers have helped fill the medical void for low-income communities and uninsured individuals.

The health centers program's focus on primary and preventive care has garnered savings for our health care system because the health centers provide the uninsured and underserved with access to care they would usually receive at hospital emergency rooms.

By providing access to affordable primary care, health centers have also reduced the need for in-patient and specialty care in hospitals, because medical problems in health center patients are treated earlier, before they require in-patient hospital care.

Studies suggest that health centers save Medicaid approximately 30 percent in annual spending for health centers due to reduced specialty care referrals, fewer hospital admissions, and emergency room visits.

Forty percent of health center patients are uninsured, and 35 percent depend on Medicaid, making health centers a critical feature of our country's safety net and, for many individuals, their only source for health care services.

Unfortunately, the number of uninsured in our country is 47 million and has been steadily rising, and in turn, the need for health centers are increasing.

Our district in Texas and many other communities nationwide are desperately in need of more health centers. Houston has approximately 1 million uninsured but only 10 federally qualified health centers.

As the fourth largest city in the United States, Houston lags far behind the number of health centers located in our area when compared to Chicago, with over 80 community health centers and the third largest city in the country.

Houston is not alone in this need for more health centers. Studies show that 56 million Americans lack access to primary care or a health care home.

The Health Centers Renewal Act will reauthorize the health centers program, which would address the growing need for community health centers in not only my area but throughout the United States.

This legislation would authorize the increased funding necessary for our community to build on the success of the health centers program and develop additional health centers to meet our

tremendous need for affordable and quality health care.

This bill would allow health centers to serve approximately 23 million patients in the next 5 years.

I want to thank my colleague, Mr. PICKERING, who is the original cosponsor, along with the Energy and Commerce Committee and my subcommittee for their full support of this legislation.

I believe the bill is truly an investment in the future of health centers for the medically underserved communities throughout our country.

Madam Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Madam Speaker, I rise today in support of H.R. 1343, the Health Centers Renewal Act. I have been a long time supporter of the community health centers program because health centers provide quality health care services to people and communities which might not otherwise have access to such care.

Last Congress, I sponsored a 5-year health centers reauthorization measure which passed the House by large margins. But unfortunately, we were unable to finalize the legislation and see it signed into law.

I would like to thank Mr. GREEN for his leadership on the legislation this year and for the willingness of our subcommittee chairman, Mr. PALLONE, and our full committee chairman, Mr. DINGELL, who worked in a bipartisan way to improve this reauthorization measure.

We made important reforms to the program to encourage the participation of volunteer physicians at health centers. It is my understanding that many physicians would be more willing to volunteer their time at a health center if they knew they would have liability protection from frivolous lawsuits. This bill provides that assurance through the Federal Tort Claims Act.

Through our work in the committee, we also addressed a situation which developed following Hurricanes Katrina and Rita where some health center employees were not able to carry their liability protection out of their home facility to go work on the gulf coast. We made a common-sense change to address this situation to ensure that health centers can meet their staffing needs during times of emergency. This amendment mirrored the legislation introduced by the late Representative Paul Gilmore, and I am glad that we can honor him by including this in this measure.

Community health centers are an important component of our health care safety net. While many communities across the country enjoy the benefits of having a health center, there are still many areas which could benefit from continued expansion of the program.

I would urge my colleagues to support this measure and give medically underserved communities across this country greater access to health care

providers at a local community health center.

Madam Speaker, I would reserve the balance of my time.

Mr. GENE GREEN of Texas. Madam Speaker, we will reserve the balance of our time.

Mr. DEAL of Georgia. Madam Speaker, I'm pleased to yield to one of the members of our Health Subcommittee of Energy and Commerce and a gentleman whose language has been incorporated into this bill, Mr. TIM MURPHY, for 5 minutes.

Mr. TIM MURPHY of Pennsylvania. Madam Speaker, I thank Ranking Member DEAL and I thank Mr. GREEN for this very, very important bill, this Health Centers Renewal Act to provide some very, very important coverage for some of our most needy citizens.

You know, when people oftentimes will comment upon how many people in America don't have health care, who recognize that actually many of them are covered by programs such as Medicaid, they may or may not know it, or SCHIP or some choose not to have health insurance. But there are also those millions of Americans who simply are not low-income enough for Medicaid. They don't have children, so they're not covered by SCHIP. And they're not old enough for Medicare. Where do they go?

Well, community health centers provide the very health care that they need, give them health care home, give them peace of mind. It is a place where, for a low fee, they can have ongoing health care, know that they have a doctor who knows them, and dentist and psychologist and other ones who provide the vital care for them, and it keeps costs down. Keeps costs down tremendously.

I believe some 30 percent of people who go to community health centers do not have health care insurance, and of those who do attend, it maintains even lower costs for Medicaid patients. So it is savings at all levels.

But unfortunately, there are huge vacancies with community health centers. Those vacancies have to do with normal family physicians or psychiatrists or OB/GYNs, and that has led to backups. That has led to delays in appointments. And the question is, is there a way we can resolve that?

Well, here's something we discovered that was odd, and this bill corrects that. Strangely enough, if physicians want to volunteer at a free clinic, they can do so, and they're covered by the Federal Tort Claims Act. On the other hand, if they are paid medical staff at a free clinic, they're not covered under the Federal Tort Claims Act.

Reverse that for a community health center. If they're paid staff at a community health center, they're covered under the Federal Tort Claims Act, but if they want to volunteer, they are not.

I introduced a bill, H.R. 1626, the Family Healthcare Accessibility Act, a couple of years ago to correct that, and I am pleased that Mr. GREEN has put

this into this bill. That basically provides that physicians and other health professionals, nurse practitioners who want to volunteer are covered.

What does this mean? That means lower costs for clinics, and that means that physicians, for example, who may want to give some of their time each week or each month, a clinic will be there with welcome arms. It has not been something that's been allowed before, but it does provide lower health care costs. It is a way for physicians and other primary practitioners to be able to give back to the community. It is a way to lower health care costs.

In this Nation, where there are 760 primary care physician openings, 290 nurse practitioners openings and 310 dentist openings just a couple of years ago—and those numbers may have climbed—this provides a way that we can fulfill those needs at basically no cost.

I thank the chairman, I thank Ranking Member DEAL and everybody else who has been part of this bill in making this a working bill to help bring health care costs down, help bring health care to America's needy citizens and help bring a health care home for so many Americans.

Mr. GENE GREEN of Texas. Madam Speaker, we will continue to reserve. We have no other speakers.

Mr. DEAL of Georgia. I would yield 3 minutes to the gentleman from Nebraska (Mr. TERRY), a member of the committee who has also worked on this legislation.

Mr. TERRY. Thank you, and I, too, rise in support of our community health centers and the reauthorization.

We have two in my district in Omaha. We have the One World Health Center. It used to be known as the Chicano Awareness Center, but now it has kind of created a new name and new marketing in the sense that it really helps all of our community, and then in the north Omaha community we have the Charles Drew Center.

I frequent these facilities, meeting with their physicians who work there and their directors, and every time I have been impressed with the high quality of the health care that they provide for our communities. They are first-rate. Both of them are in brand new buildings that can rival any physicians' offices anywhere else in the metropolitan Omaha community.

And I think these health centers really are key in our try to provide universal health care or at least access for everybody so those that have minimal insurance or no insurance can show up at our community health centers and receive first-class medical care. And that is one of the major reasons why I stand in support.

Now, just quickly here, I feel compelled from listening to some of the testimony from a previous bill, we had a speaker that stood up and talked about how it was the White House or George Bush's fault that we have to import more oil during his administration.

□ 1145

And of course that does appear to be our energy policy. But keep in mind that this House has voted, in the 10 years I've been here, at least I think eight or nine times to open up either offshore or Alaska oil, which has been shut down on every attempt. We've been able to pass it a handful of times; it has either been vetoed or blocked within the Senate.

So if you aren't allowed to use American supply of energy, of course the only alternative is to import more. I'm personally embarrassed that our administration is going to the Middle East and begging for them to increase production. What that shows, to me, is they're giving up on the fact that we should be using more of our own American resources. And we can do that. We should open up offshore. We should open Alaska. We should open up the oil shale in Colorado.

Now, what the public should know is, just in the last 6 months, back in November-December, this House voted to take the oil shale in Colorado and Wyoming off limits to oil companies to be able to extract oil from there. We made it so you cannot extract that oil.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. DEAL of Georgia. I yield the gentleman 1 additional minute.

Mr. TERRY. Just 2 weeks ago, this House voted to ban the military from using synthetic aviation fuel made from coal, also known as coal-to-liquid. So here's another alternative energy source that we could use to provide aviation fuel not only to the military, but to the civilian side, that would be stable, reliable, no cost fluctuations like you see because of the oil markets. But yet this House voted 2 weeks ago to say no to using that source for fuel. So of course if we're going to limit every source of energy in this country, you have no other place to go.

Last week, I rolled out a plan at home that showed if we allowed all of our resources to be used from the conservation from new vehicles and tax credits to help consumers purchase them, we open up offshore oil shale in Alaska, as well as the alternative, we can become energy independent.

Mr. GENE GREEN of Texas. Madam Speaker, as much as I would like to debate energy prices, hopefully we can deal with renewal of qualified health centers.

Madam Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Madam Speaker, I am pleased to yield 3 minutes to the gentelady from Texas (Ms. GRANGER).

Ms. GRANGER. Madam Speaker, I rise today in strong support of the Health Centers Renewal Act.

As important as this bill is to local communities, I believe the first thing we should be dealing with is gas prices and the devastating effect it's having on American families. Unfortunately, the majority refuses to deal with this issue.

Our Nation has over 1,000 community health centers which provide high-quality, affordable primary health care to more than 16 million Americans in over 6,000 communities nationwide.

I come from Fort Worth, Texas and was mayor there before I came to Congress. When I was mayor, we didn't have a community health center in Fort Worth. And I quickly realized the need for one because of the huge concentration of people we had who weren't able to access health care except for emergency centers.

When I came to Congress, I sat on the committee that funds health centers and worked to get a community health center in Fort Worth. We now have the Albert Galvan Health Clinic in Fort Worth, which serves a terrific need.

Parents who take their children to the center have developed a relationship with a primary care physician who can track families and their needs. They're also receiving good preventative care, which is taking away the need to visit an emergency room.

In Texas, community health centers are helping ease the burden tremendously on hospitals and local providers across the State, with 10 percent of low-income, uninsured Texans now relying on community health centers for their primary care. Texas health centers are caring for over 700,000 patients.

Nationally they're having a strong impact as well. A 2006 study by the National Association of Community Health Centers shows the number of patients treated by health centers increased by 46 percent between 1999 and 2004.

Overall, it's estimated community health centers care for over 17 million underserved people in rural and urban areas across the country. However, there is still a great need for more community health centers. Too many families have to drive long distances to reach a health center, and with gas prices at an all-time high, many families can't afford the drive to the doctor.

Thirty-six million people—one in eight Americans—don't have a doctor or regular source of care. If these 36 million Americans did have a regular source of care at a community health center, billions of dollars in health care costs could be saved from reduced ER visits.

There is evidence that people who get most of their primary care from a health center have 41 percent lower overall health care costs than the others who don't, saving Federal dollars of \$10 to \$17 billion in 2007 alone.

Health care centers are considered one of the most effective government programs in the country and have a solid record of keeping communities healthy and disease free.

The SPEAKER pro tempore. The time of the gentlewoman from Texas has expired.

Mr. DEAL of Georgia. I would yield the gentlelady 1 additional minute.

Ms. GRANGER. Because community health care centers provide families

and the community with a health care safety net they can rely on and also ease the burden of our entire system, they're becoming increasingly important to meeting a national demand. Health care should be affordable, accessible and convenient so that individuals and families can access care when they're sick and get the care they need.

I urge my colleagues to support H.R. 1343.

Mr. DEAL of Georgia. Madam Speaker, I am pleased to yield 2 minutes to my colleague from Georgia, Dr. BROUN.

Mr. BROUN of Georgia. Madam Speaker, I'm a medical doctor. As a physician, I have been a medical director in a National Health Service Corps community health clinic. I have given away hundreds of thousands of dollars of my services to the poor over my 30-some-odd years' career of practicing medicine in rural southwest Georgia, as well as in northeast Georgia where I currently live.

Health care costs are issues that particularly poor people have a tremendous difficulty dealing with. And it certainly is a very important issue. We've got to solve the crisis we have in health care financing today. We don't have a health care quality problem, we have a health care financing problem. And a lot of this is due to an overregulation on the health care system, on doctors, hospitals, pharmaceutical companies, and other entities.

But an issue that actually affects poor people more than health care today is the tremendous cost of energy. Right now today, we're drilling for ice on the ground in Mars, and we can't even drill for oil in America. It's got to stop. We've got to bring down the cost of gasoline. And we can do that. We can do that by drilling offshore. We can do that by tapping into the oil sources we have throughout the west and in Alaska. And it's absolutely critical.

The cost of gasoline is hurting everyone. It's driving up the cost of groceries in the supermarket. It's driving up the cost of all goods and services, including health care. So if we're going to lower the cost of the health care, if we're going to lower the cost of food in the grocery store, we've got to lower the cost of gasoline by drilling now and streamlining the permitting process to get refineries so that they're producing more gasoline and we can bring the cost down. So I encourage my colleagues to push for drilling for oil now.

Mr. DEAL of Georgia. Madam Speaker, I believe the majority is ready to close, and I will close at this point if he has no other speakers.

I believe that the importance of community health centers has certainly been underscored in a bipartisan fashion by the discussion we've had here on this floor. I would remind us all that this is an initiative that President Bush inaugurated several years ago when his goal was to expand the number of community health centers across this country, ultimately so that every county in this country would be served

from one of these facilities. Certainly all of us recognize it is one of the better ways that we have available to us to be able to provide needed health care to communities that are underserved at the current time.

Once again, in closing, I would commend Mr. GREEN for his willingness to work in a bipartisan fashion on this reauthorization legislation. I believe that the amendments that were added to it before its reaching the floor today have considerably improved this bill. In particular, it now will allow physicians who are either retired or who want to volunteer a portion of their time to assist in one of these community health centers the ability to do so with some degree of limited liability protection. I think that will increase the number of physicians who are available in these facilities, and by doing that, it will increase the quality of care to those who are receiving services in community health centers.

With that, I would encourage passage of this resolution.

Madam Speaker, I yield back the balance of my time.

Mr. GENE GREEN of Texas. Madam Speaker, I rise to close. We have no other speakers.

First, to comment on my colleague from Georgia. Coming from Houston, Texas, I have some pipeline companies that would love to have that contract from Mars to Houston to bring oil if we discover it drilling through that ice there.

I appreciate, as a physician, your devotion to community-based health clinics, because that's what this bill is about, it's about reauthorizing. In fact, as we stand here today, Madam Speaker, we're actually expanding one in our district. Like I said earlier, we only have 10 in the Houston area, and our next largest city close to us has 80. So we have a job to do in Houston, in Texas—and my colleague from Fort Worth mentioned it—to expand community-based health centers. This bill will allow us to do that because it will go to the underserved community, areas in the country that really don't even have access to a community-based health center now and will have with this legislation, also with the additional authorization funds.

Of course we have to go back and ask the Appropriations Committee every year for additional funding that we authorize. But that's something that we do. This is very bipartisan support for community-based health centers. That's why I would hope that we would have almost unanimous support for this legislation.

Mr. DAVIS of Illinois. Madam Speaker, I enthusiastically rise today in support of H.R. 1343, The Health Centers Renewal Act of 2007. For over 40 years, community health centers have provided cost-effective, high-quality health care to poor and medically underserved people in the States, the District of Columbia, and the territories, including the working poor, the uninsured, and many high-risk and vulnerable populations. Community

Health Centers nationwide provide care to 1 of every 8 uninsured Americans, 1 of every 4 Americans in poverty, and 1 of every 9 rural Americans.

As a former president of the National Community Health Centers organization, I am honored to advocate for the expansion of this tremendously vital segment of our comprehensive healthcare system. By incorporating both H.R. 5544—The Patients and Public Health Partnership Act of 2008 and H.R. 870, which amends the Public Health Service Act to provide liability protections for practitioners of health centers who provide health services in emergency areas into this legislation; H.R. 1343 is now expanded to increase both insured coverage and access to critical resources for these invaluable medical professionals. This legislation empowers community health practitioners to serve on a larger scale and make an even greater positive impact particularly at a time when our health care delivery systems across the board are overburdened. I ask my colleagues to join me in support of H.R. 1343.

Mr. MCHUGH. Madam Speaker, I rise today in support of H.R. 1343, the Health Centers Renewal Act of 2007. I am proud to be a cosponsor of this legislation, which would reauthorize the community health centers program through fiscal year 2012.

Community health centers are an integral component of our Nation's health care infrastructure. Nationwide, more than 1,500 such centers provide high-quality, cost-effective primary health care to anyone seeking care. In New York State, health centers provide services to 1.1 million people who receive care at over 425 sites.

Of note, community health center fees are based on income and family size and services are provided regardless of insurance status or ability to pay. Forty-three percent of New York State health center patients are Medicaid beneficiaries and 28 percent are uninsured. Moreover, over 86 percent of New York State health center patients have incomes at or below 200 percent of the Federal poverty level, which in 2008 is \$42,400 for a family of four.

Access to health care is truly one of the most difficult challenges for Americans living in rural areas like northern and central New York. Community health centers have been a tremendous help in our efforts to improve access to health care. I am thankful that my constituents in New York State's 23rd Congressional District are served by four community health centers: Hudson Headwaters Health Network; Northern Oswego County Health Services; The Smith House; and the United Cerebral Palsy Association of the North Country.

I deeply appreciate the dedication and hard work of the staff at those health centers. Indeed, I am hesitant to imagine a scenario in which my constituents did not have the benefit of their excellent services. I also appreciate the efforts of the gentleman from Texas, Mr. GREEN, and the gentleman from Mississippi, Mr. PICKERING, to develop this measure and bring it to the House floor today; I look forward to its enactment.

Mr. GENE GREEN of Texas. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by

the gentleman from Texas (Mr. GENE GREEN) that the House suspend the rules and pass the bill, H.R. 1343, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. BROUN of Georgia. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

#### POISON CENTER SUPPORT, ENHANCEMENT, AND AWARENESS ACT OF 2008

Mr. GENE GREEN of Texas. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 5669) to amend the Public Health Service Act to reauthorize the poison center national toll-free number, national media campaign, and grant program to provide assistance for poison prevention, sustain the funding of poison centers, and enhance the public health of people of the United States.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5669

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

#### SECTION 1. SHORT TITLE.

This Act may be cited as the "Poison Center Support, Enhancement, and Awareness Act of 2008".

#### SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Poison centers are the primary defense of the United States against injury and deaths from poisoning. Twenty-four hours a day, the general public as well as health care practitioners contact their local poison centers for help in diagnosing and treating victims of poisoning. In 2007, more than 4 million calls were managed by poison centers providing ready and direct access for all people of the United States, including many underserved populations in the United States, with vital emergency public health information and response.

(2) Poisoning is the second most common form of unintentional death in the United States. In any given year, there will be between 3 million and 5 million poison exposures. Sixty percent of these exposures will involve children under the age of 6 who are exposed to toxins in their home. Poisoning accounts for 285,000 hospitalizations, 1.2 million days of acute hospital care, and more than 26,000 fatalities in 2005.

(3) In 2008, the Harvard Injury Control Research Center reported that poisonings from accidents and unknown circumstances more than tripled in rate since 1990. In 2005, the last year for which data are available, 26,858 people died from accidental or unknown poisonings. This represents an increase of 20,000 since 1990 and an increase of 2,400 between 2004 and 2005. Fatalities from poisoning are increasing in the United States in near epidemic proportions. The funding of programs to reverse this trend is needed now more than ever.

(4) In 2004, The Institute of Medicine, of the National Academies recommended that the

"Congress should amend the current Poison Control Center Enhancement and Awareness Act Amendments of 2003 to provide sufficient funding to support the proposed Poison Prevention and Control System with its national network of poison centers. Support for the core activities at the current level of service is estimated to require more than \$100 million annually."

(5) Sustaining the funding structure and increasing accessibility to poison control centers will promote the utilization of poison control centers and reduce the inappropriate use of emergency medical services and other more costly health care services. The 2004 Institute of Medicine Report to Congress determined that for every \$1 invested in the Nation's poison centers \$7 of health care costs are saved. In 2005, direct Federal health care program savings totaled in excess of \$525 million as the result of poison center public health services.

(6) More than 30 percent of the cost savings and financial benefits of the Nation's network of poison centers are realized annually by Federal health care programs (estimated to be more than \$1 billion), yet Federal funding support (as demonstrated by the annual authorization of \$30.1 million in Public Law 108-194) comprises less than 11 percent of the annual network expenditures of poison centers.

(7) Real-time data collected from the Nation's certified poison centers can be an important source of information for the detection, monitoring, and response for contamination of the air, water, pharmaceutical, or food supply.

(8) In the event of a terrorist event, poison centers will be relied upon as a critical source for accurate medical information and public health emergency response concerning the treatment of patients who have had an exposure to a chemical, radiological, or biological agent.

#### SEC. 3. REAUTHORIZATION OF POISON CENTERS NATIONAL TOLL-FREE NUMBER.

Section 1271 of the Public Health Service Act (42 U.S.C. 300d-71) is amended to read as follows:

#### "SEC. 1271. MAINTENANCE OF THE NATIONAL TOLL-FREE NUMBER.

"(a) IN GENERAL.—The Secretary shall provide coordination and assistance to poison centers for the establishment of a nationwide toll-free phone number, and the maintenance of such number, to be used to access such centers.

"(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$2,000,000 for each of the fiscal years 2000 through 2009 to carry out this section; and \$1,000,000 for each of the fiscal years 2010 through 2014 for the maintenance of the nationwide toll-free phone number under subsection (a)."

#### SEC. 4. REAUTHORIZATION OF NATIONWIDE MEDIA CAMPAIGN TO PROMOTE POISON CENTER UTILIZATION.

(a) IN GENERAL.—Section 1272 of the Public Health Service Act (42 U.S.C. 300d-72) is amended to read as follows:

#### "SEC. 1272. NATIONWIDE MEDIA CAMPAIGN TO PROMOTE POISON CENTER UTILIZATION.

"(a) IN GENERAL.—The Secretary shall carry out, and expand upon, a national media campaign to educate the public and health care providers about poison prevention and the availability of poison center resources in local communities and to conduct advertising campaigns concerning the nationwide toll-free number established under section 1271(a).

"(b) CONTRACT WITH ENTITY.—The Secretary may carry out subsection (a) by entering into contracts with a nationally recognized organization in the field of poison