S. 1130

Eighty-seventh Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Wednesday, the tenth day of January, one thousand nine hundred and sixty-two

Resource ID # 6202

Family Health Services Amendments Act of 1988

An Act

To amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., ch. 6A, subch. II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR FAMILY HEALTH SERVICE CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

"SEC. 310. There are hereby authorized to be appropriated for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operating of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families."

Speaker of the House of Representatives.

Vice President of the United States and President of the Senate.

Calendar No. 669

100TH CONGRESS
2d Session

SENATE

REPORT
100-343

FAMILY HEALTH SERVICES AMENDMENTS ACT OF 1988

MAY 13 (legislative day, MAY 9), 1988.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 2385]

The Committee on Labor and Human Resources, having considered an original bill to amend title III of the Public Health Service Act to revise and extend the programs of assistance for primary health care, the program of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases, and for other purposes, reports favorably thereon without amendment and recommends that the bill do pass.

CONTENTS

I. SUMMARY OF THE BILL

As reported by the Committee, the bill revises and extends the authority under title III of the Public Health Service (PHS) Act for the programs of assistance for primary health care, the program of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases (STD).

(e) AUTHORITY WITH RESPECT TO EXPANSION AND CONSTRUCTION OF CENTERS.—

(1) Section 329 (42 U.S.C. 254b) is amended—

(A) in the second sentence of subsection (c)(1)(A), by striking "acquisition and modernization of existing buildings" and inserting "acquisition, expansion, and modernization of existing buildings and construction of new buildings";

(B) in the matter after and below subsection (c)(1)(B)(iv), by striking "acquisition and modernization of existing buildings" and inserting "acquisition, expansion, and modernization of existing buildings, construction of new buildings,";

(C) in the matter after and below subsection (d)(1)(B)(iv), by striking "acquisition and modernization of existing buildings" and inserting "acquisition, expansion, and modernization of existing buildings, construction of new buildings,";

(D) in the matter after and below subsection (d)(1)(C)(iii), by striking "acquisition and modernization of existing buildings" and inserting "acquisition, expansion, and modernization of existing buildings, construction of new buildings,";

(E) in subsection (d)(2), by striking "acquiring and modernizing existing buildings" and inserting "acquiring, expanding, and modernizing existing buildings and constructing new buildings"; and

(F) in subsection (d)(4)(B)(ii)(III), by striking "construct and modernize" and inserting "construct, expand, and modernize".

(2) Section 329(f) (42 U.S.C. 254b(f)) is amended by adding at the end the following:

Grants.

"(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 sources funds, in lieu of the grant, to construct such facilities.".

(f) AMOUNT OF GRANTS FOR COSTS OF OPERATION.—

(1) Section 329(d)(4)(A)(i) (42 U.S.C. 254b(d)(4)(A)(i)) is amended to read as follows:

"(i) State, local, and other operational funding, and".

(2) Section 329(d)(4)(B) (42 U.S.C. 254b(d)(4)(B)) is amended by striking out "may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center" in the matter immediately following clause (ii) and inserting in lieu thereof "shall be entitled to retain the additional amount of fees, premiums, and other third party reimbursements as the center will use".

(g) ADMINISTRATION OF PROGRAMS.—Section 329 (42 U.S.C. 254b) is amended by adding at the end the following:

Grants. Contracts.

"(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.".

(h) AUTHORIZATION OF APPROPRIATIONS.—Section 329(h) (42 U.S.C. 254b(h)) is amended— Grants.

(1) by amending paragraph (1) to read as follows:

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

"(B) Of the amounts appropriated pursuant to subparagraph (A) for a fiscal year, the Secretary may obligate for grants and contracts 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."; and Contracts.

(2) by redesignating paragraph (2) as paragraph (3) and inserting after paragraph (1) the following new paragraph:

"(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, and $2,500,000 for fiscal year 1991.

"(B) The Secretary may make grants to migrant health centers to assist such centers in— Children and youth.

"(i) providing services for the reduction of the incidence of infant mortality; and

"(ii) developing and coordinating referral arrangements between migrant health centers and other entities for the health management of infants and pregnant women. Women.

"(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.". Children and youth.

SEC. 3. COMMUNITY HEALTH CENTERS.

(a) ADDITION OF PATIENT CASE MANAGEMENT SERVICES TO LIST OF PROVIDED SERVICES.—Section 330(a)(1) (42 U.S.C. 254c(a)(1)) is amended—

(1) by striking "and" at the end of paragraph (4) and inserting "and" at the end of paragraph (5); and

(2) by inserting after paragraph (5) the following new paragraph:

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

(b) ADDITION OF APPROPRIATE HEALTH NEEDS TO LIST OF SUPPLEMENTAL HEALTH SERVICES.—Section 330(b)(2) (42 U.S.C. 254c(b)(2)) is amended—

(1) by striking "and" at the end of subparagraph (L);

(2) by striking the period at the end of subparagraph (M) and inserting "; and"; and

(3) by adding at the end the following new subparagraph: Disadvantaged persons.

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

(c) REQUIREMENT OF NOTICE AND COMMENT WITH RESPECT TO REGULATIONS ON MEDICALLY UNDERSERVED POPULATIONS.—Section 330(b)(4) (42 U.S.C. 254c(b)(4)) is amended by inserting after and below subparagraph (B) the following:

TITLE I—PRIMARY HEALTH CENTERS

The bill amends the authorities under sections 329 and 330 of the PHS Act for support of Migrant Health Centers and Community Health Centers. In addition to extending the authorities of both programs for 3 years, through FY 1991, the bill authorizes the Secretary to set aside a portion of the appropriation for each program each year for the provision of services targeted at reducing the incidence of infant mortality. These targeted funds will be used in part to develop and coordinate referral arrangements between migrant and community health centers and entities for the health management of infants and pregnant children.

Title I of the bill amends sections 329 and 330 to include patient case management services in the list of services that they provide to the populations they serve. In addition, the bill amends the authorities of both sections 329 and 330 to permit the use of grant funds for expansion of existing buildings and construction of new buildings in addition to acquisition and modernization of existing buildings, which is permitted under current authority. The bill also amends the way in which the amount of the grant to a migrant or community health center is determined, and reward efficient management by allowing centers to retain fees, premiums, and third party reimbursements that are greater than the amount projected at the beginning of the year. The bill also authorizes procedures for termination of grants and denial of application for grants under the migrant and community health centers programs.

TITLE II—HEALTH SERVICES FOR THE HOMELESS

Title II of the bill extends through FY 1991 the authority in section 340 of the PHS Act for grants for health services for the homeless authorized in P.L. 100-77, the Stewart B. McKinney Homeless Assistance Act of 1987. The bill authorizes an increase in the required matching funds for grants under this authority and modifies the provision for eligibility for a waiver from the matching fund requirements. The bill also amends the authority to permit grantees to continue to provide health services for 12 months to a homeless individual who has become a resident in permanent housing.

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

Title III of the bill extends for 3 years the authority in section 318 of the PHS Act for projects and programs for the prevention and control of sexually transmitted diseases. The authority is also amended to include grants for the prevention and control of, and grants for research and other projects, programs, and activities relating to chlamydia.

II. Background and Need for Legislation

COMMUNITY HEALTH CENTERS AND MIGRANT HEALTH CENTERS

The Community Health Centers (CHC) and Migrant Health Centers (MHC) programs are the principal Federal health service delivery program for medically underserved areas of the country and medically underserved populations. The CHC program as authorized under section 330 of the PHS Act was established in 1975 by Public Law 94-63. The legislation grew out of earlier initiatives for funding neighborhood health centers and family health centers. Currently, the authority under section 330 authorizes the Secretary of Health and Human Services to award grants for projects to provide the primary health care services to medically underserved populations. The authority defines a medically underserved populations as an urban or rural area or population group designated by the Secretary as having a shortage of personal health services. In designating a medically underserved area, the Secretary takes into consideration the following factors:

(1) Available health resources in relation to the size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to the area's population;

(2) Health indices for the population of the area, such as infant mortality rates;

(3) Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level; and

(4) Demographic factors affecting the population's need and demand for health services, such as percentage of population age 65 and over.

The Migrant Health Centers program supports primary health services as well as certain supplemental and environmental health services for migratory and seasonal agricultural workers and their families. A migratory agricultural worker is one whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes a temporary abode for the purposes of such employment. A seasonal agricultural worker is a person whose principal employment is in agriculture on a seasonal basis but who is not a migratory worker.

The MHC program was established by the Migrant Health Act of 1962, Public Law 87-692, and authorized in its current form in 1975 by Public Law 94-63. Under the MHC authority in section 329 of the PHS Act, State and local agencies are eligible to apply for grants to establish and operate health centers for migratory and seasonal farmworkers and their families living in communities which experience influxes of migrant workers.

In FY 1988, 540 CHCs are provide primary care services to approximately 5.25 million medically underserved persons; 117 MHCs are providing care to approximately 470,000 migrants and seasonal farmworkers and their families. Of those served by CHCs and MHCs, it is estimated that 60 percent are poor, 58 percent lack any form of health insurance, over one-third are children under the age of 14, and over one-third are women of child bearing age.

Both the CHC and MHC programs make a significant contribution in the fight to reduce infant deaths in the United States. While the United States has continued to make strides in reducing infant mortality, there has been a recognized decline in the rate of progress in recent years. The United States now ranks 17th in the world in its infant mortality rate. Over 40,000 of the 3.76 million children who were born in the United States in 1985 died before

veillance systems, referral services, prevention messages to persons at risk, clinical skills training, and other related activities.

III. Text of the Bill as Reported

A bill to amend title III of the Public Health Service Act to revise and extend the programs of assistance for primary health care, the program of health services for the homeless, and the program for the prevention and control of sexually transmitted diseases, and for other purposes

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the "Family Health Services Amendments Act of 1988".

(b) Table of Contents.—The table of contents is as follows:

SEC. 2. REFERENCES TO THE PUBLIC HEALTH SERVICE ACT.

Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201n et seq.).

TITLE I—PRIMARY HEALTH CENTERS

SEC. 101. MIGRANT HEALTH CENTERS.

(a) Definition.—Section 329(a)(1) (42 U.S.C. 254b(a)(1)) is amended—

(1) in subparagraph (F), by striking out "and";

(2) in subparagraph (G), by adding "and" after the comma at the end thereof; and

(3) by adding at the end thereof the following new subparagraph:

"(H) patient case management services (including outreach, counseling, referral, and follow-up),"

(b) High Impact Area Definition.—Section 329(a)(5) (42 U.S.C. 254b(a)(5)) is amended by adding at the end thereof the following

new sentence: "The Secretary may not remove a project or program's 'high impact area' designation unless and until the project or program is afforded reasonable notice and an opportunity to provide data and information in support of continuing such designation.".

(c) Supplemental Health Services Definition.—Section 329(a)(7) (42 U.S.C. 254b(a)(7)) is amended—

(1) in subparagraph (K), by striking out "and";

(2) in subparagraph (L), by striking out the period at the end thereof and inserting in lieu thereof "; and"; and

(3) by adding at the end thereof the following new subparagraph:

"(M) other services appropriate to meet the health needs of the service area population.".

(d) Grants for Expansion and Construction.—The second sentence of section 329(c)(1)(A) (42 U.S.C. 254b(c)(1)(A)) is amended by striking out "acquisition and modernization of existing buildings" and inserting in lieu thereof "acquisition, expansion, and modernization of existing buildings, and construction of new facilities".

(e) Costs of Operation.—Section 329(d)(2) (42 U.S.C. 254b(d)(2)) is amended by striking out "acquiring and modernizing existing buildings" and inserting in lieu thereof "acquiring, expanding, and modernizing existing buildings, and construction of new facilities".

(f) Amount of Grants for Costs of Operation.—Section 329(d)(4) (42 U.S.C. 254b(d)(4)) is amended—

(1) by striking out subparagraph (A) and inserting in lieu thereof the following new subparagraph:

"(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 the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), 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 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."; and

(2) in subparagraph (B)—

(A) by striking out "clauses (i) and (ii) of" in clause (i); and

(B) by striking out "may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center" in the matter immediately following clause (ii), and inserting in lieu thereof "shall be entitled to retain

(2) in subparagraph (B)—

(A) by striking out "clauses (i) and (ii) of" in clause (i); and

(B) by striking out "may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center" in the matter immediately following clause (ii), and inserting in lieu thereof "shall be entitled to retain the additional amount of fees, premiums, and third party reimbursements as the center will use".

(g) APPLICATION.—Section 330(e)(3)(F)(i) (42 U.S.C. 254c(e)(3)(F)(i)) is amended by inserting "which is consistent with locally prevailing rates or charges and which is" after "of its services".

(h) AUTHORIZATION OF APPROPRIATIONS.—Section 330(g) (42 U.S.C. 254c(g)) is amended—

(1) by striking out paragraph (1) and inserting in lieu thereof the following new paragraph:

"(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $500,000,000 for fiscal year 1989, and such sums as may be necessary in each of the fiscal years 1990 and 1991."; and

(2) by adding at the end thereof the following new paragraphs:

"(4)(A) In any case in which the amounts appropriated under paragraph (1) exceed $435,000,000 for fiscal year 1989, $465,000,000 for fiscal year 1990, or $495,000,000 for fiscal year 1991, the Secretary shall make the total amount of such excess available for grants to community health centers for—

"(i) the provision of services for the reduction of the incidence of infany mortality; and

"(ii) the development and coordination of referral arrangements between community health centers and entities for the medical management of infants and pregnant women.

"(B) In making grants described in subparagraph (A) from amounts made available pursuant to such subparagraph, 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.

"(5) The Secretary shall prescribe procedures to assure that—

"(A) Grants under subsection (d) of this section to a center or project shall not be terminated in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record; and

"(B) No application for a grant under subsection (d) of this section from a center or project that received such a grant in the prior year shall be denied in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.".

SEC. 103. REQUIREMENT WITH RESPECT TO FRONTIER AREAS.

Section 330 (42 U.S.C. 254c) is amended by adding at the end thereof the following new subsection:

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

SEC. 104. ADMINISTRATION OF PROGRAMS.

Subpart I of part D of title III (42 U.S.C. 254B et seq.) is amended by adding at the end thereof the following new section:

"SEC. 330A. ADMINISTRATION OF PROGRAMS.

"The Secretary may delegate the authority to administer the programs authorized under section 329 and section 330 to any office within the Public Health 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.".

TITLE II—HEALTH SERVICES FOR THE HOMELESS

SEC. 201. INCREASE IN REQUIRED AMOUNT OF MATCHING FUNDS AND MODIFICATION IN ELIGIBLE FOR WAIVER WITH RESPECT TO MATCHING FUNDS.

(a) INCREASE IN REQUIRED AMOUNT.—Section 340(e)(1)(A)(ii) (42 U.S.C. 256(e)(1)(A)(ii)) is amended by striking out "Federal funds provided in such grant" and inserting in lieu thereof the following: "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 $3 of Federal funds provided for any subsequent fiscal year of payments under the grant".

(b) EFFECTIVE DATE FOR INCREASE.—The amendments made by subsection (a) shall take effect October 1, 1989.

(c) MODIFICATION IN ELIGIBILITY FOR WAIVER.—Section 340(e)(2) (42 U.S.C. 256(e)(2)) is amended to read as follows:

"(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.".

SEC. 202. TEMPORARY CONTINUED PROVISION OF SERVICES TO CERTAIN FORMER HOMELESS INDIVIDUALS.

(a) IN GENERAL.—Section 340 (42 U.S.C. 256) is amended—

(1) by redesignating subsections (h) through (q) as subsections (i) through (r), respectively; and

(2) by adding after subsection (g) the following new subsection:

(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.".

(b) CONFORMING AMENDMENTS.—

(1) Section 340(d)(1) (42 U.S.C. 256(d)(1)) is amended—

1950 and 1985, the U.S., which ranked 6th amongst 20 industralized nations in infant mortality, fell to a tie for last place. In 1985, the U.S. ranked 19th overall in the world in infant mortality. When only white births are considered the nation placed 14th, behind Hong Kong and Singapore. When black rates are considered the nation ranked 28th behind Cuba, Czechoslovakia and Hungary and tied with Costa Rica.

The Committee is committed to aggressive action to meet the Surgeon General's 1990 maternal and child health objectives. Most notably, those objectives relating to prenatal care improvements, reductions in low birthweight, mortality reduction for minority infants and overall postneonatal mortality reductions are of great concern. The Committee recognizes that action is necessary to reduce the thousands of unnecessary low birthweight births and hundreds of preventable infant deaths.

Community and Migrant Health Centers have long played a pivotal role in the nation's effort to reduce infant mortality. Located in medically underserved areas suffering a high incidence of poverty and infant mortality, studies show that health centers have had a significant impact on their communities' infant mortality rates. The comprehensive services which health centers offer, and their ability to gain needed hospital access for high risk women and infants, contributed heavily to the 50 percent reduction in infant mortality which occurred between 1965 and 1980.

The need for strong health center maternal and infant health programs has never been greater. In 1985, 14.5 million women of childbearing age were uninsured for maternity care, and two-thirds of these (9.6 million) were completed uninsured. More than 11 million children were uninsured. One in every five babies born in 1985 was completely uninsured. Between two-thirds and three-quarters of all uninsured women and children have family incomes below 200 percent of the federal poverty level and thus are unable to pay directly for even basic health care.

Moreover, the problem appears to be growing worse. Census data show that between 1985 and 1986, the number of uninsured Americans grew from 35 million to 37 million—a nearly six percent increases. Despite the largest peacetime recovery in U.S. history, the number of uninsured Americans continues to grow.

In 1986, Community and Migrant Health Centers provided maternity care to 120,000 pregnant women and pediatric care to at least as many infants. However, the OTA found that despite extraordinary growth in the number of low income and uninsured women and children during the 1980s, health center funds in real dollar terms declined by one-third between 1980 and 1984 alone. Since 1984, real dollar declines have grown further. These real dollar declines mean that at the very time when health center services have been needed most, their ability to respond to this need has been severely reduced.

In 1987, the Committee and the Senate approved legislation (S. 1441) to increase the programs' fiscal year 1988 authorization levels to provide for the immediate expansion of services to high risk women and children in order to reduce infant mortality. Although that legislation has not yet been enacted, the Committee is pleased to note that the Congress, in its fiscal year 1988 appropriations, did

provide funds for this new initiative. The Committee bill would continue and expand this special infant mortality effort over the next three years.

The purpose of this effort is to contribute directly to the reduction of perinatal mortality/morbidity rates, improve pregnancy outcomes and enable underserved areas to reach the Surgeon General's 1990 infant health goals by:

Improving pregnant women's and children's access to needed health services;

Enhancing the ability of C/MHCs to provide comprehensive case-managed perinatal ambulatory care services;

Enriching the services of C/MHCs through addition of staff for outreach, health care, nutrition education, and the like;

Development, or expansion, of service delivery systems for women and infants, including contractual arrangements with community obstetricians to serve patients at health centers that do not have their own obstetrical staff, and formal referral arrangements with local hospitals and with regional medical centers furnishing level II or III perinatal services; and

Better coordination of services between C/MHCs and other local public and private providers of medical, health and health-related services.

Under the provisions of the bill, the fiscal year 1989 appropriations for CHCs that exceed $435 million, and the appropriations for Migrant Health that exceed $47.4 million, would be used for special grants to enhance the ability of the C/MHC programs to reach and serve high risk pregnant women, infants and children, through a combination of:

Development of new service delivery systems in identified communities where no C/MHC services now exist, to include perinatal care as part of the scope of services;

Expansion of service delivery capacity in existing C/MHCs, to provide delivery of services through expanded or additional sites in identified communities where current services are insufficient to meet needs;

Enhancement of current primary and supplemental services at existing C/MHCs to improve quality and scope of care provided to pregnant women, infants and children; or

Better coordination with other statewide services in order to enhance perinatal and pediatric delivery systems.

The Committee believes that using these funds to establish new centers or expand existing centers (through the addition of new service sites or new personnel, or both) will improve the availability of comprehensive, high quality maternal and infant care. In many high risk areas of the country, pregnant women are unable to find accessible and affordable prenatal care. Following birth, basic care for an infant's health needs (particularly in the case of high risk infants) may be equally difficult to locate. The Committee has special concern about areas of the country and States where infant mortality remains unusually high and where no community services are available. Southern States, border States along the U.S.-Mexico border, and frontier areas are identified by the Committee as areas meriting special attention for establishment of new facilities to improve access to care.

Because of the importance of this activity, the Committee expects the Secretary to evaluate the effect of these new efforts, although they should not be subject to formal demonstration evaluation procedures. In order to evaluate the success of these efforts in reducing the incidence of infant mortality, the Committee believes that the following data should be collected; (1) the number of women and infants served; (2) in the case of pregnant women, the trimester of initiation of prenatal care; and (3) the conditions disclosed among pregnant women and infants served. This information should be reported to the Secretary annually, in conjunction with other reports already required of CHC and MH grantees. The Secretary shall aggregate and analyze the information provided, and issue a public report describing the analysis and findings.

B. CHANGES IN BASIC STATUTORY PROVISIONS

1. Health Center Services

The Committee bill would establish, as a new primary (required) health service at C/MHCs, Patient Case Management Services (including outreach, counseling, referral, and followup). The Committee is aware that these services—which were once an integral part of a typical health center's service package—are today offered by fewer than one-third of all C/MHCs. In most cases, these services were either reduced or eliminated due to funding constraints. The Committee wishes to note that these very services have been cited by numerous independent experts—most recently the Institute of Medicine in its report on *Preventing Low Birthweight*—as being particularly important in serving high-risk, hard-to-reach populations, such as pregnant women, children, the elderly, AIDS patients, migrant farmworkers and new immigrants.

The Committee wishes to stipulate, however, that it does not intend to require that federal support be shifted away from direct medical and health services in order to support these added services. The Committee recognizes that these medical and health services have been critical to the medical management of their patients, especially those persons who are at high-risk. Rather, it is the Committee's desire that, as additional funds are made available for these programs through future appropriations, priority should be given to the development or restoration of the patient case management services at existing health centers.

The Committee also recognizes that C/MHCs must have the ability to tailor their services to the unique health needs of their patients and local communities. The Committee bill would accomplish this by adding "other appropriate health services" to the current list of supplemental (optional) services. This provision would give C/MHCs, the flexibility to respond to the changing social and epidemiological characteristics of their patient populations. For example, the current list of primary and supplemental services does not mention such services as substance abuse, services to the elderly (such as adult day care, respite care, or hospice care), or referral to medical specialty services, such as neurology and oncology. Addition of this provision to the statutory language would remedy this problem.

Under current law, C/MHCs are encouraged to apply for and provide certain "priority" supplemental (optional) services, including home health, dental, public health, health education and environmental health services. The Committee believes that, while the intent of the provision is appropriate, the current list of "priority" supplemental health services is too limited. For example, while some communities may need home health or dental services, others may need vision care or mental health services. The Committee bill would remedy this problem by eliminating the current limitation, and extending application of the provision to all supplemental health services.

2. Designation of Areas Eligible for Assistance

The bill would prohibit the removal of a Migrant Health-funded project or program's "high impact area" designation until the project or program has a reasonable opportunity to respond with data and information supporting the continuation of the designation. The Committee has two reasons for adding this requirement. First, inasmuch as the high impact area designation affords programs and projects a key priority for funding under this program, principles of fairness warrant the provision of some procedural protections before eliminating any program or project's designation. Second, the Committee feels it imperative to insure that any decision by the Secretary to remove a designation is fully informed. The Committee believes that a program or project often may have access to data and information regarding the population it serves which is more accurate or more comprehensive than what is available to the Secretary through other channels.

Since 1976, eligibility for Community Health Center grants has been restricted to entities serving designated medically underserved areas with high rates of poverty, health manpower shortages, and poor health indicators (especially high infant mortality). Designation is accomplished through comparison of an area's statistical data against established criteria, with priority for grant support accorded to those areas showing greatest need. Because changes in these criteria can critically affect a health center's funding priority, not to mention its fundamental eligibility, the Committee finds it appropriate to have the Secretary comply with the notice and comment requirements of the Administrative Procedure Act in connection with any proposed changes to the criteria.

3. Use of Grant Funds for Expansion and Construction

It has come to the Committee's attention that the Department's interpretation of current law authorizing funding for acquisition and modernization of existing buildings has been very narrow, resulting in a refusal to support (even minimally) critically needed expansion projects. Under this interpretation, facility renovations which do not modify the exterior walls of a facility currently used by a health center are fully acceptable, while *any* change to an exterior wall (for example, to add a wing with medical examining rooms or a small storage area, or an additional floor, to an existing facility) are wholly unacceptable. Thus, health centers that have experienced regular growth in patients or have added services are often faced with the Hobbesian choice of remaining in an inad-

than fiscal reasons. Thus, it seems appropriate for a programmatic official to be the one who makes the final decision.

The Committee does not expect the HRSA Administrator actually to preside at hearings. Rather, the Committee expects that the Administrator will delegate this responsibility to an impartial official and generally oversee the results either by treating the official's decision as a "recommendation" or by allowing the decision to become final after he has reviewed it.

The Committee wishes to provide the Secretary with the latitude to make less than substantial funding reductions to meet needs that arise in other locations. Accordingly, the Committee intends that the Secretary should be permitted to reduce current funding levels by as much as ten percent without triggering an applicant's right to a hearing (as long as the reduction in any several-year period does not exceed fifteen percent). The funding level against which funding denials are to be measured should not include special one-time awards or reductions occasioned solely as a consequence of cuts in available appropriations.

6. Administration of Health Center Programs

The Committee is concerned by persistent reports of serious inconsistencies in important policy interpretations by various HHS regional offices, of unexplained funding reductions, of cash flow crises occasioned by grant award delays of several weeks or even months, and so on. In an effort to bring uniformity, equity and greater accountability in Federal oversight of this program, the Committee has determined that the Secretary's authority to enter into, modify, or issue health center grants should be delegated to the central office within the Health Resources and Services Administration. The Committee hopes that centralized administration will ensure consistent and even-handed implementation of policy and priorities across the various HHS regions. Although the basic monitoring functions of HHS regional offices would remain intact, the Committee expects all final decisions to be centrally made.

7. Other Committee Concerns

The Committee recognizes the wisdom of current law provisions which require that Community and Migrant Health Centers be governed by a policy board composed of representatives of the community, at least 51 percent of whom are users of the center's services. These policy boards are required, by Federal mandate, to provide policy leadership and guidance to the health center's management and clinical staff, and to monitor and evaluate all elements of the center's performance. Federal managers should respect the role and responsibilities of these governing boards, as well as the need for continuity in board membership to assure appropriate policy oversight, and should provide them with the necessary guidance, technical assistance, and training to assist them in fulfilling their responsibilities.

The Committee is also aware of existing difficulties for the governing boards of many Migrant Health Centers (Section 329) in meeting the current regulatory requirement for regular board meetings, particularly when their migrant farmworker board members have left the area to follow the agricultural harvest and

cannot attend meetings. To remedy this situation, the Committee recommends that health centers endeavor to have a good mix of both migrant farmworkers who can participate in the board during the harvest season, and seasonal farmworkers, who are generally year-round residents of the local community.

The Committee is aware that, with the enactment of the Immigration Reform and Control Act of 1986 (IRCA), newly legalized immigrants and special agricultural workers (SAWs) will likely become eligible for the services of C/MHCs. The Committee believes that Community and Migrant Health Centers across the country have an important role to play in the implementation of the Immigration Reform and Control Act. Many health centers have already been designated as "civil surgeons", to provide the medical examinations necessary for persons seeking legalization. Subsequently, health centers will serve as an entry point for new immigrants into an established system of managed care. The Committee, therefore, recommends that grant funds be made available, on a reasonable basis, to serve these new populations. It also strongly encourages Community and Migrant Health Centers to access the funds provided by IRCA through the State Legalization Impact Assistance Grants (SLIAG) program. These funds are allocated to state governments to reimburse costs incurred in providing public assistance, public health assistance, and educational assistance to legalized aliens. The Committee believes that states should recognize the C/MHCs as preferred providers in distributing SLIAG funds, especially in rural or urban areas where no other providers exist.

8. Frontier Areas

In recent years, as the public policy debate on the problems of financing and delivering health care services in rural areas has unfolded, the Committee has become aware of the special problems inherent in attempting to develop and operate health care delivery systems in the most sparsely populated rural areas of America. Borrowing from a DHHS-funded Task Force, the Committee has used the term "frontier" to describe these areas, which are defined as those with a population density of no more than six persons per square mile, spread over a broad geographical area (generally an entire county or multiple counties, although a sub-county area or adjoining parts of two or more counties would also fit this definition).

According to the 1980 U.S. Census, there were at least 382 counties, with a population of nearly 2.9 million persons, which would meet the above definition. These areas are principally found in 20 Western states, and encompass 45 percent of the U.S. land area.

In addition to having sparse populations, these areas tend to be geographically isolated, have a fragile economic base and offer limited health services. The geographic isolation and population sparcity of such areas militate against traditional approaches to development and efficient operation of ambulatory health care delivery systems. The small size of such systems results in inherent cost inefficiencies, decreased productivity of clinical providers, difficulty in arranging referrals, and difficulties in recruiting and retaining high quality clinical and management personnel.

projects can continue to target their services on the currently homeless.

The Committee wishes to clarify that the definition of homelessness contained in Section 340 (as amended) is the operative definition to be used in determining an individuals eligibility to receive services under this program. Individuals or families who lack housing or who reside in transitional housing pending location of more stable and permanent homes are considered eligible for health services under the definition provided in this legislation. Furthermore, while the Committee clearly intends that the "obviously" homeless such as those living on the streets and heating vents, in cars and abandoned buildings and in temporary shelters, are eligible to receive health services under Section 340, the Committee also recognizes that individuals and families who take temporary refuge with neighbors or friends due to inability to secure housing and who are seeking stable housing may also be considered homeless. This frequently may be the case in rural areas, for example, where there are no public or private emergency shelter facilities. Families or individuals, on the other hand, who share housing arrangements on a more or less stable and permanent basis, even in overcrowded conditions, generally are not considered homeless, although they may be inadequately housed. Section 340 projects are expected to make reasonable and justifiable judgments on a case-by-case basis as to whether the less obvious homeless are eligible for the program's services within the spirit and intent of the legislation. Furthermore, the Committee wishes to clarify that Section 340 is an outreach-oriented program intended to provide access to health care for homeless persons. It is understood that in the course of successful outreach in substantially homeless settings, such as soup kitchens, services occasionally will be provided to persons, who, though probably indigent, have housing of some sort. Such occasional service is considered incidental to the outreach-oriented nature of this program and should not be a matter of concern.

3. Clarification of Project Services

The Section 340 Health Services Program includes Primary Care and Substance Abuse services and optional provision of Mental Health Services. It should be noted that while the legislation indicates that "Primary Care Services" has the meaning given in Section 330(b)(1) of the Public Health Service Act, the Committee recognizes that this definition originally was developed for providers of health care for medically underserved populations rather than specifically for the homeless. Therefore, the Committee wishes to clarify that certain supplemental health services appropriate for and urgently needed by many homeless people but not specifically included in Section 330(b)(1) may also be provided with Section 340 support, including podiatry services, dental services (including dentures if necessary), and vision services. These supplemental services are optional, and should be provided where appropriate for patients' needs, subject to the availability of funds.

4. Authorization Levels

The Committee has provided an authorization of appropriations for this program at levels necessary to sustain currently-funded projects, to assist in continuing the services of the RWJ/PEW Memorial Trust-funded demonstration projects upon termination of foundation support later this year, and to enable development of services in a limited number of communities with homeless populations that did not receive funding in the first round. The Committee is aware that smaller cities and rural communities were initially discouraged from applying for support during the first round of funding, and that some larger cities did not apply for funding because of the short time frame provided for application. Developing coalitions and consortia that may transcend county lines, for example, can require considerable more time than the six-week period available to prepare applications in the first funding cycle. For example, approximately 40 cities with populations above 100,000 did not receive any support in the first round. Furthermore, to the extent possible, the Committee wishes to urge the Department to establish normal grant cycles that ensure adequate and stable funding throughout the winter months when homelessness presents the greatest threat to life and safety.

TITLE III—PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES

The Committee recognizes that in the recent past, a greater percentage of resources in these programs have been, necessarily, expended on the AIDS epidemic. Unfortunately this has occurred at a time when the less well known but serious, and until recently difficult to diagnose, infection by Chlamydia has become an alarming problem. The Committee therefore authorizes $100,000,000 for fiscal year 1988 and such sums as necessary for 1989 and 1990. Language has been included specifically directing that programs for Chlamydia control, prevention and research be developed. It is the Committee's intent that a substantial part of the increase in the appropriation compared to last year be directed toward Chlamydia programs which are now possible because of the development of a relatively inexpensive diagnostic test for Chlamydia. The Committee also recognizes the need to increase the number of health professionals trained in the area of Sexually Transmitted Diseases and encourages expansion of the intramural and extramural CDC supported training programs.

V. Committee Action

The bill was considered before the Committee on March 2, 1988, and reported favorably without amendment by unanimous vote.

Section 101(b) of the bill amends the definition of the term "high impact area" in section 329(a)(5) of the Act to provide that the Secretary may not remove a project or program's 'high impact area' designation unless and until the project or program is afforded reasonable notice and an opportunity to provide data and information in support of continuing such designation.

Section 101(c) of the bill amends the definition of the term "supplemental health services" in section 329(a)(7) of the Act to include in that definition "other services appropriate to meet the health needs of the service are population."

Section 101(d) of the bill amends section 329(c)(1) of the Act authorizing the use of migrant health center project grants for expansion of existing buildings and construction of new facilities.

Section 101(e) of the bill amends section 329(d)(2) of the Act to provide that the costs of operation of a migrant health center for which a grant may be made shall include the cost of expanding existing buildings and construction of new facilities.

Section 101(f) of the bill amends section 329(d)(4)(A) of the Act, which provides for the determination of the amount of a migrant health center grant. Under the bill, the amount of the grant may not exceed the amount by which the costs of operation of a center for a fiscal year exceeds the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive in the year.

Section 101(f) of the bill also amends section 329(d)(4)(B) of the Act, which provides for centers to retain one-half of any excess in money collected from patient fees, premiums, and third party reimbursement over the amount projected at the beginning of the year. These monies may be used by the center to expand and improve its services, increase the number of persons served, construct and modernize its facilities, improve its administration, and establish the financial reserve required to furnish services on a prepaid basis. Under this bill, a center shall be entitled to retain the entire additional amount of fees, premiums, and other third party reimbursements as the center will use to expand and improve services, increase number of persons served, construct and modernize facilities, improve administration, and establish required financial reserve.

Section 101(g) of the bill amends section 329(f)(3)(i) of the Act, which requires a migrant health center to prepare a schedule of fees and payments for the provision of its services. The amendment in this bill requires this schedule to be consistent with locally prevailing rates or charges.

Section 101(h) of the bill amends section 329(h) of the Act, which authorizes appropriations for the migrant health centers program. This provision authorizes appropriations for section 329 of $52.4 million in FY 1989 and such sums as are necessary in each of FY 1990 and FY 1991. Anything appropriated over $47.4 million for FY 1989, $51.4 million for FY 1990, or $55 million for FY 1991, must be made available for grants to migrant health centers for the provision of services for the reduction of the incidence of infant mortality, and the development and coordination of referral arrangements between migrant health centers and entities for the health management of infants and pregnant women. In making such grants, 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.

Section 101(h) of the bill also amends section 329(h) of the Act to provide for procedures to terminate grants under this authority for migrant health center operating costs. These grants cannot be terminated unless there is cause and the program or project has first been given reasonable notice and opportunity for a hearing on the record. In addition, no grant application from a program or project that received a grant in the previous year may be denied without cause and unless the program or project has first been given reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration (HRSA).

Community Health Centers

Section 102 of the bill amends section 330 of the PHS, which provides the authority for the Community Health Centers program. Section 102(a) of the bill amends the definition of the term "community health center" to include in the list of services such a center provides, "patient case management services (including outreach, counseling, referral, and follow-up)."

Section 102(b) of the bill amends the definition of the term "supplemental health services" to include in that definition "other services appropriate to meet the health needs of the service area population."

Section 102(c) of the bill amends section 330(b) of the Act to prohibit the Secretary from changing the criteria established to determine the specific shortages of personal health services of an area or population group unless public notice and an opportunity for comment on proposed changes in accordance with section 553 of title 5, United States Code been offered.

Section 102(d) of the bill amends section 330(c) of the Act to authorize the use of community health center grants to expand existing buildings and construct new facilities.

Section 102(e) of the bill amends section 330(d)(2) of the Act to provide that grants made for community health center operating costs can be used for the costs of expanding existing buildings and construction of new facilities.

Section 102(f) of the bill amends section 330(d)(4)(A) of the Act, which provides for the determination of the amount of a community health center grant. Under the bill, the amount of the grant may not exceed the amount by which costs of operation in a fiscal year exceed the total of the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), which the center may reasonably be expected to receive in the year.

Section 102(f) also amends section 330(d)(4)(B) of the Act, which provides for centers to retain one-half of any excess in money collected from patient fees, premiums, and third party reimbursement over the amount projected at the beginning of the year. These

PUBLIC HEALTH SERVICE ACT

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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PART B—FEDERAL-STATE COOPERATION

PROJECTS AND PROGRAMS FOR THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED DISEASES AND ACQUIRED IMMUNE DEFICIENCY SYNDROME

SEC. 318. (a)-(d) * * *

(e)[(1) For the purpose of making grants under subsections (b), (c), and (d) there are authorized to be appropriated $45,000,000 for the fiscal year ending September 30, 1979, $51,500,000 for the fiscal year ending September 30, 1980, $59,000,000 for the fiscal year ending September 30, 1981, $40,000,000 for the fiscal year ending September 30, 1982, $46,500,000 for the fiscal year ending September 30, 1983, $50,000,000 for the fiscal year ending September 30, 1984, $57,000,000 for the fiscal year ending September 30, 1985, $62,500,000 for the fiscal year ending September 30, 1986, and $68,000,000 for the fiscal year ending September 30, 1987. For grants under subsection (b) in any fiscal year, the Secretary shall obligate not less than 10 per centum of the amount appropriated for such fiscal year under the preceding sentence. Grants made under subsection (b), (c), or (d) of this section shall be made on such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary. If the appropriations under the first sentence for fiscal year 1985 exceed $50,000,000, one-half of the amount in excess of $50,000,000 shall be made available for grants under subsection (d); if the appropriations under the first sentence for fiscal year 1986 exceed $52,500,000, one-half of the amount in excess of $52,500,000 shall be made available for such grants; and if the appropriations under the first sentence for fiscal year 1987 exceed $55,000,000, one-half of the amount in excess of $55,000,000 shall be made available for such grants.]

(1)(A) For grants under subsections (b), (c), and (d), there are authorized to be appropriated $100,000,000 for fiscal year 1988 and such sums as may be necessary for each of the fiscal years 1989 and 1990.

(B) For grants under subsection (b) for any fiscal year, the Secretary shall obligate not less than 10 percent of the total amount appropriated for such fiscal year under subparagraph (A).

(C) Grants made under subsection (b), (c), or (d) shall be made under such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance by way of reimbursement and in such installments as the Secretary finds necessary.

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(h) Grants under subsections (b) and (c) shall include grants for the prevention and control of, and grants for research and other projects, and programs, and activities relating to, chlamydia.

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PART D—PRIMARY HEALTH CARE

Subpart I—Primary Health Centers

MIGRANT HEALTH

SEC. 329. (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, [and]

(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),

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.

[(i) the State, local, and other funds, 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.]

(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 the fees, premiums, and third party reimbursements (as well as State, local, and other operational funding), 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 request 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 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; and

(B) Payments under grants under subparagraph (A) or 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 [may retain such an amount (equal to not less than one-half of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable 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 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.

* * * * * * * *

(f) (1)–(2) * * *

(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 submitted 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 *which is consistent with locally prevailing rates or charges and which is* designed to cover its reasonable costs of operation and 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,

(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) services which promote and facilitate optimal use of primary health services and the services referred to in the preceding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a community health 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*
(N) other services appropriate to meet the health needs of the service area population.

(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.

(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 helth 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 States recommended the designation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services.

(7) The Secretary may not change the criteria established under paragraph (4) without affording public notice and an opportunity for comment on any such proposed changes in accordance with section 553 of title 5, United States Code.

(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 and modernization of existing buildings] *acquisition, expansion, and modernization of existing buildings, and construction of new facilities* (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 government 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 perpaid 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

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 for fees or payments for the provision of its services *which is consistent with locally prevailing rates or charges and which is* designed to cover its reasonable costs of operation and 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;

* * * * * * *

(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) There are authorized to be appropriated for payments pursuant to grants under this section $400,000,000 for fiscal year 1987 and $400,000,000 for fiscal year 1988.]

(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $500,000,000 for fiscal year 1989, and such sums as may be necessary in each of the fiscal years 1990 and 1991.

(2) The Secretary may not in any fiscal year—

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

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

(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.

(4)(A) In any case in which the amounts appropriated under paragraph (1) exceed $435,000,000 for fiscal year 1989, $465,000,000 for fiscal year 1990, or $495,000,000 for fiscal year 1990, the Secretary shall make the total amount of such excess available for grants to community health ceters for—

(i) the provision of services for the reduction of the incidence of infant mortality; and

(ii) the development and coordination of referral arrangements between community health centejrs and entities for the medical management of infants and pregnant women.

(B) In making grants described in supbparagraph (A) from amounts made available pursuant to such subparagraph, 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.

(5) The Secretary shall prescribe procedures to assure that—

(A) Grants under subsection (d) of this section to a center or project shall not be terminated in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record; and

(B) No application for a grant under subsection (d) of this section from a center or project that received such a grant in the prior year shall be denied in whole or in part unless there is cause and the center or project has first been afforded reasonable notice and opportunity for a hearing on the record before the Administrator of the Health Resources and Services Administration.

(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 ceters; and

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