(1) enter into agreements or arrangements with schools of medicine, schools of osteopathic medicine, and with other health professions schools, agencies, or institutions, for such interchange or cooperative use of facilities and services on a reciprocal or reimbursable basis, as will be of benefit to the training or research programs of the participating agencies; and

(2) enter into agreements or arrangements with hospitals and other health care facilities for the mutual use or the exchange of use of specialized health resources, and providing for reciprocal reimbursement.

Any reimbursement pursuant to any such agreement or arrangement shall be based on charges covering the reasonable cost of such utilization, including normal depreciation and amortization costs of equipment. Any proceeds to the Government under this subsection shall be credited to the applicable appropriation of the Public Health Service for the year in which such proceeds are received.

(July 1, 1944, ch. 373, title III, § 327A, formerly § 328, as added Pub. L. 90–174, § 7, Dec. 5, 1967, 81 Stat. 539; renumbered § 327A, Pub. L. 95–626, title I, § 113(a)(2), Nov. 10, 1978, 92 Stat. 3562; amended Pub. L. 100–607, title VI, § 629(a)(1), Nov. 4, 1988, 102 Stat. 3146.)

AMENDMENTS

1988—Subsec. (b)(1). Pub. L. 100–607 inserted ''schools of osteopathic medicine,'' after ''schools of medicine,'' and ''professions'' after ''health''.

AVAILABILITY OF APPROPRIATIONS FOR EXPENSES OF SHARING MEDICAL CARE FACILITIES AND RESOURCES

Pub. L. 102–394, title II, § 204, Oct. 6, 1992, 106 Stat. 1811, provided that: ''Funds advanced to the National Institutes of Health Management Fund from appropriations in this Act or subsequent Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Acts shall be available for the expenses of sharing medical care facilities and resources pursuant to section 327A of the Public Health Service Act [42 U.S.C. 254a].''

Similar provisions were contained in the following prior appropriation acts:

Pub. L. 102–170, title II, § 204, Nov. 26, 1991, 105 Stat. 1126.

Pub. L. 101–517, title II, § 204, Nov. 5, 1990, 104 Stat. 2208.

Pub. L. 101–166, title II, § 205, Nov. 21, 1989, 103 Stat. 1177.

Pub. L. 100–202, § 101(h) [title II, § 205], Dec. 22, 1987, 101 Stat. 1329–256, 1329–274.

Pub. L. 99–500, § 101(i) [H.R. 5233, title II, § 205], Oct. 18, 1986, 100 Stat. 1783–287, and Pub. L. 99–591, § 101(i) [H.R. 5233, title II, § 205], Oct. 30, 1986, 100 Stat. 3341–287.

Pub. L. 99–178, title II, § 205, Dec. 12, 1985, 99 Stat. 1119.

Pub. L. 98–619, title II, § 205, Nov. 8, 1984, 98 Stat. 3321.

Pub. L. 98–139, title II, § 205, Oct. 31, 1983, 97 Stat. 887.

Pub. L. 97–377, title I, § 101(e)(1) [title II, § 205], Dec. 21, 1982, 96 Stat. 1878, 1894.

PART D—PRIMARY HEALTH CARE

CODIFICATION

Pub. L. 95–626, title I, § 113(a)(3), Nov. 10, 1978, 92 Stat. 3562, added heading ''Part D—Primary Health Care''.

SUBPART I—HEALTH CENTERS

CODIFICATION

Pub. L. 104–299, § 2, Oct. 11, 1996, 110 Stat. 3626, substituted ''Health Centers'' for ''Primary Health Centers'' in subpart heading.

Pub. L. 95–626, title I, § 113(a)(3), Nov. 10, 1978, 92 Stat. 3562, added heading ''Subpart I—Primary Health Centers''.

§ 254b. Health centers

(a) "Health center" defined

(1) In general

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

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

(B) as may be appropriate for particular centers, additional health services (as defined in subsection (b)(2)) necessary for the adequate support of the primary health services required under subparagraph (A);

for all residents of the area served by the center (hereafter referred to in this section as the ''catchment area'').

(2) Limitation

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

(b) Definitions

For purposes of this section:

(1) Required primary health services

(A) In general

The term ''required primary health services'' means—

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

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

(II) diagnostic laboratory and radiologic services;

(III) preventive health services, including—

(aa) prenatal and perinatal services;

(bb) appropriate cancer screening;

(cc) well-child services;

(dd) immunizations against vaccine-preventable diseases;

(ee) screenings for elevated blood lead levels, communicable diseases, and cholesterol;

(ff) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;

(gg) voluntary family planning services; and

(hh) preventive dental services;

(IV) emergency medical services; and

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

(ii) referrals to providers of medical services (including specialty referral when medically indicated) and other health-related services (including substance use disorder and mental health services);

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

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

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

(B) Exception

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

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

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

(2) Additional health services

The term ''additional health services'' means services that are not included as required primary health services and that are appropriate to meet the health needs of the population served by the health center involved. Such term may include—

(A) behavioral and mental health and substance use disorder services;

(B) recuperative care services;

(C) environmental health services, including—

(i) the detection and alleviation of unhealthful conditions associated with—

(I) water supply;

(II) chemical and pesticide exposures;

(III) air quality; or

(IV) exposure to lead;

(ii) sewage treatment;

(iii) solid waste disposal;

(iv) rodent and parasitic infestation;

(v) field sanitation;

(vi) housing; and

(vii) other environmental factors related to health; and

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

(i) screening for and control of infectious diseases, including parasitic diseases; and

(ii) injury prevention programs, including prevention of exposure to unsafe levels of agricultural chemicals including pesticides.

(3) Medically underserved populations

(A) In general

The term ''medically underserved population'' means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

(B) Criteria

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

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

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

(C) Limitation

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

(i) the chief executive officer of such State;

(ii) local officials in such State; and

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

(D) Permissible designation

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

(c) Planning grants

(1) Centers

The Secretary may make grants to public and nonprofit private entities for projects to plan and develop health centers which will serve medically underserved populations. A

project for which a grant may be made under this subsection may include the cost of the acquisition and lease of buildings and equipment (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 health center for which the project is undertaken has for required primary health services and additional health services;

(B) the design of a 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;

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

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

(2) Limitation

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

(3) Recognition of high poverty

(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.

(d) Improving quality of care

(1) Supplemental awards

The Secretary may award supplemental grant funds to health centers funded under this section to implement evidence-based models for increasing access to high-quality primary care services, which may include models related to—

(A) improving the delivery of care for individuals with multiple chronic conditions;

(B) workforce configuration;

(C) reducing the cost of care;

(D) enhancing care coordination;

(E) expanding the use of telehealth and technology-enabled collaborative learning and capacity building models;

(F) care integration, including integration of behavioral health, mental health, or substance use disorder services;

(G) addressing emerging public health or substance use disorder issues to meet the health needs of the population served by the health center; and

(H) improving access to recommended immunizations.

(2) Sustainability

In making supplemental awards under this subsection, the Secretary may consider whether the health center involved has submitted a plan for continuing the activities funded under this subsection after supplemental funding is expended.

(3) Special consideration

The Secretary may give special consideration to applications for supplemental funding under this subsection that seek to address significant barriers to access to care in areas with a greater shortage of health care providers and health services relative to the national average.

(e) Operating grants

(1) Authority

(A) In general

The Secretary may make grants for the costs of the operation of public and nonprofit private health centers that provide health services to medically underserved populations.

(B) Entities that fail to meet certain requirements

The Secretary may make grants, for a period of not to exceed 1 year, for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which the Secretary is unable to make each of the determinations required by subsection (k)(3). The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementation plan to meet the requirements of subsection (k)(3). The Secretary may extend such 120-day period for achieving compliance upon a demonstration of good cause by the health center.

(C) Operation of networks

The Secretary may make grants to health centers that receive assistance under this section, or at the request of the health centers, directly to a network that is at least majority controlled and, as applicable, at least majority owned by such health centers receiving assistance under this section, for the costs associated with the operation of such network including—

(i) the purchase or lease of equipment, which may include data and information systems (including the costs of amortizing the principal of, and paying the interest on, loans for equipment);

(ii) the provision of training and technical assistance; and

(iii) other activities that—

(I) reduce costs associated with the provision of health services;

(II) improve access to, and availability of, health services provided to individuals served by the centers;

(III) enhance the quality and coordination of health services; or

(IV) improve the health status of communities.

(2) Use of funds

The costs for which a grant may be made under subparagraph (A) or (B) of paragraph (1) may include the costs of acquiring and leasing buildings and equipment (including the costs of amortizing the principal of, and paying interest on, loans), and the costs of providing training related to the provision of required primary health services and additional health services and to the management of health center programs.

(3) Construction

The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings or constructing new buildings (including the costs of amortizing the principal of, and paying the interest on, loans) for projects approved prior to October 1, 1996.

(4) Limitation

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

(5) Amount

(A) In general

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

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

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

(B) Networks

The total amount of grant funds made available for any fiscal year under paragraph (1)(C) to a health center or to a network shall be determined by the Secretary, but may not exceed 2 percent of the total amount appropriated under this section for such fiscal year.

(C) Payments

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

(D) Use of nongrant funds

Nongrant funds described in clauses (i) and (ii) of subparagraph (A), including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.

(6) New access points and expanded services

(A) Approval of new access points

(i) In general

The Secretary may approve applications for grants under subparagraph (A) or (B) of paragraph (1) to establish new delivery sites.

(ii) Special consideration

In carrying out clause (i), the Secretary may give special consideration to applicants that have demonstrated the new delivery site will be located within a sparsely populated area, or an area which has a level of unmet need that is higher relative to other applicants.

(iii) Consideration of applications

In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be expected to use the services provided by the applicants is not less than two to three or greater than three to two.

(iv) Service area overlap

If in carrying out clause (i) the applicant proposes to serve an area that is currently served by another health center funded under this section, the Secretary may consider whether the award of funding to an additional health center in the area can be justified based on the unmet need for additional services within the catchment area.

(B) Approval of expanded service applications

(i) In general

The Secretary may approve applications for grants under subparagraph (A) or (B) of paragraph (1) to expand the capacity of the applicant to provide required primary health services described in subsection (b)(1) or additional health services described in subsection (b)(2).

(ii) Priority expansion projects

In carrying out clause (i), the Secretary may give special consideration to expanded service applications that seek to address emerging public health or behavioral health, mental health, or substance abuse issues through increasing the availability of additional health services described in subsection (b)(2) in an area in which there are significant barriers to accessing care.

(iii) Consideration of applications

In carrying out clause (i), the Secretary shall approve applications for grants in such a manner that the ratio of the medically underserved populations in rural areas which may be expected to use the services provided by the applicants involved to the medically underserved populations in urban areas which may be ex-

pected to use the services provided by such applicants is not less than two to three or greater than three to two.

(f) Infant mortality grants

(1) In general

The Secretary may make grants to health centers for the purpose of assisting such centers in—

(A) providing comprehensive health care and support services for the reduction of—

(i) the incidence of infant mortality; and

(ii) morbidity among children who are less than 3 years of age; and

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

(2) Priority

In making grants under this subsection the Secretary shall give priority to health centers providing services to any medically underserved population among which there is a substantial incidence of infant mortality or among which there is a significant increase in the incidence of infant mortality.

(3) Requirements

The Secretary may make a grant under this subsection only if the health center involved agrees that—

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

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

(C) the center will provide follow-up services for individuals who are referred by the center for services described in paragraph (1);

(D) the grant will be expended to supplement, and not supplant, the expenditures of the center for primary health services (including prenatal care) with respect to the purpose described in this subsection; and

(E) the center will coordinate the provision of services with other maternal and child health providers operating in the catchment area.

(g) Migratory and seasonal agricultural workers

(1) In general

The Secretary may award grants for the purposes described in subsections (c), (e), and (f) for the planning and delivery of services to a special medically underserved population comprised of—

(A) migratory agricultural workers, seasonal agricultural workers, and members of the families of such migratory and seasonal agricultural workers who are within a designated catchment area; and

(B) individuals who have previously been migratory agricultural workers but who no longer meet the requirements of subparagraph (A) of paragraph (3) because of age or disability and members of the families of such individuals who are within such catchment area.

(2) Environmental concerns

The Secretary may enter into grants or contracts under this subsection with public and private entities to—

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

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

(3) Definitions

For purposes of this subsection:

(A) Migratory agricultural worker

The term ''migratory agricultural worker'' means an individual whose principal employment is in agriculture, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.

(B) Seasonal agricultural worker

The term ''seasonal agricultural worker'' means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

(C) Agriculture

The term ''agriculture'' means farming in all its branches, including—

(i) cultivation and tillage of the soil;

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

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

(h) Homeless population

(1) In general

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

(2) Required services

In addition to required primary health services (as defined in subsection (b)(1)), an entity

that receives a grant under this subsection shall be required to provide substance abuse services as a condition of such grant.

(3) Supplement not supplant requirement

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

(4) Temporary continued provision of services to certain former homeless individuals

If any grantee under this subsection has provided services described in this section under the grant to a homeless individual, 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.

(5) Definitions

For purposes of this section:

(A) Homeless individual

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

(B) Substance use disorder services

The term ''substance use disorder services'' includes detoxification, risk reduction, outpatient treatment, residential treatment, and rehabilitation for substance abuse provided in settings other than hospitals.

(i) Residents of public housing

(1) In general

The Secretary may award grants for the purposes described in subsections (c), (e), and (f) for the planning and delivery of services to a special medically underserved population comprised of residents of public housing (such term, for purposes of this subsection, shall have the same meaning given such term in section 1437a(b)(1) of this title) and individuals living in areas immediately accessible to such public housing.

(2) Supplement not supplant

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

(3) Consultation with residents

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

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

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

(j) Access grants

(1) In general

The Secretary may award grants to eligible health centers with a substantial number of clients with limited English speaking proficiency to provide translation, interpretation, and other such services for such clients with limited English speaking proficiency.

(2) Eligible health center

In this subsection, the term ''eligible health center'' means an entity that—

(A) is a health center as defined under subsection (a);

(B) provides health care services for clients for whom English is a second language; and

(C) has exceptional needs with respect to linguistic access or faces exceptional challenges with respect to linguistic access.

(3) Grant amount

The amount of a grant awarded to a center under this subsection shall be determined by the Administrator. Such determination of such amount shall be based on the number of clients for whom English is a second language that is served by such center, and larger grant amounts shall be awarded to centers serving larger numbers of such clients.

(4) Use of funds

An eligible health center that receives a grant under this subsection may use funds received through such grant to—

(A) provide translation, interpretation, and other such services for clients for whom English is a second language, including hiring professional translation and interpretation services; and

(B) compensate bilingual or multilingual staff for language assistance services provided by the staff for such clients.

(5) Application

An eligible health center desiring a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including—

(A) an estimate of the number of clients that the center serves for whom English is a second language;

(B) the ratio of the number of clients for whom English is a second language to the total number of clients served by the center;

(C) a description of any language assistance services that the center proposes to provide to aid clients for whom English is a second language; and

(D) a description of the exceptional needs of such center with respect to linguistic access or a description of the exceptional challenges faced by such center with respect to linguistic access.

(6) Authorization of appropriations

There are authorized to be appropriated to carry out this subsection, in addition to any

funds authorized to be appropriated or appropriated for health centers under any other subsection of this section, such sums as may be necessary for each of fiscal years 2002 through 2006.

(k) Applications

(1) Submission

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

(2) Description of unmet need

An application for a grant under subparagraph (A) or (B) of subsection (e)(1) or subsection (e)(6) for a health center shall include—

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

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

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

(D) in the case of an application for a grant pursuant to subsection (e)(6), a demonstration that the applicant has consulted with appropriate State and local government agencies, and health care providers regarding the need for the health services to be provided at the proposed delivery site.

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

(3) Requirements

Except as provided in subsection (e)(1)(B) or subsection (e)(6), the Secretary may not approve an application for a grant under subparagraph (A) or (B) of subsection (e)(1) unless the Secretary determines that the entity for which the application is submitted is a health center (within the meaning of subsection (a)) and that—

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

(B) the center has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers, including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments;

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

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

(E) the center—

(i)(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 [42 U.S.C. 1396 et seq.] 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; and

(II) has or will have a contractual or other arrangement with the State agency administering the program under title XXI of such Act (42 U.S.C. 1397aa et seq.) with respect to individuals who are State children's health insurance program beneficiaries; or

(ii) has made or will make every reasonable effort to enter into arrangements described in subclauses (I) and (II) of clause (i);

(F) 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 [42 U.S.C. 1395 et seq.], to medical assistance under a State plan approved under title XIX of such Act [42 U.S.C. 1396 et seq.], or to assistance for medical expenses under any other public assistance program or private health insurance program;

(G) the center—

(i) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay;

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

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

(II) to collect reimbursement for health services to persons described in

subparagraph (F) on the basis of the full amount of fees and payments for such services without application of any discount;

(iii)(I) will assure that no patient will be denied health care services due to an individual's inability to pay for such services; and

(II) will assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill the assurance described in subclause (I); and

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

(H) the center has established a governing board which except in the case of an entity operated by an Indian tribe or tribal or Indian organization under the Indian Self-Determination Act [25 U.S.C. 5321 et seq.] or an urban Indian organization under the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.)—

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

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

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

except that, upon a showing of good cause the Secretary shall waive, for the length of the project period, all or part of the requirements of this subparagraph in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p);

(I) the center has developed—

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

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

(I) the costs of its operations;

(II) the patterns of use of its services;

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

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

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

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

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

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

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

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

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

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

(M) the center encourages persons receiving or seeking health services from the center to participate in any public or private (including employer-offered) health programs or plans for which the persons are eligible, so long as the center, in complying with this subparagraph, does not violate the requirements of subparagraph (G)(iii)(I); and

(N) the center has written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.

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

(*l*) Technical assistance

The Secretary shall establish a program through which the Secretary shall provide (either through the Department of Health and Human Services or by grant or contract) technical and other assistance to eligible entities to assist such entities to meet the requirements of subsection (k)(3). Services provided through the program may include necessary technical and nonfinancial assistance, including fiscal and program management assistance, training in fiscal and program management, operational and

administrative support, and the provision of information to the entities of the variety of resources available under this subchapter and how those resources can be best used to meet the health needs of the communities served by the entities. Funds expended to carry out activities under this subsection and operational support activities under subsection (m) shall not exceed 3 percent of the amount appropriated for this section for the fiscal year involved.

(m) Memorandum of agreement

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

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

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

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

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

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

(n) Records

(1) In general

Each entity which receives a grant under subsection (e) shall establish and maintain such records as the Secretary shall require.

(2) Availability

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

(*o*) Delegation of authority

The Secretary may delegate the authority to administer the programs authorized by this section to any office, 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.

(p) Special consideration

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

(q) Audits

(1) In general

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

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

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

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

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

(2) Records

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

(3) Availability of records

Each entity which is required to establish and maintain records or to provide for and[1] audit under this subsection shall make such books, documents, papers, and records available to the Secretary or the Comptroller General of the United States, or any of their duly authorized representatives, for examination, copying or mechanical reproduction on or off the premises of such entity upon a reasonable request therefore. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have the authority to conduct such examination, copying, and reproduction.

(4) Waiver

The Secretary may, under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an entity. A waiver provided by the Secretary under this paragraph may not remain in effect for more than 1 year and may not be extended after such period. An en-

[1] So in original. Probably should be ''an''.

tity may not receive more than one waiver under this paragraph in consecutive years.

(r) Authorization of appropriations

(1) General amounts for grants

For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

(A) For fiscal year 2010, $2,988,821,592.

(B) For fiscal year 2011, $3,862,107,440.

(C) For fiscal year 2012, $4,990,553,440.

(D) For fiscal year 2013, $6,448,713,307.

(E) For fiscal year 2014, $7,332,924,155.

(F) For fiscal year 2015, $8,332,924,155.

(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

(i) one plus the average percentage increase in costs incurred per patient served; and

(ii) one plus the average percentage increase in the total number of patients served.

(2) Special provisions

(A) Public centers

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

(B) Distribution of grants

For fiscal year 2002 and each of the following fiscal years, the Secretary, in awarding grants under this section, shall ensure that the proportion of the amount made available under each of subsections (g), (h), and (i), relative to the total amount appropriated to carry out this section for that fiscal year, is equal to the proportion of the amount made available under that subsection for fiscal year 2001, relative to the total amount appropriated to carry out this section for fiscal year 2001.

(3) Funding report

The Secretary shall annually prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report including, at a minimum—

(A) the distribution of funds for carrying out this section that are provided to meet the health care needs of medically underserved populations, including the homeless, residents of public housing, and migratory and seasonal agricultural workers, and the appropriateness of the delivery systems involved in responding to the needs of the particular populations;

(B) an assessment of the relative health care access needs of the targeted populations;

(C) the distribution of awards and funding for new or expanded services in each of rural areas and urban areas;

(D) the distribution of awards and funding for establishing new access points, and the number of new access points created;

(E) the amount of unexpended funding for loan guarantees and loan guarantee authority under subchapter XIV;

(F) the rationale for any substantial changes in the distribution of funds;

(G) the rate of closures for health centers and access points;

(H) the number and reason for any grants awarded pursuant to subsection (e)(1)(B); and

(I) the number and reason for any waivers provided pursuant to subsection (q)(4).

(4) Rule of construction with respect to rural health clinics

(A) In general

Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act [42 U.S.C. 1395x(aa)(2)]), a low-volume hospital (as defined for purposes of section 1886 of such Act [42 U.S.C. 1395ww]), a critical access hospital, a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act), or a medicare-dependent share hospital (as defined for purposes of section 1886(d)(5)(G)(iv) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.[2]

(B) Assurances

In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

(i) nondiscrimination based on the ability of a patient to pay; and

(ii) the establishment of a sliding fee scale for low-income patients.

(5) Funding for participation of health centers in All of Us Research Program

In addition to any amounts made available pursuant to paragraph (1) of this subsection, section 282a of this title, or section 254b–2 of this title, there is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, to the Secretary $25,000,000 for fiscal year 2018 to support the participation of health centers in the All of Us Research Program under the Precision Medicine Initiative under section 289g–5 of this title.

[2] So in original. Probably should be ''hospital''.

(6) Additional amounts for supplemental awards

In addition to any amounts made available pursuant to this subsection, section 282a of this title, or section 254b—2 of this title, there is authorized to be appropriated, and there is appropriated, out of any monies in the Treasury not otherwise appropriated, $1,320,000,000 for fiscal year 2020 for supplemental awards under subsection (d) for the detection of SARS–CoV–2 or the prevention, diagnosis, and treatment of COVID–19.

(July 1, 1944, ch. 373, title III, § 330, as added Pub. L. 104–299, § 2, Oct. 11, 1996, 110 Stat. 3626; amended Pub. L. 107–251, title I, § 101, Oct. 26, 2002, 116 Stat. 1622; Pub. L. 108–163, § 2(a), Dec. 6, 2003, 117 Stat. 2020; Pub. L. 110–355, § 2(a), (c)(1), Oct. 8, 2008, 122 Stat. 3988, 3992; Pub. L. 111–148, title IV, § 4206, title V, § 5601, Mar. 23, 2010, 124 Stat. 576, 676; Pub. L. 115–123, div. E, title IX, § 50901(b), Feb. 9, 2018, 132 Stat. 283; Pub. L. 116–136, div. A, title III, § 3211(a), Mar. 27, 2020, 134 Stat. 368; Pub. L. 116–260, div. BB, title III, § 311(c), Dec. 27, 2020, 134 Stat. 2925.)

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (k)(3)(E)(i), (F), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

The Indian Self-Determination Act, referred to in subsec. (k)(3)(H), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§ 5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (k)(3)(H), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400, which is classified principally to chapter 18 (§ 1601 et seq.) of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

PRIOR PROVISIONS

A prior section 254a–1, act July 1, 1944, ch. 373, title III, § 328, as added Nov. 10, 1978, Pub. L. 95–626, title I, § 114, 92 Stat. 3563; amended Pub. L. 96–88, title V, § 509(b), Oct. 17, 1979, 93 Stat. 695, related to hospital-affiliated primary care centers, prior to repeal by Pub. L. 99–117, § 12(c), Oct. 7, 1985, 99 Stat. 495.

A prior section 254b, act July 1, 1944, ch. 373, title III, § 329, formerly § 310, as added Sept. 25, 1962, Pub. L. 87–692, 76 Stat. 592; amended Aug. 5, 1965, Pub. L. 89–109, § 3, 79 Stat. 436; Oct. 15, 1968, Pub. L. 90–574, title II, § 201, 82 Stat. 1006; Mar. 12, 1970, Pub. L. 91–209, 84 Stat. 52; June 18, 1973, Pub. L. 93–45, title I, § 105, 87 Stat. 91; renumbered § 319, July 23, 1974, Pub. L. 93–353, title I, § 102(d), 88 Stat. 362; amended July 29, 1975, Pub. L. 94–63, title IV, § 401(a), title VII, § 701(c), 89 Stat. 334, 352; Apr. 22, 1976, Pub. L. 94–278, title VIII, § 801(a), 90 Stat. 414; Aug. 1, 1977, Pub. L. 95–83, title III, § 303, 91 Stat. 388; renumbered § 329 and amended Nov. 10, 1978, Pub. L. 95–626, title I, §§ 102(a), 103(a)–(g)(1)(B), (2), (h), (i), 92 Stat. 3551–3555; July 10, 1979, Pub. L. 96–32, § 6(a), 93 Stat. 83; Oct. 17, 1979, Pub. L. 96–88, title V, § 509(b), 93 Stat. 695; Aug. 13, 1981, Pub. L. 97–35, title IX, § 930, 95 Stat. 569; Dec. 21, 1982, Pub. L. 97–375, title I, § 107(b), 96 Stat. 1820; Apr. 24, 1986, Pub. L. 99–280, §§ 6, 7, 100 Stat. 400, 401; Aug. 10, 1988, Pub. L. 100–386, § 2, 102 Stat. 919; Nov. 6, 1990, Pub. L. 101–527, § 9(b), 104 Stat. 2333; Oct. 27, 1992, Pub. L. 102–531, title III, § 309(a), 106 Stat. 3499, related to migrant health centers, prior to the general amendment of this subpart by Pub. L. 104–299, § 2.

Another prior section 254b, act July 1, 1944, ch. 373, title III, § 329, as added Dec. 31, 1970, Pub. L. 91–623, § 2, 84 Stat. 1868; amended Nov. 18, 1971, Pub. L. 92–157, title II, § 203, 85 Stat. 462; Oct. 27, 1972, Pub. L. 92–585, § 2, 86 Stat. 1290; July 29, 1975, Pub. L. 94–63, title VIII, §§ 801–803, 89 Stat. 353, 354; Oct. 12, 1976, Pub. L. 94–484, title I, § 101(b), 90 Stat. 2244, related to establishment of National Health Service Corps, assignment of personnel and statement of purpose, prior to repeal by Pub. L. 94–484, title IV, § 407(b)(1), Oct. 12, 1976, 90 Stat. 2268. See section 254d et seq. of this title.

A prior section 330 of act July 1, 1944, was classified to section 254c of this title prior to the general amendment of this subpart by Pub. L. 104–299.

AMENDMENTS

2020—Subsec. (d)(1)(H). Pub. L. 116–260 added subpar. (H).

Subsec. (r)(6). Pub. L. 116–136 added par. (6).

2018—Subsec. (b)(1)(A)(ii), (2)(A). Pub. L. 115–123, § 50901(b)(1), (2), substituted ''use disorder'' for ''abuse''.

Subsec. (c)(1). Pub. L. 115–123, § 50901(b)(3), substituted ''Centers'' for ''In general'' in heading, struck out subpar. (A) designation and heading, redesignated cls. (i) to (v) of former subpar. (A) as subpars. (A) to (E), respectively, realigned margins, and struck out former subpars. (B) to (D) which related to managed care networks and plans, practice management networks, and use of funds, respectively.

Subsec. (d). Pub. L. 115–123, § 50901(b)(4), added subsec. (d) and struck out former subsec. (d) which related to loan guarantee program.

Subsec. (e)(1)(B). Pub. L. 115–123, § 50901(b)(5)(A), substituted ''1 year'' for ''2 years'' and inserted at end ''The Secretary shall not make a grant under this paragraph unless the applicant provides assurances to the Secretary that within 120 days of receiving grant funding for the operation of the health center, the applicant will submit, for approval by the Secretary, an implementation plan to meet the requirements of subsection (k)(3). The Secretary may extend such 120-day period for achieving compliance upon a demonstration of good cause by the health center.''

Subsec. (e)(1)(C). Pub. L. 115–123, § 50901(b)(5)(B), in heading, struck out ''and plans'' after ''networks'', and in text, struck out ''or plan (as described in subparagraphs (B) and (C) of subsection (c)(1))'' after ''to a network'', substituted ''including—'' for ''or plan, including'', inserted cl. (i) designation before ''the purchase'' and '', which may include data and information systems'' after ''of equipment'', and added cls. (ii) and (iii).

Subsec. (e)(5)(B). Pub. L. 115–123, § 50901(b)(6), in heading, struck out ''and plans'' after ''Networks'' and in text, substituted ''to a health center or to a network'' for ''and subparagraphs (B) and (C) of subsection (c)(1) to a health center or to a network or plan''.

Subsec. (e)(6). Pub. L. 115–123, § 50901(b)(7), added par. (6).

Subsec. (h)(1). Pub. L. 115–123, § 50901(b)(8)(A), substituted '', children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness'' for ''and children and youth at risk of homelessness''.

Subsec. (h)(5)(B). Pub. L. 115–123, § 50901(b)(8)(B)(iii)(II), which directed substitution of ''use disorder'' for ''abuse'', was executed by making the substitution the first place it appeared, to reflect the probable intent of Congress.

Pub. L. 115–123, § 50901(b)(8)(B)(iii)(I), substituted ''use disorder'' for ''abuse'' in heading.

Pub. L. 115–123, § 50901(b)(8)(B)(i), (ii), redesignated subpar. (C) as (B) and struck out former subpar. (B). Prior to amendment, text of subpar. (B) read as follows: ''The term 'substance abuse' has the same meaning given such term in section 290cc–34(4) of this title.''

Subsec. (h)(5)(C). Pub. L. 115–123, § 50901(b)(8)(B)(ii), redesignated subpar. (C) as (B).

Subsec. (k)(2). Pub. L. 115–123, § 50901(b)(9)(A)(i), (ii), in heading, inserted ''unmet'' before ''need'', and in introductory provisions, inserted ''or subsection (e)(6)'' after ''subsection (e)(1)''.

Subsec. (k)(2)(A). Pub. L. 115–123, § 50901(b)(9)(A)(iii), inserted ''unmet'' before ''need for health services''.

Subsec. (k)(2)(D). Pub. L. 115–123, § 50901(b)(9)(A)(iv)–(vi), added subpar. (D).

Subsec. (k)(3). Pub. L. 115–123, § 50901(b)(9)(B)(i), inserted ''or subsection (e)(6)'' after ''subsection (e)(1)(B)'' in introductory provisions.

Subsec. (k)(3)(B). Pub. L. 115–123, § 50901(b)(9)(B)(ii), substituted '', including other health care providers that provide care within the catchment area, local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments'' for ''in the catchment area of the center''.

Subsec. (k)(3)(H)(ii). Pub. L. 115–123, § 50901(b)(9)(B)(iii), inserted ''who shall be directly employed by the center'' after ''approves the selection of a director for the center''.

Subsec. (k)(3)(N). Pub. L. 115–123, § 50901(b)(9)(B)(iv)–(vi), added subpar. (N).

Subsec. (k)(4). Pub. L. 115–123, § 50901(b)(9)(C), struck out par. (4) which related to approval of new or expanded service applications.

Subsec. (*l*). Pub. L. 115–123, § 50901(b)(10), inserted at end ''Funds expended to carry out activities under this subsection and operational support activities under subsection (m) shall not exceed 3 percent of the amount appropriated for this section for the fiscal year involved.''

Subsec. (q)(4). Pub. L. 115–123, § 50901(b)(11), inserted at end ''A waiver provided by the Secretary under this paragraph may not remain in effect for more than 1 year and may not be extended after such period. An entity may not receive more than one waiver under this paragraph in consecutive years.''

Subsec. (r)(3). Pub. L. 115–123, § 50901(b)(12), substituted ''Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives, a report including, at a minimum—'' for ''appropriate committees of Congress a report concerning the distribution of funds under this section'', inserted ''(A) the distribution of funds for carrying out this section'' before ''that are provided'', substituted ''particular populations;'' for ''particular populations. Such report shall include'', inserted subsec. (B) designation before ''an assessment'', substituted ''targeted populations;'' for ''targeted populations and the rationale for any substantial changes in the distribution of funds.'', and added subpars. (C) to (I).

Subsec. (r)(5). Pub. L. 115–123, § 50901(b)(13), added par. (5).

Subsec. (s). Pub. L. 115–123, § 50901(b)(14), struck out subsec. (s) which related to demonstration program for individualized wellness plans.

2010—Subsec. (r)(1). Pub. L. 111–148, § 5601(a), added par. (1) and struck out former par. (1). Prior to amendment, text read as follows: ''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) $2,065,000,000 for fiscal year 2008;

''(B) $2,313,000,000 for fiscal year 2009;

''(C) $2,602,000,000 for fiscal year 2010;

''(D) $2,940,000,000 for fiscal year 2011; and

''(E) $3,337,000,000 for fiscal year 2012.''

Subsec. (r)(4). Pub. L. 111–148, § 5601(b), added par. (4).

Subsec. (s). Pub. L. 111–148, § 4206, added subsec. (s).

2008—Subsec. (c)(3). Pub. L. 110–355, § 2(c)(1), added par. (3).

Subsec. (r)(1). Pub. L. 110–355, § 2(a), amended par. (1) generally. Prior to amendment, text read as follows: ''For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d) of this section, there are authorized to be appropriated $1,340,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006.''

2003—Subsec. (c)(1)(B). Pub. L. 108–163, § 2(a)(2)(A), substituted ''plan.'' for ''plan..'' in introductory provisions.

Subsec. (d)(1)(B)(iii)(I). Pub. L. 108–163, § 2(a)(2)(B), inserted ''or'' at end.

Subsec. (e)(3) to (5). Pub. L. 108–163, § 2(a)(1)(A), amended pars. (3) to (5) to read as if subpar. (C) of the second par. (4) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment notes below.

Subsec. (j). Pub. L. 108–163, § 2(a)(2)(E), added subsec. (j) identical to the subsec. (j) appearing in the amendment by section 101(8)(C) of Pub. L. 107–251. See 2002 Amendment notes below. Former subsec. (j) redesignated (k).

Pub. L. 108–163, § 2(a)(1)(C), amended subsec. (j) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment notes below.

Subsec. (j)(3)(H). Pub. L. 108–163, § 2(a)(1)(B), amended subpar. (H) to read as if subpar. (C) of par. (7) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment note below.

Subsec. (k). Pub. L. 108–163, § 2(a)(2)(C), (D), redesignated subsec. (j) as (k) and struck out heading and text of former subsec. (k). Text read as follows: ''The Secretary may provide (either through the Department of Health and Human Services 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 entities in developing plans for, or operating as, health centers, and in meeting the requirements of subsection (j)(2) of this section.''

Pub. L. 108–163, § 2(a)(1)(C), amended subsec. (k) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment notes below.

Subsec. (*l*). Pub. L. 108–163, § 2(a)(2)(H), inserted ''(either through the Department of Health and Human Services or by grant or contract)'' after ''shall provide'' and substituted ''(k)(3)'' for ''(*l*)(3)''.

Pub. L. 108–163, § 2(a)(2)(G), added subsec. (*l*) identical to the subsec. (m) appearing in the amendment by section 101(9) of Pub. L. 107–251. See 2002 Amendment notes below. Former subsec. (*l*) redesignated (r).

Pub. L. 108–163, § 2(a)(1)(C), amended subsec. (*l*) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment note below.

Subsecs. (m) to (*o*). Pub. L. 108–163, § 2(a)(1)(C), amended subsecs. (m) to (*o*) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment notes below.

Subsec. (p). Pub. L. 108–163, § 2(a)(2)(I), substituted ''(k)(3)(G)'' for ''(j)(3)(G)''.

Pub. L. 108–163, § 2(a)(1)(C), amended subsec. (p) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment note below.

Subsec. (q). Pub. L. 108–163, § 2(a)(1)(C), amended subsec. (q) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment note below.

Subsec. (r). Pub. L. 108–163, § 2(a)(2)(F), redesignated subsec. (*l*) as (r).

Pub. L. 108–163, § 2(a)(1)(C), amended subsec. (r) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment note below.

Subsec. (r)(1). Pub. L. 108–163, § 2(a)(2)(J)(i), substituted ''$1,340,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006'' for ''$802,124,000 for fiscal year 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2001''.

Subsec. (r)(2)(A). Pub. L. 108–163, § 2(a)(2)(J)(ii), substituted ''(k)(3)'' for ''(j)(3)'' and ''(k)(3)(H)'' for ''(j)(3)(G)(ii)''.

Subsec. (r)(2)(B). Pub. L. 108–163, §2(a)(2)(J)(iii), added subpar. (B) identical to the subpar. (B) appearing in the amendment by section 101(11)(B)(ii) of Pub. L. 107–251 and struck out heading and text of former subpar. (B) relating to distribution of grants for fiscal years 1997 through 1999. See 2002 Amendment note below.

Subsec. (s). Pub. L. 108–163, §2(a)(1)(C), amended subsec. (s) to read as if pars. (8) through (11) of section 101 of Pub. L. 107–251 had not been enacted. See 2002 Amendment notes below.

2002—Subsec. (b)(1)(A)(i)(III)(bb). Pub. L. 107–251, §101(1)(A), substituted ''appropriate cancer screening'' for ''screening for breast and cervical cancer''.

Subsec. (b)(1)(A)(ii). Pub. L. 107–251, §101(1)(B), inserted ''(including specialty referral when medically indicated)'' after ''medical services''.

Subsec. (b)(1)(A)(iii). Pub. L. 107–251, §101(1)(C), inserted ''housing,'' after ''social,''.

Subsec. (b)(2)(A). Pub. L. 107–251, §101(2)(C), added subpar. (A). Former subpar. (A) redesignated (C).

Subsec. (b)(2)(A)(i). Pub. L. 107–251, §101(2)(A), substituted ''associated with—'' and subcls. (I) to (IV) for ''associated with water supply;''.

Subsec. (b)(2)(B) to (D). Pub. L. 107–251, §101(2)(B), (C), added subpar. (B) and redesignated former subpars. (A) and (B) as (C) and (D), respectively.

Subsec. (c)(1)(B). Pub. L. 107–251, §101(3)(A)(iii), struck out concluding provisions which read as follows: ''Any such grant may include the acquisition and lease of buildings and equipment which may include data and information systems (including the costs of amortizing the principal of, and paying the interest on, loans), and providing training and technical assistance related to the provision of health services on a prepaid basis or under another managed care arrangement, and for other purposes that promote the development of managed care networks and plans.''

Pub. L. 107–251, §101(3)(A)(ii), in introductory provisions, substituted ''managed care network or plan.'' for ''network or plan for the provision of health services, which may include the provision of health services on a prepaid basis or through another managed care arrangement, to some or to all of the individuals which the centers serve''.

Pub. L. 107–251, §101(3)(A)(i), substituted ''Managed care'' for ''Comprehensive service delivery'' in heading.

Subsec. (c)(1)(C), (D). Pub. L. 107–251, §101(3)(B), added subpars. (C) and (D).

Subsec. (d). Pub. L. 107–251, §101(4)(A), substituted ''Loan guarantee program'' for ''Managed care loan guarantee program'' in heading.

Subsec. (d)(1)(A). Pub. L. 107–251, §101(4)(B)(i), substituted ''up to 90 percent of the principal and interest on loans made by non-Federal lenders to health centers, funded under this section, for the costs of developing and operating managed care networks or plans described in subsection (c)(1)(B), or practice management networks described in subsection (c)(1)(C)'' for ''the principal and interest on loans made by non-Federal lenders to health centers funded under this section for the costs of developing and operating managed care networks or plans''.

Subsec. (d)(1)(B)(iii). Pub. L. 107–251, §101(4)(B)(ii), added cl. (iii).

Subsec. (d)(1)(D), (E). Pub. L. 107–251, §101(4)(B)(iii), added subpars. (D) and (E).

Subsec. (d)(6) to (8). Pub. L. 107–251, §101(4)(C), redesignated par. (8) as (6) and struck out headings and text of former pars. (6) and (7) which related to annual reports and program evaluation, respectively.

Subsec. (e)(1)(B). Pub. L. 107–251, §101(4)(A)(i), substituted ''subsection (k)(3)'' for ''subsection (j)(3)''.

Subsec. (e)(1)(C). Pub. L. 107–251, §101(4)(A)(ii), added subpar. (C).

Subsec. (e)(3). Pub. L. 107–251, §101(4)(C), redesignated par. (4), relating to limitation, as (3).

Subsec. (e)(4). Pub. L. 107–251, §101(4)(C), redesignated par. (5) as (4). Former par. (4) redesignated (3).

Subsec. (e)(5). Pub. L. 107–251, §101(4)(B), (C), redesignated par. (5) as (4), inserted ''subparagraphs (A) and (B) of'' after ''any fiscal year under'' in subpar. (A), added subpar. (B), and redesignated former subpars. (B) and (C) as (C) and (D), respectively.

Subsec. (g)(2)(A). Pub. L. 107–251, §101(5)(A)(i), inserted ''and seasonal agricultural worker'' after ''migratory agricultural worker''.

Subsec. (g)(2)(B). Pub. L. 107–251, §101(5)(A)(ii), substituted ''and seasonal agricultural workers, and members of their families,'' for ''and members of their families''.

Subsec. (g)(3)(A). Pub. L. 107–251, §101(5)(B), struck out ''on a seasonal basis'' after ''in agriculture''.

Subsec. (h)(1). Pub. L. 107–251, §101(6)(A), substituted ''homeless children and youth and children and youth at risk of homelessness'' for ''homeless children and children at risk of homelessness''.

Subsec. (h)(4). Pub. L. 107–251, §101(6)(B)(ii), added par. (4). Former par. (4) redesignated (5).

Subsec. (h)(5). Pub. L. 107–251, §101(6)(B)(i), (C), redesignated par. (4) as (5) and substituted '', risk reduction, outpatient treatment, residential treatment, and rehabilitation'' for ''and residential treatment'' in subpar. (C).

Subsec. (j). Pub. L. 107–251, §101(8)(C), added subsec. (j) relating to access grants.

Pub. L. 107–251, §101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsec. (j)(3)(E)(i). Pub. L. 107–251, §101(7)(A)(i), designated existing provisions as subcl. (I) and added subcl. (II).

Subsec. (j)(3)(E)(ii). Pub. L. 107–251, §101(7)(A)(ii), substituted ''arrangements described in subclauses (I) and (II) of clause (i)'' for ''such an arrangement''.

Subsec. (j)(3)(G)(iii), (iv). Pub. L. 107–251, §101(7)(B), added cl. (iii) and redesignated former cl. (iii) as (iv).

Subsec. (j)(3)(H). Pub. L. 107–251, §101(7)(C), substituted ''or (q)'' for ''or (p)'' in concluding provisions.

Subsec. (j)(3)(M). Pub. L. 107–251, §101(7)(D)–(F), added subpar. (M).

Subsec. (k). Pub. L. 107–251, §101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsec. (*l*). Pub. L. 107–251, §101(8)(A), redesignated subsec. (*l*) as (s).

Subsec. (m). Pub. L. 107–251, §101(9), which directed striking subsec. (m) (as redesignated by paragraph (9)(B)) and adding a new subsec. (m), could not be executed. The new subsec. (m) to be added read as follows: ''(m) TECHNICAL ASSISTANCE.—The Secretary shall establish a program through which the Secretary shall provide technical and other assistance to eligible entities to assist such entities to meet the requirements of subsection (*l*)(3). Services provided through the program may include necessary technical and nonfinancial assistance, including fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the entities of the variety of resources available under this subchapter and how those resources can be best used to meet the health needs of the communities served by the entities.''

Pub. L. 107–251, §101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsecs. (n) to (p). Pub. L. 107–251, §101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsec. (q). Pub. L. 107–251, §101(10), which directed the substitution of ''(*l*)(3)(G)'' for ''(j)(3)(G)'' in subsec. (q) ''(as redesignated by paragraph (9)(B))'', could not be executed.

Pub. L. 107–251, §101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsec. (r). Pub. L. 107–251, § 101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsec. (s). Pub. L. 107–251, § 101(8)(B), which directed the redesignation of subsecs. (j), (k), and (m) through (q) as subsecs. (n), (*o*), and (p) through (s), respectively, could not be executed.

Subsec. (s)(1). Pub. L. 107–251, § 101(11)(A), substituted ''$1,340,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006'' for ''$802,124,000 for fiscal year 1997, and such sums as may be necessary for each of the fiscal years 1998 through 2001''.

Subsec. (s)(2)(A). Pub. L. 107–251, § 101(11)(B)(i), substituted ''(*l*)(3)'' for ''(j)(3)'' and ''(*l*)(3)(H)'' for ''(j)(3)(G)(ii)''.

Subsec. (s)(2)(B). Pub. L. 107–251, § 101(11)(B)(ii), added subpar. (B) and struck out heading and text of former subpar. (B) relating to distribution of grants for fiscal years 1997 through 1999.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–355, § 2(c)(2), Oct. 8, 2008, 122 Stat. 3992, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to grants made on or after January 1, 2009.''

EFFECTIVE DATE OF 2003 AMENDMENT

Amendments by Pub. L. 108–163 deemed to have taken effect immediately after the enactment of Pub. L. 107–251, see section 3 of Pub. L. 108–163, set out as a note under section 233 of this title.

EFFECTIVE DATE

Section effective Oct. 1, 1996, see section 5 of Pub. L. 104–299, as amended, set out as an Effective Date of 1996 Amendment note under section 233 of this title.

SAVINGS PROVISION FOR CURRENT GRANTS, CONTRACTS, AND COOPERATIVE AGREEMENTS

Pub. L. 104–299, § 3(b), Oct. 11, 1996, 110 Stat. 3644, provided that: ''The Secretary of Health and Human Services shall ensure the continued funding of grants made, or contracts or cooperative agreements entered into, under subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) (as such subpart existed on the day prior to the date of enactment of this Act [Oct. 11, 1996]), until the expiration of the grant period or the term of the contract or cooperative agreement. Such funding shall be continued under the same terms and conditions as were in effect on the date on which the grant, contract or cooperative agreement was awarded, subject to the availability of appropriations.''

NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS

Pub. L. 111–148, title V, § 5602, Mar. 23, 2010, 124 Stat. 677, provided that:

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the 'Secretary') shall establish, through a negotiated rulemaking process under subchapter 3 [III] of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

''(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

''(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

''(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

''(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

''(B) shall take into account—

''(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

''(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

''(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

''(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

''(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act [Mar. 23, 2010].

''(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the 'target date for publication', as referred to in section 564(a)(5) of title 5, United Sates [sic] Code, shall be July 1, 2010.

''(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

''(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

''(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

''(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

''(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

''(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.''

STUDIES RELATING TO COMMUNITY HEALTH CENTERS

Pub. L. 110–355, § 2(b)(1)–(3), Oct. 8, 2008, 122 Stat. 3988, 3989, provided that:

''(1) DEFINITIONS.—For purposes of this subsection—

''(A) the term 'community health center' means a health center receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b); and

''(B) the term 'medically underserved population' has the meaning given that term in such section 330.

''(2) SCHOOL-BASED HEALTH CENTER STUDY.—

''(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act [Oct. 8, 2008], the Comptroller General of the United States shall issue a study of the economic costs and benefits of school-based health centers and the impact on the health of students of these centers.

''(B) CONTENT.—In conducting the study under subparagraph (A), the Comptroller General of the United States shall analyze—

''(i) the impact that Federal funding could have on the operation of school-based health centers;

''(ii) any cost savings to other Federal programs derived from providing health services in school-based health centers;

''(iii) the effect on the Federal Budget and the health of students of providing Federal funds to school-based health centers and clinics, including the result of providing disease prevention and nutrition information;

''(iv) the impact of access to health care from school-based health centers in rural or underserved areas; and

''(v) other sources of Federal funding for school-based health centers.

''(3) HEALTH CARE QUALITY STUDY.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act [Oct. 8, 2008], the Secretary of Health and Human Services (referred to in this Act [see Short Title of 2008 Amendment note set out under section 201 of this title] as the 'Secretary'), acting through the Administrator of the Health Resources and Services Administration, and in collaboration with the Agency for Healthcare Research and Quality, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes agency efforts to expand and accelerate quality improvement activities in community health centers.

''(B) CONTENT.—The report under subparagraph (A) shall focus on—

''(i) Federal efforts, as of the date of enactment of this Act, regarding health care quality in community health centers, including quality data collection, analysis, and reporting requirements;

''(ii) identification of effective models for quality improvement in community health centers, which may include models that—

''(I) incorporate care coordination, disease management, and other services demonstrated to improve care;

''(II) are designed to address multiple, co-occurring diseases and conditions;

''(III) improve access to providers through non-traditional means, such as the use of remote monitoring equipment;

''(IV) target various medically underserved populations, including uninsured patient populations;

''(V) increase access to specialty care, including referrals and diagnostic testing; and

''(VI) enhance the use of electronic health records to improve quality;

''(iii) efforts to determine how effective quality improvement models may be adapted for implementation by community health centers that vary by size, budget, staffing, services offered, populations served, and other characteristics determined appropriate by the Secretary;

''(iv) types of technical assistance and resources provided to community health centers that may facilitate the implementation of quality improvement interventions;

''(v) proposed or adopted methodologies for community health center evaluations of quality improvement interventions, including any development of new measures that are tailored to safety-net, community-based providers;

''(vi) successful strategies for sustaining quality improvement interventions in the long-term; and

''(vii) partnerships with other Federal agencies and private organizations or networks as appropriate, to enhance health care quality in community health centers.

''(C) DISSEMINATION.—The Administrator of the Health Resources and Services Administration shall establish a formal mechanism or mechanisms for the ongoing dissemination of agency initiatives, best practices, and other information that may assist health care quality improvement efforts in community health centers.''

GUARANTEE STUDY

Pub. L. 107–251, title V, § 501, Oct. 26, 2002, 116 Stat. 1664, as amended by Pub. L. 108–163, § 2(n)(2), Dec. 6, 2003, 117 Stat. 2023, required the Secretary of Health and Human Services to conduct a study regarding the ability of the Department of Health and Human Services to provide for guarantees of solvency for managed care networks or plans involving health centers receiving funding under this section and to prepare and submit a report to Congress regarding such ability by 2 years after Oct. 26, 2002.

REFERENCE TO COMMUNITY, MIGRANT, PUBLIC HOUSING, OR HOMELESS HEALTH CENTER CONSIDERED REFERENCE TO HEALTH CENTER

Pub. L. 104–299, § 4(c), Oct. 11, 1996, 110 Stat. 3645, provided that: ''Whenever any reference is made in any provision of law, regulation, rule, record, or document to a community health center, migrant health center, public housing health center, or homeless health center, such reference shall be considered a reference to a health center.''

LEGISLATIVE PROPOSAL FOR CHANGES CONFORMING TO PUB. L. 104–299

Pub. L. 104–299, § 4(e), Oct. 11, 1996, 110 Stat. 3645, provided that: ''After consultation with the appropriate committees of the Congress, the Secretary of Health and Human Services shall prepare and submit to the Congress a legislative proposal in the form of an implementing bill containing technical and conforming amendments to reflect the changes made by this Act [see Short Title of 1996 Amendments note set out under section 201 of this title].''

EX. ORD. NO. 13937. ACCESS TO AFFORDABLE LIFE-SAVING MEDICATIONS

Ex. Ord. No. 13937, July 24, 2020, 85 F.R. 45755, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

SECTION 1. *Purpose*. Insulin is a critical and life-saving medication that approximately 8 million Americans rely on to manage diabetes. Likewise, injectable epinephrine is a life-saving medication used to stop severe allergic reactions.

The price of insulin in the United States has risen dramatically over the past decade. The list price for a single vial of insulin today is often more than $250 and most patients use at least two vials per month. As for injectable epinephrine, recent increased competition is helping to drive prices down. Nevertheless, the price for some types of injectable epinephrine remains more than $600 per kit. While Americans with diabetes and severe allergic reactions may have access to affordable insulin and injectable epinephrine through commercial insurance or Federal programs such as Medicare and Medicaid, many Americans still struggle to purchase these products.

Federally Qualified Health Centers (FQHCs), as defined in section 1905(l)(2)(B)(i) and (ii) of the Social Security Act, as amended, 42 U.S.C. 1396d(l)(2)(B)(i) and

(ii), receive discounted prices through the 340B Prescription Drug Program on prescription drugs. Due to the sharp increases in list prices for many insulins and some types of injectable epinephrine in recent years, many of these products may be subject to the ''penny pricing'' policy when distributed to FQHCs, meaning FQHCs may purchase the drug at a price of one penny per unit of measure. These steep discounts, however, are not always passed through to low-income Americans at the point of sale. Those with low-incomes can be exposed to high insulin and injectable epinephrine prices, as they often do not benefit from discounts negotiated by insurers or the Federal or State governments.

SEC. 2. *Policy*. It is the policy of the United States to enable Americans without access to affordable insulin and injectable epinephrine through commercial insurance or Federal programs, such as Medicare and Medicaid, to purchase these pharmaceuticals from an FQHC at a price that aligns with the cost at which the FQHC acquired the medication.

SEC. 3. *Improving the Availability of Insulin and Injectable Epinephrine for the Uninsured*. To the extent permitted by law, the Secretary of Health and Human Services shall take action to ensure future grants available under section 330(e) of the Public Health Service Act, as amended, 42 U.S.C. 254b(e), are conditioned upon FQHCs' having established practices to make insulin and injectable epinephrine available at the discounted price paid by the FQHC grantee or subgrantee under the 340B Prescription Drug Program (plus a minimal administration fee) to individuals with low incomes, as determined by the Secretary, who:

(a) have a high cost sharing requirement for either insulin or injectable epinephrine;

(b) have a high unmet deductible; or

(c) have no health care insurance.

SEC. 4. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof;

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP.

MEDICARE DEMONSTRATION TO TEST MEDICAL HOMES IN FEDERALLY QUALIFIED HEALTH CENTERS

Memorandum of President of the United States, Dec. 9, 2009, 74 F.R. 66207, provided:

Memorandum for the Secretary of Health And Human Services

My Administration is committed to building a high-quality, efficient health care system and improving access to health care for all Americans. Health centers are a vital part of the health care delivery system. For more than 40 years, health centers have served populations with limited access to health care, treating all patients regardless of ability to pay. These include low-income populations, the uninsured, individuals with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and individuals living in public housing. There are over 1,100 health centers across the country, delivering care at over 7,500 sites. These centers served more than 17 million patients in 2008 and are estimated to serve more than 20 million patients in 2010.

The American Recovery and Reinvestment Act of 2009 (Recovery Act) provided $2 billion for health centers, including $500 million to expand health centers' services to over 2 million new patients by opening new health center sites, adding new providers, and improving hours of operations. An additional $1.5 billion is supporting much-needed capital improvements, including funding to buy equipment, modernize clinic facilities, expand into new facilities, and adopt or expand the use of health information technology and electronic health records.

One of the key benefits health centers provide to the communities they serve is quality primary health care services. Health centers use interdisciplinary teams to treat the ''whole patient'' and focus on chronic disease management to reduce the use of costlier providers of care, such as emergency rooms and hospitals.

Federally qualified health centers provide an excellent environment to demonstrate the further improvements to health care that may be offered by the medical homes approach. In general, this approach emphasizes the patient's relationship with a primary care provider who coordinates the patient's care and serves as the patient's principal point of contact for care. The medical homes approach also emphasizes activities related to quality improvement, access to care, communication with patients, and care management and coordination. These activities are expected to improve the quality and efficiency of care and to help avoid preventable emergency and inpatient hospital care. Demonstration programs establishing the medical homes approach have been recommended by the Medicare Payment Advisory Commission, an independent advisory body to the Congress.

Therefore, I direct you to implement a Medicare Federally Qualified Health Center Advanced Primary Care Practice demonstration, pursuant to your statutory authority to conduct experiments and demonstrations on changes in payments and services that may improve the quality and efficiency of services to beneficiaries. Health centers participating in this demonstration must have shown their ability to provide comprehensive, coordinated, integrated, and accessible health care.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

You are authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA.

§ 254b–1. State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations

(a) In general

A State may award grants to health care providers who treat a high percentage, as determined by such State, of medically underserved populations or other special populations in such State.

(b) Source of funds

A grant program established by a State under subsection (a) may not be established within a department, agency, or other entity of such State that administers the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and no Federal or State funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 55 of title 10 may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a).