By focusing on those areas that have suffered a high incidence of mosquito-borne diseases, H.R. 4793 will provide the targeted financial assistance needed by local communities to expand their mosquito spraying programs, purchase new equipment, or update their laboratories. The CDC has recommended mosquito control measures as one of the most effective methods of West Nile prevention. H.R. 4793 provides the federal assistance to help local communities maintain and expand those spraying programs. Mosquito control programs also have the added benefit of protecting local communities from a host of other diseases besides West Nile Virus, including St. Louis encephalitis, La Crosse encephalitis, and dengue fever.

For all of these reasons, I support the passage of H.R. 4793 and urge my colleagues to support this measure as well. And I will continue to work with my colleagues to ensure that adequate funding for these programs is secured to safeguard our local communities from this national public health threat.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I am a cosponsor and firm supporter of H.R. 4793, the Mosquito Abatement for Safety and Health—or MASH—Act. We have a public health emergency on our hands. What was once an obscure African disease buried in the back of medical school pathology books, has the potential for turning into a full-blown epidemic if we do not make smart policy and well-directed investments in prevention and education.

So far this year 2,405 people have tested positive for West Nile Virus in the United States. The infection that starts with flu-like symptoms can end in swelling of the brain, and eventually death. There is no known cure for, or vaccine against, West Nile Virus. Out of the 2,405 infected this year, the virus has killed 117 people. And the season is not near over.

The 18th Congressional District of Texas that I represent has not been spared this insidious disease. Two months ago tragedy struck Houston when one of my constituents became the first Texan to die of complications of West Nile infection. Two weeks later, I walked the streets of her community, to check on her neighbors, and to get information and advice to those in need. I was accompanied by West Nile experts from health departments of every level—Texas, Harris County, and the City of Houston.

Although I was pleased with the expertise and dedication of those officials, I was struck by two problems. One, was that there are too many gaps in the funding and efforts to tackle this problem at the state and local levels. For example, although Harris County was playing a huge and important role in monitoring disease spread and spraying insecticides to control the mosquitoes that carry the virus—the county could not directly receive any money directly form the Centers for Disease Control and Prevention. They were forced to apply through the city of Houston or through the State Health Department, and then wait as funds trickled down to them, hoping it would get there in time to stem the tide of the encroaching epidemic.

This was unacceptable. I made calls and wrote letters to extract funds from the CDC, and ensured efficient flow of the funds down to the local levels where they could actually be put to work. But, this is not the way the system should have to work. The MASH Act addresses this problem, by providing for Mosquito Control Program Grants issued directly to counties. The grants would provide $2 of Federal funding for every $1 of local funding. The Secretary could even waive the matching portion in cases of extraordinary economic conditions. This is how to get things done.

To ensure that funds are used effectively, the MASH Act requires the counties conduct assessments and surveys of the needs of the county submit plan of attack, and, afterward, a report that describes the effectiveness of the program. West Nile Virus is probably here to stay. These reports will enable us to hone our national strategy for controlling the associated disease.

The MASH Act also funds a one-time grant of up to $10,000 to States to develop a plan to coordinate programs within the State. This will ensure good coordination and flow of information throughout each affected state.

The other problem I notice during my walk through the neighborhood in my district struck by West Nile Virus, is that too many people are still scared and confused. Some seemed to feel like hostages in their homes. It is the elderly who are most vulnerable to West Nile Virus, and these seniors are being told to go out in their yards and remove all standing water, such as cement birdbaths and old tires. They are told by public service announcements and the news not to go without DEET-containing mosquito repellent, but of course they have to go outside to get to the drugstore to buy some. And if they do find a way to get to the drugstore to protect themselves, they find that 56 percent of mosquito repellents that contain DEET—do not have the word DEET written anywhere on the label. I am continuing my work with the EPA and industry leaders to make sure that all DEET-containing product are clearly labeled by next season, to cut down on confusion and save lives. But, we need some quick fixes to these other pressing problems as well.

The MASH Act will provide funds directly to the people who know the needs of the community. The funds will enable them to establish appropriate budgets to control mosquitoes—I hope, by going straight out into the communities, clearing out tires and stagnant water, and delivering DEET with clear labels. Most importantly, they need to get the word out that West Nile Virus is a serious problem, but with smart precautions, and a well-funded and well-coordinated effort—it does not need to become a national disaster.

I support the MASH Act and encourage my colleagues to do the same.

Mr. JOHN. Mr. Speaker, I yield back the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. BOOZMAN). The question is on the motion offered by the gentleman from Louisiana (Mr. TAUZIN) that the House suspend the rules and pass the bill, H.R. 4793, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

HEALTH CARE SAFETY NET IMPROVEMENT ACT

Mr. BILIRAKIS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3450) to amend the Public Health Service Act to reauthorize and strengthen the health centers program and the National Health Service Corps, and for other purposes.

The Clerk read as follows:

H.R. 3450

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Safety Net Improvement Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—CONSOLIDATED HEALTH CENTER PROGRAM AMENDMENTS

SEC. 101. HEALTH CENTERS.

(a) INCREASE OF AUTHORIZATION OF APPROPRIATIONS FROM $802,124,000 FOR FISCAL YEAR

1997 TO $1,293,000,000 FOR FISCAL YEAR 2002.—Section 330(l)(1) of the Public Health Service Act (42 U.S.C. 254b(l(1))) is amended by striking ''$802,124,000'' and all that follows and inserting ''$1,293,000,000 for fiscal year 2002, and such sums as may be necessary for each of the fiscal years 2003 through 2006.''.

(b) ADDITIONAL AMENDMENTS.—Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) in subsection (b)(1)(A)—

(A) in clause (i)(III)(bb), by striking ''screening for breast and cervical cancer'' and inserting ''appropriate cancer screening'';

(B) in clause (ii), by inserting ''(including specialty referral when medically indicated)'' after ''medical services''; and

(C) in clause (iii), by inserting ''housing,'' after ''social,'';

(2) in subsection (b)(2)—

(A) by redesignating subparagraphs (A) and (B) as subparagraphs (B) and (C), respectively; and

(B) by inserting before subparagraph (B) (as so redesignated) the following:

''(A) behavioral and mental health and substance abuse services;'';

(3) in subsection (c)(1)—

(A) in subparagraph (B)—

(i) in the heading, by striking ''COMPREHENSIVE SERVICE DELIVERY'' and inserting ''MANAGED CARE'';

(ii) in the matter preceding clause (i), by striking ''network or plan'' and all that follows to the period and inserting ''managed care network or plan.''; and

(iii) in the matter following clause (ii), by striking ''Any such grant may include'' and all that follows through the period; and

(B) by adding at the end the following:

''(C) PRACTICE MANAGEMENT NETWORKS.—The Secretary may make grants to health centers that receive assistance under this section to enable the centers to plan and develop practice management networks that will enable the centers to—

''(i) reduce costs associated with the provision of health care services;

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

''(iii) enhance the quality and coordination of health care services; or

''(iv) improve the health status of communities.

''(D) USE OF FUNDS.—The activities for which a grant may be made under subparagraph (B) or (C) may include the purchase or lease of equipment, which may include data and information systems (including paying for the costs of amortizing the principal of, and paying the interest on, loans for equipment), the provision of training and technical assistance related to the provision of health care services on a prepaid basis or under another managed care arrangement, and other activities that promote the development of practice management or managed care networks and plans.'';

(4) in subsection (d)—

(A) by striking the subsection heading and inserting ''LOAN GUARANTEE PROGRAM.—'';

(B) in paragraph (1)—

(i) in subparagraph (A), by striking ''the principal and interest on loans'' and all that follows through the period and inserting ''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), and for the costs of acquiring or leasing buildings, or purchasing or leasing equipment.'';

(ii) in subparagraph (B)—

(I) in clause (i), by striking ''or'';

(II) in clause (ii), by striking the period and inserting ''; or''; and

(III) by adding at the end the following:

''(iii) to refinance a loan to the center or centers, if the Secretary determines that—

''(I) such refinancing will result in more favorable terms;

''(II) the savings resulting from the refinancing will be beneficial to both the center (or centers) and the Government; and

''(III) the center (or centers) can demonstrate an ability to repay the refinanced loan equal to or greater than the ability of the center (or centers) to repay the original loan on the date the original loan was made.''; and

(iii) by adding at the end the following:

''(D) PROVISION DIRECTLY TO NETWORKS OR PLANS.—At the request of health centers receiving assistance under this section, loan guarantees provided under this paragraph may be made directly to networks or plans that are at least majority controlled and, as applicable, at least majority owned by those health centers.''; and

(C)(i) by striking paragraphs (6) and (7); and

(ii) by redesignating paragraph (8) as paragraph (6);

(5) in subsection (e)—

(A) in paragraph (1), by adding at the end the following:

''(C) OPERATION OF NETWORKS AND PLANS.—

''(i) IN GENERAL.—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 or plan (as described in subparagraphs (B) and (C) of subsection (c)(1)) 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 or plan, including the purchase or lease of equipment (including the costs of amortizing the principal of, and paying the interest on, loans for equipment).

''(ii) CERTAIN REQUIREMENTS.—Subsection (j) applies with respect to grants under clause (i) to the same extent and in the same manner as such subsection applies with respect to grants under subparagraph (A) or (B), except to the extent that as applied to clause (i) the Secretary waives any requirement under subsection (j) on the basis that the requirement is not necessary with respect to the purposes for which grants under clause (i) are made.''; and

(B) in paragraph (5)—

(i) in subparagraph (A), by inserting ''subparagraphs (A) and (B) of'' after ''any fiscal year under'';

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), respectively; and

(iii) by inserting after subparagraph (A) the following:

''(B) NETWORKS AND PLANS.—The total amount of grant funds made available for any fiscal year under paragraph (1)(C) and subparagraphs (B) and (C) of subsection (c)(1) to a health center shall be determined by the Secretary, but may not exceed 2 percent of the total amount appropriated under this section for such fiscal year.'';

(6) in subsection (h)—

(A) in paragraph (1), by striking ''homeless children and children at risk of homelessness'' and inserting ''homeless children and youth and children and youth at risk of homelessness'';

(B)(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following:

''(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.''; and

(C) in paragraph (5)(C) (as redesignated by subparagraph (B)), by striking ''and residential treatment'' and inserting '', risk reduction, outpatient treatment, residential treatment, and rehabilitation'';

(7) in subsection (j)(3)—

(A) in subparagraph (E)—

(i) in clause (i)—

(I) by striking ''(i)'' and inserting ''(i)(I)'';

(II) by striking ''plan; or'' and inserting ''plan; and''; and

(III) by adding at the end the following:

''(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''; and

(ii) by striking clause (ii) and inserting the following:

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

(B) in subparagraph (G)—

(i) in clause (ii)(II), by striking ''; and'' and inserting '';'';

(ii) by redesignating clause (iii) as clause (iv); and

(iii) by inserting after clause (ii) the following:

''(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'';

(C) in subparagraph (K)(ii), by striking ''and'' after the semicolon at the end;

(D) in subparagraph (L), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following subparagraph:

''(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.'';

(8) by striking subsection (k) and inserting the following:

''(k) 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 paragraphs (2) and (3) of subsection (j) and in developing plans for, and operating health centers. Services provided through the program may include necessary technical and nonfinancial assistance, including fiscal and program management assistance, training in program management, operational and administrative support, and the provision of information to the entities of the variety of resources available under this title and how those resources can be best used to meet the health needs of the communities served by the entities.'';

(9)(A) in subsection (l) (as amended by subsection (a) of this section), by striking ''(l) AUTHORIZATION'';

(B) by transferring such undesignated subsection to the end of the section;

(C) by redesignating subsections (m) through (q) as subsections (l) through (p), respectively; and

(D) in the subsection transferred by subparagraph (B), by inserting ''(q) AUTHORIZATION'' before ''OF APPROPRIATIONS.—''; and

(10) in subsection (q) (as transferred and redesignated by paragraph (9)), in paragraph (2)—

(A) in subparagraph (A), by striking ''(j)(3)(G)(ii)'' and inserting ''(j)(3)(H)''; and

(B) by striking subparagraph (B) and inserting the following:

''(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.''.

(c) TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.—

(1) IN GENERAL.—The Secretary of Health and Human Services may make grants to State professional licensing boards to carry out programs under which such licensing boards of various States cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine.

(2) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out paragraph (1), there are authorized to be appropriated $10,000,000 for fiscal year 2002, and such sums as may be necessary for each of the fiscal years 2002 through 2006.

SEC. 102. MIGRATORY AND SEASONAL AGRICULTURAL WORKERS.

Section 330(g) of the Public Health Service Act (42 U.S.C. 254b(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (A), by inserting ''and seasonal agricultural worker'' after ''agricultural worker''; and

(B) in subparagraph (B), by striking ''and members of their families'' and inserting ''and seasonal agricultural workers, and members of their families,''; and

(2) in paragraph (3)(A), by striking ''on a seasonal basis''.

TITLE II—RURAL HEALTH

Subtitle A—Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs

SEC. 201. GRANT PROGRAMS.

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended to read as follows:

''SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, AND SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

''(a) PURPOSE.—The purpose of this section is to provide grants for expanded delivery of health care services in rural areas, for the planning and implementation of integrated health care networks in rural areas, and for the planning and implementation of small health care provider quality improvement activities.

''(b) DEFINITIONS.—

''(1) DIRECTOR.—The term 'Director' means the Director specified in subsection (d).

''(2) FEDERALLY QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC.—The terms 'Federally qualified health center' and 'rural health clinic' have the meanings given the terms in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

''(3) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' means a health professional shortage area designated under section 332.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' has the meaning given the term in section 799B.

''(5) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given the term in section 330(b)(3).

''(c) PROGRAM.—The Secretary shall establish, under section 301, a small health care provider quality improvement grant program.

''(d) ADMINISTRATION.—

''(1) PROGRAMS.—The rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs established under section 301 shall be administered by the Director of the Office of Rural Health Policy of the Health Resources and Services Administration, in consultation with State offices of rural health or other appropriate State government entities.

''(2) GRANTS.—

''(A) IN GENERAL.—In carrying out the programs described in paragraph (1), the Director may award grants under subsections (e), (f), and (g) to expand access to, coordinate, and improve the quality of essential health care services, and enhance the delivery of health care, in rural areas.

''(B) TYPES OF GRANTS.—The Director may award the grants—

''(i) to promote expanded delivery of health care services in rural areas under subsection (e);

''(ii) to provide for the planning and implementation of integrated health care networks in rural areas under subsection (f); and

''(iii) to provide for the planning and implementation of small health care provider quality improvement activities under subsection (g).

''(e) RURAL HEALTH CARE SERVICES OUTREACH GRANTS.—

''(1) GRANTS.—The Director may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

''(A) shall be a rural public or private entity;

''(B) shall represent a consortium composed of members—

''(i) that include 3 or more health care providers; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection for the same or a similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural underserved populations in the local community or region to be served;

''(C) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

''(D) a plan for sustaining the project after Federal support for the project has ended; and

''(E) a description of how the project will be evaluated.

''(f) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

''(1) GRANTS.—

''(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

''(i) achieve efficiencies;

''(ii) expand access to, coordinate, and improve the quality of essential health care services; and

''(iii) strengthen the rural health care system as a whole.

''(B) GRANT PERIODS.—The Director may award such a rural health network development grant for implementation activities for a period of 3 years. The Director may also award such a rural health network development grant for planning activities for a period of 1 year, to assist in the development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

''(A) shall be a rural public or private entity;

''(B) shall represent a network composed of participants—

''(i) that include 3 or more health care providers; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection (other than a grant for planning activities) for the same or a similar project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of—

''(i) the history of collaborative activities carried out by the participants in the network;

''(ii) the degree to which the participants are ready to integrate their functions; and

''(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network;

''(E) a plan for sustaining the project after Federal support for the project has ended; and

''(F) a description of how the project will be evaluated.

''(g) SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

''(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

''(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

''(A)(i) shall be a rural public or rural nonprofit private health care provider or provider of health care services, such as a critical access hospital or a rural health clinic; or

''(ii) shall be another rural provider or network of small rural providers identified by the Secretary as a key source of local care; and

''(B) shall not previously have received a grant under this subsection for the same or a similar project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health, another appropriate State entity, or a hospital association, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the activities carried out by the entity;

''(E) a plan for sustaining the project after Federal support for the project has ended; and

''(F) a description of how the project will be evaluated.

''(4) EXPENDITURES FOR SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—In awarding a grant under this subsection, the Director shall ensure that the funds made available through the grant will be used to provide services to residents of rural areas. The Director shall award not less than 50 percent of the funds made available under this subsection to providers located in and serving rural areas.

''(h) GENERAL REQUIREMENTS.—

''(1) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(A) to build or acquire real property; or

''(B) for construction, except that such funds may be expended for minor renovations relating to the installation of equipment.

''(2) COORDINATION WITH OTHER AGENCIES.—The Secretary shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

''(3) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to entities that—

''(A) are located in health professional shortage areas or medically underserved communities, or serve medically underserved populations; or

''(B) propose to develop projects with a focus on primary care, and wellness and prevention strategies.

''(i) REPORT.—Not later than September 30, 2005, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsections (e), (f), and (g).

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.''.

Subtitle B—Telehealth Grant Consolidation

SEC. 211. SHORT TITLE.

This subtitle may be cited as the ''Telehealth Grant Consolidation Act of 2001''.

SEC. 212. CONSOLIDATION AND REAUTHORIZATION OF PROVISIONS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq) is amended by adding at the end the following:

''SEC. 330I. TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.

''(a) DEFINITIONS.—In this section:

''(1) DIRECTOR; OFFICE.—The terms 'Director' and 'Office' mean the Director and Office specified in subsection (c).

''(2) FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC.—The term 'Federally qualified health center' and 'rural health clinic' have the meanings given the terms in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

''(3) FRONTIER COMMUNITY.—The term 'frontier community' means an area with fewer than 6 residents per square mile, based on the latest population data published by the Bureau of the Census.

''(4) MEDICALLY UNDERSERVED AREA.—The term 'medically underserved area' has the meaning given the term 'medically underserved community' in section 799B.

''(5) MEDICALLY UNDERSERVED POPULATION.—The term 'medically underserved population' has the meaning given the term in section 330(b)(3).

''(6) TELEHEALTH SERVICES.—The term 'telehealth services' means services provided through telehealth technologies.

''(7) TELEHEALTH TECHNOLOGIES.—The term 'telehealth technologies' means technologies relating to the use of electronic information, and telecommunications technologies, to support and promote, at a distance, health care, patient and professional health-related education, health administration, and public health.

''(b) PROGRAMS.—The Secretary shall establish, under section 301, telehealth network and telehealth resource centers grant programs.

''(c) ADMINISTRATION.—

''(1) ESTABLISHMENT.—There is established in the Health and Resources and Services Administration an Office for the Advancement of Telehealth. The Office shall be headed by a Director.

''(2) DUTIES.—The telehealth network and telehealth resource centers grant programs established under section 301 shall be administered by the Director, in consultation with the State offices of rural health, State offices concerning primary care, or other appropriate State government entities.

''(d) GRANTS.—

''(1) TELEHEALTH NETWORK GRANTS.—The Director may, in carrying out the telehealth network grant program referred to in subsection (b), award grants to eligible entities for projects to demonstrate how telehealth technologies can be used through telehealth networks in rural areas, frontier communities, and medically underserved areas, and for medically underserved populations, to—

''(A) expand access to, coordinate, and improve the quality of health care services;

''(B) improve and expand the training of health care providers; and

''(C) expand and improve the quality of health information available to health care providers, and patients and their families, for decisionmaking.

''(2) TELEHEALTH RESOURCE CENTERS GRANTS.—The Director may, in carrying out the telehealth resource centers grant program referred to in subsection (b), award grants to eligible entities for projects to demonstrate how telehealth technologies can be used in the areas and communities, and for the populations, described in paragraph (1), to establish telehealth resource centers.

''(e) GRANT PERIODS.—The Director may award grants under this section for periods of not more than 4 years.

''(f) ELIGIBLE ENTITIES.—

''(1) TELEHEALTH NETWORK GRANTS.—

''(A) GRANT RECIPIENT.—To be eligible to receive a grant under subsection (d)(1), an entity shall be a nonprofit entity.

''(B) TELEHEALTH NETWORKS.—

''(i) IN GENERAL.—To be eligible to receive a grant under subsection (d)(1), an entity shall demonstrate that the entity will provide services through a telehealth network.

''(ii) NATURE OF ENTITIES.—Each entity participating in the telehealth network may be a nonprofit or for-profit entity.

''(iii) COMPOSITION OF NETWORK.—The telehealth network shall include at least 2 of the following entities (at least 1 of which shall be a community-based health care provider):

''(I) Community or migrant health centers or other Federally qualified health centers.

''(II) Health care providers, including pharmacists, in private practice.

''(III) Entities operating clinics, including rural health clinics.

''(IV) Local health departments.

''(V) Nonprofit hospitals, including community access hospitals.

''(VI) Other publicly funded health or social service agencies.

''(VII) Long-term care providers.

''(VIII) Providers of health care services in the home.

''(IX) Providers of outpatient mental health services and entities operating outpatient mental health facilities.

''(X) Local or regional emergency health care providers.

''(XI) Institutions of higher education.

''(XII) Entities operating dental clinics.

''(2) TELEHEALTH RESOURCE CENTERS GRANTS.—To be eligible to receive a grant under subsection (d)(2), an entity shall be a nonprofit entity.

''(g) APPLICATIONS.—To be eligible to receive a grant under subsection (d), an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(1) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(2) a description of the manner in which the project funded under the grant will meet the health care needs of rural or other populations to be served through the project, or improve the access to services of, and the quality of the services received by, those populations;

''(3) evidence of local support for the project, and a description of how the areas, communities, or populations to be served will be involved in the development and ongoing operations of the project;

''(4) a plan for sustaining the project after Federal support for the project has ended;

''(5) information on the source and amount of non-Federal funds that the entity will provide for the project;

''(6) information demonstrating the long-term viability of the project, and other evidence of institutional commitment of the entity to the project; and

''(7) in the case of an application for a project involving a telehealth network, information demonstrating how the project will promote the integration of telehealth technologies into the operations of health care providers, to avoid redundancy, and improve access to and the quality of care.

''(h) TERMS; CONDITIONS; MAXIMUM AMOUNT OF ASSISTANCE.—The Secretary shall establish the terms and conditions of each grant program described in subsection (b) and the maximum amount of a grant to be awarded to an individual recipient for each fiscal year under this section. The Secretary shall publish, in a publication of the Health Resources and Services Administration, notice of the application requirements for each grant program described in subsection (b) for each fiscal year.

''(i) PREFERENCES.—

''(1) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for projects involving telehealth networks, the Secretary shall give preference to an eligible entity that meets at least 1 of the following requirements:

''(A) ORGANIZATION.—The eligible entity is a rural community-based organization or another community-based organization.

''(B) SERVICES.—The eligible entity proposes to use Federal funds made available through such a grant to develop plans for, or to establish, telehealth networks that provide mental health, public health, long-term care, home care, preventive, or case management services.

''(C) COORDINATION.—The eligible entity demonstrates how the project to be carried out under the grant will be coordinated with other relevant federally funded projects in the areas, communities, and populations to be served through the grant.

''(D) NETWORK.—The eligible entity demonstrates that the project involves a telehealth network that includes an entity that—

''(i) provides clinical health care services, or educational services for health care providers and for patients or their families; and

''(ii) is—

''(I) a public school;

''(II) a public library;

''(III) an institution of higher education; or

''(IV) a local government entity.

''(E) CONNECTIVITY.—The eligible entity proposes a project that promotes local connectivity within areas, communities, or populations to be served through the project.

''(F) INTEGRATION.—The eligible entity demonstrates that health care information has been integrated into the project.

''(2) TELEHEALTH RESOURCE CENTERS.—In awarding grants under subsection (d)(2) for projects involving telehealth resource centers, the Secretary shall give preference to an eligible entity that meets at least 1 of the following requirements:

''(A) PROVISION OF SERVICES.—The eligible entity has a record of success in the provision of telehealth services to medically underserved areas or medically underserved populations.

''(B) COLLABORATION AND SHARING OF EXPERTISE.—The eligible entity has a demonstrated record of collaborating and sharing expertise with providers of telehealth services at the national, regional, State, and local levels.

''(C) BROAD RANGE OF TELEHEALTH SERVICES.—The eligible entity has a record of providing a broad range of telehealth services, which may include—

''(i) a variety of clinical specialty services;

''(ii) patient or family education;

''(iii) health care professional education; and

''(iv) rural residency support programs.

''(j) DISTRIBUTION OF FUNDS.—

''(1) IN GENERAL.—In awarding grants under this section, the Director shall ensure, to the greatest extent possible, that such grants are equitably distributed among the geographical regions of the United States.

''(2) TELEHEALTH NETWORKS.—In awarding grants under subsection (d)(1) for a fiscal year, the Director shall ensure that—

''(A) not less than 50 percent of the funds awarded shall be awarded for projects in rural areas; and

''(B) the total amount of funds awarded for such projects for that fiscal year shall be not less than the total amount of funds awarded for such projects for fiscal year 2001 under section 330A (as in effect on the day before the date of enactment of the Health Care Safety Net Improvement Act).

''(k) USE OF FUNDS.—

''(1) TELEHEALTH NETWORK PROGRAM.—The recipient of a grant under subsection (d)(1) may use funds received through such grant for salaries, equipment, and operating or other costs, including the cost of—

''(A) developing and delivering clinical telehealth services that enhance access to community-based health care services in rural areas, frontier communities, or medically underserved areas, or for medically underserved populations;

''(B) developing and acquiring, through lease or purchase, computer hardware and software, audio and video equipment, computer network equipment, interactive equipment, data terminal equipment, and other equipment that furthers the objectives of the telehealth network grant program;

''(C)(i) developing and providing distance education, in a manner that enhances access to care in rural areas, frontier communities, or medically underserved areas, or for medically underserved populations; or

''(ii) mentoring, precepting, or supervising health care providers and students seeking to become health care providers, in a manner that enhances access to care in the areas and communities, or for the populations, described in clause (i);

''(D) developing and acquiring instructional programming;

''(E)(i) providing for transmission of medical data, and maintenance of equipment; and

''(ii) providing for compensation (including travel expenses) of specialists, and referring health care providers, who are providing telehealth services through the telehealth network, if no third party payment is available for the telehealth services delivered through the telehealth network;

''(F) developing projects to use telehealth technology to facilitate collaboration between health care providers;

''(G) collecting and analyzing usage statistics and data to document the cost-effectiveness of the telehealth services; and

''(H) carrying out such other activities as are consistent with achieving the objectives of this section, as determined by the Secretary.

''(2) TELEHEALTH RESOURCE CENTERS.—The recipient of a grant under subsection (d)(2) may use funds received through such grant for salaries, equipment, and operating or other costs for—

''(A) providing technical assistance, training, and support, and providing for travel expenses, for health care providers and a range of health care entities that provide or will provide telehealth services;

''(B) disseminating information and research findings related to telehealth services;

''(C) promoting effective collaboration among telehealth resource centers and the Office;

''(D) conducting evaluations to determine the best utilization of telehealth technologies to meet health care needs;

''(E) promoting the integration of the technologies used in clinical information systems with other telehealth technologies;

''(F) fostering the use of telehealth technologies to provide health care information and education for health care providers and consumers in a more effective manner; and

''(G) implementing special projects or studies under the direction of the Office.

''(l) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds made available through the grant—

''(1) to acquire real property;

''(2) for expenditures to purchase or lease equipment, to the extent that the expenditures would exceed 40 percent of the total grant funds;

''(3) in the case of a project involving a telehealth network, to purchase or install transmission equipment (such as laying cable or telephone lines, or purchasing or installing microwave towers, satellite dishes, amplifiers, or digital switching equipment);

''(4) to pay for any equipment or transmission costs not directly related to the purposes for which the grant is awarded;

''(5) to purchase or install general purpose voice telephone systems;

''(6) for construction, except that such funds may be expended for minor renovations relating to the installation of equipment; or

''(7) for expenditures for indirect costs (as determined by the Secretary), to the extent that the expenditures would exceed 10 percent of the total grant funds.

''(m) COLLABORATION.—In providing services under this section, an eligible entity shall collaborate, if feasible, with entities that—

''(1)(A) are private or public organizations, that receive Federal or State assistance; or

''(B) are public or private entities that operate centers, or carry out programs, that receive Federal or State assistance; and

''(2) provide telehealth services or related activities.

''(n) COORDINATION WITH OTHER AGENCIES.—The Secretary shall coordinate activities carried out under grant programs described in subsection (b), to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar programs, to maximize the effect of public dollars in funding meritorious proposals.

''(o) OUTREACH ACTIVITIES.—The Secretary shall establish and implement procedures to carry out outreach activities to advise potential end users of telehealth services in rural areas, frontier communities, medically underserved areas, and medically underserved populations in each State about the grant programs described in subsection (b).

''(p) TELEHEALTH.—It is the sense of Congress that, for purposes of this section, States should develop reciprocity agreements so that a provider of services under this section who is a licensed or otherwise authorized health care provider under the law of 1 or more States, and who, through telehealth technology, consults with a licensed or otherwise authorized health care provider in another State, is exempt, with respect to such consultation, from any State law of the other State that prohibits such consultation on the basis that the first health care provider is not a licensed or authorized health care provider under the law of that State.

''(q) REPORT.—Not later than September 30, 2005, the Secretary shall prepare and submit

to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsection (b).

''(r) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for grants under subsection (d)(1), $40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006; and

''(2) for grants under subsection (d)(2), $20,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.''.

Subtitle C—Mental Health Services Telehealth Program and Rural Emergency Medical Service Training and Equipment Assistance Program

SEC. 221. PROGRAMS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) (as amended by section 212) is further amended by adding at the end the following:

''SEC. 330J. RURAL EMERGENCY MEDICAL SERVICE TRAINING AND EQUIPMENT ASSISTANCE PROGRAM.

''(a) GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the 'Secretary') shall award grants to eligible entities to enable such entities to provide for improved emergency medical services in rural areas.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be—

''(A) a State emergency medical services office;

''(B) a State emergency medical services association;

''(C) a State office of rural health;

''(D) a local government entity;

''(E) a State or local ambulance provider; or

''(F) any other entity determined appropriate by the Secretary; and

''(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, that includes—

''(A) a description of the activities to be carried out under the grant; and

''(B) an assurance that the eligible entity will comply with the matching requirement of subsection (e).

''(c) USE OF FUNDS.—An entity shall use amounts received under a grant made under subsection (a), either directly or through grants to emergency medical service squads that are located in, or that serve residents of, a nonmetropolitan statistical area, an area designated as a rural area by any law or regulation of a State, or a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification, originally published in a notice of availability of funds in the Federal Register on February 27, 1992, 57 Fed. Reg. 6725), to—

''(1) recruit emergency medical service personnel;

''(2) recruit volunteer emergency medical service personnel;

''(3) train emergency medical service personnel in emergency response, injury prevention, safety awareness, and other topics relevant to the delivery of emergency medical services;

''(4) fund specific training to meet Federal or State certification requirements;

''(5) develop new ways to educate emergency health care providers through the use of technology-enhanced educational methods (such as distance learning);

''(6) acquire emergency medical services equipment, including cardiac defibrillators;

''(7) acquire personal protective equipment for emergency medical services personnel as required by the Occupational Safety and Health Administration; and

''(8) educate the public concerning cardiopulmonary resuscitation, first aid, injury prevention, safety awareness, illness prevention, and other related emergency preparedness topics.

''(d) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to—

''(1) applications that reflect a collaborative effort by 2 or more of the entities described in subparagraphs (A) through (F) of subsection (b)(1); and

''(2) applications submitted by entities that intend to use amounts provided under the grant to fund activities described in any of paragraphs (1) through (5) of subsection (c).

''(e) MATCHING REQUIREMENT.—The Secretary may not award a grant under this section to an entity unless the entity agrees that the entity will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant in an amount equal to 25 percent of the amount received under the grant.

''(f) EMERGENCY MEDICAL SERVICES.—In this section, the term 'emergency medical services'—

''(1) means resources used by a qualified public or private nonprofit entity, or by any other entity recognized as qualified by the State involved, to deliver medical care outside of a medical facility under emergency conditions that occur—

''(A) as a result of the condition of the patient; or

''(B) as a result of a natural disaster or similar situation; and

''(2) includes services delivered by an emergency medical services provider (either compensated or volunteer) or other provider recognized by the State involved that is licensed or certified by the State as an emergency medical technician or its equivalent (as determined by the State), a registered nurse, a physician assistant, or a physician that provides services similar to services provided by such an emergency medical services provider.

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2002 through 2006.

''(2) ADMINISTRATIVE COSTS.—The Secretary may use not more than 10 percent of the amount appropriated under paragraph (1) for a fiscal year for the administrative expenses of carrying out this section.

''SEC. 330K. MENTAL HEALTH SERVICES DELIVERED VIA TELEHEALTH.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or nonprofit private telehealth provider network that offers services that include mental health services provided by qualified mental health providers.

''(2) QUALIFIED MENTAL HEALTH PROFESSIONALS.—The term 'qualified mental health professionals' refers to providers of mental health services reimbursed under the medicare program carried out under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who have additional training in the treatment of mental illness in children and adolescents or who have additional training in the treatment of mental illness in the elderly.

''(3) SPECIAL POPULATIONS.—The term 'special populations' refers to the following 2 distinct groups:

''(A) Children and adolescents in mental health underserved rural areas or in mental health underserved urban areas.

''(B) Elderly individuals located in long-term care facilities in mental health underserved rural areas or in mental health underserved urban areas.

''(4) TELEHEALTH.—The term 'telehealth' means the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration.

''(b) PROGRAM AUTHORIZED.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Office for the Advancement of Telehealth of the Health Resources and Services Administration, shall award grants to eligible entities to establish demonstration projects for the provision of mental health services to special populations as delivered remotely by qualified mental health professionals using telehealth and for the provision of education regarding mental illness as delivered remotely by qualified mental health professionals and qualified mental health education professionals using telehealth.

''(2) POPULATIONS SERVED.—The Secretary shall award the grants under paragraph (1) in a manner that distributes the grants so as to serve equitably the populations described in subparagraphs (A) and (B) of subsection (a)(4).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—An eligible entity that receives a grant under this section shall use the grant funds—

''(A) for the populations described in subsection (a)(3)(A)—

''(i) to provide mental health services, including diagnosis and treatment of mental illness, in public elementary and public secondary schools as delivered remotely by qualified mental health professionals using telehealth; and

''(ii) to collaborate with local public health entities to provide the mental health services; and

''(B) for the populations described in subsection (a)(3)(B)—

''(i) to provide mental health services, including diagnosis and treatment of mental illness, in long-term care facilities as delivered remotely by qualified mental health professionals using telehealth; and

''(ii) to collaborate with local public health entities to provide the mental health services.

''(2) OTHER USES.—An eligible entity that receives a grant under this section may also use the grant funds to—

''(A) pay telecommunications costs; and

''(B) pay qualified mental health professionals on a reasonable basis as determined by the Secretary for services rendered.

''(3) PROHIBITED USES.—An eligible entity that receives a grant under this section shall not use the grant funds to—

''(A) purchase or install transmission equipment (other than such equipment used by qualified mental health professionals to deliver mental health services using telehealth under the project involved); or

''(B) build upon or acquire real property.

''(d) EQUITABLE DISTRIBUTION.—In awarding grants under this section, the Secretary shall ensure, to the greatest extent possible, that such grants are equitably distributed among geographical regions of the United States.

''(e) APPLICATION.—An entity that desires a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary determines to be reasonable.

''(f) REPORT.—Not later than 4 years after the date of enactment of the Health Care Safety Net Improvement Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report that shall evaluate activities funded with grants under this section.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $20,000,000 for fiscal year 2002 and such sums as may be necessary for fiscal years 2003 through 2006.''.

TITLE III—NATIONAL HEALTH SERVICE CORPS PROGRAM

SEC. 301. NATIONAL HEALTH SERVICE CORPS.

(a) IN GENERAL.—Section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended—

(1) by adding at the end of subsection (a)(3) the following:

''(E)(i) The term 'behaviorial and mental health professionals' means health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychiatric nurse specialists, and psychiatrists.

''(ii) The term 'graduate program of behavioral and mental health' means a program that trains behavorial and mental health professionals.'';

(2) in subsection (b)—

(A) in paragraph (1), by striking ''health professions'' and inserting ''health professions, including schools at which graduate programs of behavioral and mental health are offered,''; and

(B) in paragraph (2), by inserting ''behavioral and mental health professionals,'' after ''dentists,''; and

(3) by striking subsection (c) and inserting the following:

''(c)(1) The Secretary may reimburse an applicant for a position in the Corps (including an individual considering entering into a written agreement pursuant to section 338D) for the actual and reasonable expenses incurred in traveling to and from the applicant's place of residence to an eligible site to which the applicant may be assigned under section 333 for the purpose of evaluating such site with regard to being assigned at such site. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

''(2) The Secretary may also reimburse the applicant for the actual and reasonable expenses incurred for the travel of 1 family member to accompany the applicant to such site. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.

''(3) In the case of an individual who has entered into a contract for obligated service under the Scholarship Program or under the Loan Repayment Program, the Secretary may reimburse such individual for all or part of the actual and reasonable expenses incurred in transporting the individual to the site of the individual's assignment under section 333. The Secretary may establish a maximum total amount that may be paid to an individual as reimbursement for such expenses.''.

(b) DEMONSTRATION PROJECTS.—Section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended—

(1) by redesignating subsection (i) as subsection (j); and

(2) by inserting after subsection (h) the following:

''(i)(1) In carrying out subpart III, the Secretary may, in accordance with this subsection, carry out demonstration projects in which individuals who have entered into a contract for obligated service under the Loan Repayment Program receive waivers under which the individuals are authorized to satisfy the requirement of obligated service through providing clinical service that is not full-time.

''(2) A waiver described in paragraph (1) may be provided by the Secretary only if—

''(A) the entity for which the service is to be performed—

''(i) has been approved under section 333A for assignment of a Corps member; and

''(ii) has requested in writing assignment of a health professional who would serve less than full time;

''(B) the Secretary has determined that assignment of a health professional who would serve less than full time would be appropriate for the area where the entity is located;

''(C) a Corps member who is required to perform obligated service has agreed in writing to be assigned for less than full-time service to an entity described in subparagraph (A);

''(D) the entity and the Corps member agree in writing that the less than full-time service provided by the Corps member will not be less than 16 hours of clinical service per week;

''(E) the Corps member agrees in writing that the period of obligated service pursuant to section 338B will be extended so that the aggregate amount of less than full-time service performed will equal the amount of service that would be performed through full-time service under section 338C; and

''(F) the Corps member agrees in writing that if the Corps member begins providing less than full-time service but fails to begin or complete the period of obligated service, the method stated in 338E(c) for determining the damages for breach of the individual's written contract will be used after converting periods of obligated service or of service performed into their full-time equivalents.''.

SEC. 302. DESIGNATION OF HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) IN GENERAL.—Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by inserting after the first sentence the following: ''All Federally qualified health centers and rural health clinics, as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)), that meet the requirements of section 334 shall be automatically designated as having such a shortage. Not earlier than 6 years after such date of enactment, and every 6 years thereafter, each such center or clinic shall demonstrate that the center or clinic meets the applicable requirements of the Federal regulations, issued after the date of enactment of this Act, that revise the definition of a health professional shortage area for purposes of this section.''; and

(B) in paragraph (3), by striking ''340(r)) may be a population group'' and inserting ''330(h)(4)), seasonal agricultural workers (as defined in section 330(g)(3)) and migratory agricultural workers (as so defined)), and residents of public housing (as defined in section 3(b)(1) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(1))) may be population groups'';

(2) in subsection (b)(2), by striking ''with special consideration to the indicators of'' and all that follows through ''services.'' and inserting a period; and

(3) in subsection (c)(2)(B), by striking ''XVIII or XIX'' and inserting ''XVIII, XIX, or XXI''.

(b) REGULATIONS.—

(1) REPORT.—

(A) IN GENERAL.—The Secretary shall submit the report described in subparagraph (B) if the Secretary, acting through the Administrator of the Health Resources and Services Administration, issues—

(i) a regulation that revises the definition of a health professional shortage area for purposes of section 332 of the Public Health Service Act (42 U.S.C. 254e); or

(ii) a regulation that revises the standards concerning priority of such an area under section 333A of that Act (42 U.S.C. 254f–1).

(B) REPORT.—On issuing a regulation described in subparagraph (A), the Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that describes the regulation.

(2) EFFECTIVE DATE.—Each regulation described in paragraph (1)(A) shall take effect 180 days after the committees described in paragraph (1)(B) receive a report referred to in paragraph (1)(B) describing the regulation.

(c) SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS.—The Secretary of Health and Human Services, in consultation with organizations representing individuals in the dental field and organizations representing publicly funded health care providers, shall develop and implement a plan for increasing the participation of dentists and dental hygienists in the National Health Service Corps Scholarship Program under section 338A of the Public Health Service Act (42 U.S.C. 2541) and the Loan Repayment Program under section 338B of such Act (42 U.S.C. 2541–1).

(d) SITE DESIGNATION PROCESS.—

(1) IMPROVEMENT OF DESIGNATION PROCESS.—The Administrator of the Health Resources and Services Administration, in consultation with appropriate State and territorial dental directors, dental societies, and other interested parties, shall revise the criteria on which the designations of dental health professional shortage areas are based so that such criteria provide a more accurate reflection of oral health care need, particularly in rural areas.

(2) PUBLIC HEALTH SERVICE ACT.—Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended by adding at the end the following:

''(i) DISSEMINATION.—The Administrator of the Health Resources and Services Administration shall disseminate information concerning the designation criteria described in subsection (b) to—

''(1) the Governor of each State;

''(2) the representative of any area, population group, or facility selected by any such Governor to receive such information;

''(3) the representative of any area, population group, or facility that requests such information; and

''(4) the representative of any area, population group, or facility determined by the Administrator to be likely to meet the criteria described in subsection (b).''.

(e) GAO STUDY.—Not later than February 1, 2005, the Comptroller General of the United States shall submit to the Congress a report on the appropriateness of the criteria, including but not limited to infant mortality rates, access to health services taking into account the distance to primary health services, the rate of poverty and ability to pay for health services, and low birth rates, established by the Secretary of Health and Human Services for the designation of health professional shortage areas and whether the deeming of Federally qualified health centers and rural health clinics as such areas is appropriate and necessary.

SEC. 303. ASSIGNMENT OF CORPS PERSONNEL.

Section 333 of the Public Health Service Act (42 U.S.C. 254f) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) in the matter before subparagraph (A), by striking ''(specified in the agreement described in section 334)'';

(ii) in subparagraph (A), by striking ''nonprofit''; and

(iii) by striking subparagraph (C) and inserting the following:

''(C) the entity agrees to comply with the requirements of section 334; and''; and

(B) in paragraph (3), by adding at the end ''In approving such applications, the Secretary shall give preference to applications in which a nonprofit entity or public entity shall provide a site to which Corps members may be assigned.''; and

(2) in subsection (d)—

(A) in paragraphs (1), (2), and (4), by striking ''nonprofit'' each place it appears; and

(B) in paragraph (1)—

(i) in the second sentence—

(I) in subparagraph (C), by striking ''and'' at the end; and

(II) by striking the period and inserting '', and (E) developing long-term plans for addressing health professional shortages and improving access to health care.''; and

(ii) by adding at the end the following: ''The Secretary shall encourage entities that receive technical assistance under this paragraph to communicate with other communities, State Offices of Rural Health, State Primary Care Associations and Offices, and other entities concerned with site development and community needs assessment.''.

SEC. 304. PRIORITIES IN ASSIGNMENT OF CORPS PERSONNEL.

Section 333A of the Public Health Service Act (42 U.S.C. 254f–1) is amended—

(1) in subsection (a)(1)(A), by striking '', as determined in accordance with subsection (b)'';

(2) by striking subsection (b);

(3) in subsection (c), by striking the second sentence;

(4) in subsection (d)—

(A) by redesignating paragraphs (1) through (3) as paragraphs (2) through (4), respectively;

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

''(1) PROPOSED LIST.—The Secretary shall prepare and publish a proposed list of health professional shortage areas and entities that would receive priority under subsection (a)(1) in the assignment of Corps members. The list shall contain the information described in paragraph (2), and the relative scores and relative priorities of the entities submitting applications under section 333, in a proposed format. All such entities shall have 30 days after the date of publication of the list to provide additional data and information in support of inclusion on the list or in support of a higher priority determination and the Secretary shall reasonably consider such data and information in preparing the final list under paragraph (2).'';

(C) in paragraph (2) (as redesignated by subparagraph (A)), in the matter before subparagraph (A)—

(i) by striking ''paragraph (2)'' and inserting ''paragraph (3)'';

(ii) by striking ''prepare a list of health professional shortage areas'' and inserting ''prepare and, as appropriate, update a list of health professional shortage areas and entities''; and

(iii) by striking ''for the period applicable under subsection (f)'';

(D) by striking paragraph (3) (as redesignated by subparagraph (A)) and inserting the following:

''(3) NOTIFICATION OF AFFECTED PARTIES.—

''(A) ENTITIES.—Not later than 30 days after the Secretary has added to a list under paragraph (2) an entity specified as described in subparagraph (A) of such paragraph, the Secretary shall notify such entity that the entity has been provided an authorization to receive assignments of Corps members in the event that Corps members are available for the assignments.

''(B) INDIVIDUALS.—In the case of an individual obligated to provide service under the Scholarship Program, not later than 3 months before the date described in section 338C(b)(5), the Secretary shall provide to such individual the names of each of the entities specified as described in paragraph (2)(B)(i) that is appropriate for the individual's medical specialty and discipline.''; and

(E) by striking paragraph (4) (as redesignated by subparagraph (A)) and inserting the following:

''(4) REVISIONS.—If the Secretary proposes to make a revision in the list under paragraph (2), and the revision would adversely alter the status of an entity with respect to the list, the Secretary shall notify the entity of the revision. Any entity adversely affected by such a revision shall be notified in writing by the Secretary of the reasons for the revision and shall have 30 days to file a written appeal of the determination involved which shall be reasonably considered by the Secretary before the revision to the list becomes final. The revision to the list shall be effective with respect to assignment of Corps members beginning on the date that the revision becomes final.'';

(5) by striking subsection (e) and inserting the following:

''(e) LIMITATION ON NUMBER OF ENTITIES OFFERED AS ASSIGNMENT CHOICES IN SCHOLARSHIP PROGRAM.—

''(1) DETERMINATION OF AVAILABLE CORPS MEMBERS.—By April 1 of each calendar year, the Secretary shall determine the number of participants in the Scholarship Program who will be available for assignments under section 333 during the program year beginning on July 1 of that calendar year.

''(2) DETERMINATION OF NUMBER OF ENTITIES.—At all times during a program year, the number of entities specified under subsection (c)(2)(B)(i) shall be—

''(A) not less than the number of participants determined with respect to that program year under paragraph (1); and

''(B) not greater than twice the number of participants determined with respect to that program year under paragraph (1).'';

(6) by striking subsection (f); and

(7) by redesignating subsections (c), (d), and (e) as subsections (b), (c), and (d) respectively.

SEC. 305. COST-SHARING.

Subpart II of part D of title III of the Public Health Service Act (42 U.S.C. 254d et seq.) is amended by striking section 334 and inserting the following:

''SEC. 334. CHARGES FOR SERVICES BY ENTITIES USING CORPS MEMBERS.

''(a) AVAILABILITY OF SERVICES REGARDLESS OF ABILITY TO PAY OR PAYMENT SOURCE.—An entity to which a Corps member is assigned shall not deny requested health care services, and shall not discriminate in the provision of services to an individual—

''(1) because the individual is unable to pay for the services; or

''(2) because payment for the services would be made under—

''(A) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

''(B) the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.); or

''(C) the State children's health insurance program under title XXI of such Act (42 U.S.C. 1397aa et seq.).

''(b) CHARGES FOR SERVICES.—The following rules shall apply to charges for health care services provided by an entity to which a Corps member is assigned:

''(1) IN GENERAL.—

''(A) SCHEDULE OF FEES OR PAYMENTS.—Except as provided in paragraph (2), the entity shall prepare a schedule of fees or payments for the entity's services, consistent with locally prevailing rates or charges and designed to cover the entity's reasonable cost of operation.

''(B) SCHEDULE OF DISCOUNTS.—Except as provided in paragraph (2), the entity shall prepare a corresponding schedule of discounts (including, in appropriate cases, waivers) to be applied to such fees or payments. In preparing the schedule, the entity shall adjust the discounts on the basis of a patient's ability to pay.

''(C) USE OF SCHEDULES.—The entity shall make every reasonable effort to secure from patients fees and payments for services in accordance with such schedules, and fees or payments shall be sufficiently discounted in accordance with the schedule described in subparagraph (B).

''(2) SERVICES TO BENEFICIARIES OF FEDERAL AND FEDERALLY ASSISTED PROGRAMS.—In the case of health care services furnished to an individual who is a beneficiary of a program listed in subsection (a)(2), the entity—

''(A) shall accept an assignment pursuant to section 1842(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)(ii)) with respect to an individual who is a beneficiary under the medicare program; and

''(B) shall enter into an appropriate agreement with—

''(i) the State agency administering the program under title XIX of such Act with respect to an individual who is a beneficiary under the medicaid program; and

''(ii) the State agency administering the program under title XXI of such Act with respect to an individual who is a beneficiary under the State children's health insurance program.

''(3) COLLECTION OF PAYMENTS.—The entity shall take reasonable and appropriate steps to collect all payments due for health care services provided by the entity, including payments from any third party (including a Federal, State, or local government agency and any other third party) that is responsible for part or all of the charge for such services.''.

SEC. 306. ELIGIBILITY FOR FEDERAL FUNDS.

Section 335(e)(1)(B) of the Public Health Service Act (42 U.S.C. 254h(e)(1)(B)) is amended by striking ''XVIII or XIX'' and inserting ''XVIII, XIX, or XXI''.

SEC. 307. FACILITATION OF EFFECTIVE PROVISION OF CORPS SERVICES.

(a) HEALTH PROFESSIONAL SHORTAGE AREAS.—Section 336 of the Public Health Service Act (42 U.S.C. 254h–1) is amended—

(1) in subsection (c), by striking ''health manpower'' and inserting ''health professional''; and

(2) in subsection (f)(1), by striking ''health manpower'' and inserting ''health professional''.

(b) TECHNICAL AMENDMENT.—Section 336A(8) of the Public Health Service Act (42 U.S.C. 254i(8)) is amended by striking ''agreements under''.

SEC. 308. AUTHORIZATION OF APPROPRIATIONS.

Section 338(a) of the Public Health Service Act (42 U.S.C. 254k(a)) is amended—

(1) by striking ''(1) For'' and inserting ''For'';

(2) by striking ''1991 through 2000'' and inserting ''2002 through 2006''; and

(3) by striking paragraph (2).

SEC. 309. NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.

Section 338A of the Public Health Service Act (42 U.S.C. 254l) is amended—

(1) in subsection (a)(1), by inserting ''behavioral and mental health professionals,'' after ''dentists,'';

(2) in subsection (b)(1)(B), by inserting '', or an appropriate degree from a graduate program of behavioral and mental health'' after ''other health profession'';

(3) in subsection (c)(1)—

(A) in subparagraph (A), by striking ''338D'' and inserting ''338E''; and

(B) in subparagraph (B), by striking ''338C'' and inserting ''338D'';

(4) in subsection (d)(1)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) by redesignating subparagraph (B) as subparagraph (C); and

(C) by inserting after subparagraph (A) the following:

''(B) the Secretary, in considering applications from individuals accepted for enrollment or enrolled in dental school, shall consider applications from all individuals accepted for enrollment or enrolled in any accredited dental school in a State; and'';

(5) in subsection (f)—

(A) in paragraph (1)(B)—

(i) in clause (iii), by striking ''and'' after the semicolon;

(ii) by redesignating clause (iv) as clause (v); and

(iii) by inserting after clause (iii) the following new clause:

''(iv) if pursuing a degree from a school of medicine or osteopathic medicine, to complete a residency in a specialty that the Secretary determines is consistent with the needs of the Corps; and''; and

(B) in paragraph (3), by striking ''338D'' and inserting ''338E''; and

(6) by striking subsection (i).

SEC. 310. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.

Section 338B of the Public Health Service Act (42 U.S.C. 254l–1) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by inserting ''behavioral and mental health professionals,'' after ''dentists,''; and

(B) in paragraph (2), by striking ''(including mental health professionals)'';

(2) in subsection (b)(1), by striking subparagraph (A) and inserting the following:

''(A) have a degree in medicine, osteopathic medicine, dentistry, or another health profession, or an appropriate degree from a graduate program of behavioral and mental health, or be certified as a nurse midwife, nurse practitioner, or physician assistant;'';

(3) in subsection (e), by striking ''(1) IN GENERAL.—''; and

(4) by striking subsection (i).

SEC. 311. OBLIGATED SERVICE.

Section 338C of the Public Health Service Act (42 U.S.C. 254m) is amended—

(1) in subsection (b)—

(A) in paragraph (1), in the matter preceding subparagraph (A), by striking ''section 338A(f)(1)(B)(iv)'' and inserting ''section 338A(f)(1)(B)(v)''; and

(B) in paragraph (5)—

(i) by striking all that precedes subparagraph (C) and inserting the following:

''(5)(A) In the case of the Scholarship Program, the date referred to in paragraphs (1) through (4) shall be the date on which the individual completes the training required for the degree for which the individual receives the scholarship, except that—

''(i) for an individual receiving such a degree after September 30, 2000, from a school of medicine or osteopathic medicine, such date shall be the date the individual completes a residency in a specialty that the Secretary determines is consistent with the needs of the Corps; and

''(ii) at the request of an individual, the Secretary may, consistent with the needs of the Corps, defer such date until the end of a period of time required for the individual to complete advanced training (including an internship or residency).'';

(ii) by striking subparagraph (D);

(iii) by redesignating subparagraphs (C) and (E) as subparagraphs (B) and (C), respectively; and

(iv) in clause (i) of subparagraph (C) (as redesignated by clause (iii)) by striking ''subparagraph (A), (B), or (D)'' and inserting ''subparagraph (A)''; and

(2) by striking subsection (e).

SEC. 312. PRIVATE PRACTICE.

Section 338D of the Public Health Service Act (42 U.S.C. 254n) is amended by striking subsection (b) and inserting the following:

''(b)(1) The written agreement described in subsection (a) shall—

''(A) provide that, during the period of private practice by an individual pursuant to the agreement, the individual shall comply with the requirements of section 334 that apply to entities; and

''(B) contain such additional provisions as the Secretary may require to carry out the objectives of this section.

''(2) The Secretary shall take such action as may be appropriate to ensure that the conditions of the written agreement prescribed by this subsection are adhered to.''.

SEC. 313. BREACH OF SCHOLARSHIP CONTRACT OR LOAN REPAYMENT CONTRACT.

(a) IN GENERAL.—Section 338E of the Public Health Service Act (42 U.S.C. 254o) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (A), by striking the comma and inserting a semicolon;

(B) in subparagraph (B), by striking the comma and inserting ''; or'';

(C) in subparagraph (C), by striking ''or'' at the end; and

(D) by striking subparagraph (D);

(2) in subsection (b)—

(A) in paragraph (1)(A)—

(i) by striking ''338F(d)'' and inserting ''338G(d)'';

(ii) by striking ''either'';

(iii) by striking ''338D or'' and inserting ''338D,''; and

(iv) by inserting ''or to complete a required residency as specified in section 338A(f)(1)(B)(iv),'' before ''the United States''; and

(B) by adding at the end the following new paragraph:

''(3) The Secretary may terminate a contract with an individual under section 338A if, not later than 30 days before the end of the school year to which the contract pertains, the individual—

''(A) submits a written request for such termination; and

''(B) repays all amounts paid to, or on behalf of, the individual under section 338A(g).'';

(3) in subsection (c)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''338F(d)'' and inserting ''338G(d)''; and

(ii) by striking subparagraphs (A) through (C) and inserting the following:

''(A) the total of the amounts paid by the United States under section 338B(g) on behalf of the individual for any period of obligated service not served;

''(B) an amount equal to the product of the number of months of obligated service that were not completed by the individual, multiplied by $7,500; and

''(C) the interest on the amounts described in subparagraphs (A) and (B), at the maximum legal prevailing rate, as determined by the Treasurer of the United States, from the date of the breach;

except that the amount the United States is entitled to recover under this paragraph shall not be less than $31,000.'';

(B) by striking paragraphs (2) and (3) and inserting the following:

''(2) The Secretary may terminate a contract with an individual under section 338B if, not later than 45 days before the end of the fiscal year in which the contract was entered into, the individual—

''(A) submits a written request for such termination; and

''(B) repays all amounts paid on behalf of the individual under section 338B(g).''; and

(C) by redesignating paragraph (4) as paragraph (3);

(4) in subsection (d)(3)(A), by striking ''only if such discharge is granted after the expiration of the five-year period'' and inserting ''only if such discharge is granted after the expiration of the 7-year period''; and

(5) by adding at the end the following new subsection:

''(e) Notwithstanding any other provision of Federal or State law, there shall be no limitation on the period within which suit may be filed, a judgment may be enforced, or an action relating to an offset or garnishment, or other action, may be initiated or taken by the Secretary, the Attorney General, or the head of another Federal agency, as the case may be, for the repayment of the amount due from an individual under this section.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(4) shall apply to any obligation for which a discharge in bankruptcy has not been granted before the date that is 31 days after the date of enactment of this Act.

SEC. 314. AUTHORIZATION OF APPROPRIATIONS.

Section 338H of the Public Health Service Act (42 U.S.C. 254q) is amended to read as follows:

''SEC. 338H. AUTHORIZATION OF APPROPRIATIONS.

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this subpart, there are authorized to be appropriated $146,250,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.

''(b) SCHOLARSHIPS AND LOAN REPAYMENTS.—With respect to certification as a nurse practitioner, nurse midwife, or physician assistant, the Secretary shall, from amounts appropriated under subsection (a) for a fiscal year, obligate not less than a total of 10 percent for contracts for both scholarships under the Scholarship Program under section 338A and loan repayments under the Loan Repayment Program under section 338B to individuals who are entering the first year of a course of study or program described in section 338A(b)(1)(B) that leads to such a certification or individuals who are eligible for the loan repayment program as specified in section 338B(b) for a loan related to such certification.''.

SEC. 315. GRANTS TO STATES FOR LOAN REPAYMENT PROGRAMS.

Section 338I of the Public Health Service Act (42 U.S.C. 254q–1) is amended—

(1) in subsection (a), by striking paragraph (1) and inserting the following:

''(1) AUTHORITY FOR GRANTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States for the purpose of assisting the States in operating programs described in paragraph (2) in order to provide for the increased availability of primary health care services in health professional shortage areas. The National Advisory Council established under section 337 shall advise the Administrator regarding the program under this section.'';

(2) in subsection (e), by striking paragraph (1) and inserting the following:

''(1) to submit to the Secretary such reports regarding the States loan repayment program, as are determined to be appropriate by the Secretary; and''; and

(3) in subsection (i), by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—For the purpose of making grants under subsection (a), there are authorized to be appropriated $12,000,000 for fiscal year 2002 and such sums as may be necessary for each of fiscal years 2003 through 2006.''.

SEC. 316. DEMONSTRATION GRANTS TO STATES FOR COMMUNITY SCHOLARSHIP PROGRAMS.

Section 338L of the Public Health Service Act (42 U.S.C. 254t) is repealed.

TITLE IV—ADDITIONAL PROVISIONS

SEC. 401. COMMUNITY ACCESS DEMONSTRATION PROGRAM.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after subpart IV the following new subpart:

''Subpart V—Community Access Demonstration Program

''SEC. 340. GRANTS TO STRENGTHEN EFFECTIVENESS, EFFICIENCY, AND COORDINATION OF SERVICES FOR THE UNINSURED AND UNDERINSURED.

''(a) IN GENERAL.—

''(1) GRANTS.—The Secretary may make not more than 35 grants for the purpose of carrying out demonstration projects to improve the effectiveness, efficiency, and coordination of services for uninsured and underinsured individuals.

''(2) PROJECT PERIOD.—A demonstration project under this section may not receive funding under this section for more than three fiscal years.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity must—

''(1) be an entity that is a public or private entity such as—

''(A) a Federally qualified health center (as defined under section 1861(aa)(4) of the Social Security Act);

''(B) a hospital that meets the requirements of section 340B(a)(4)(L) (or, if none are available in the area, a hospital that is a provider of a substantial volume of nonemergency health services to uninsured individuals and families without regard to their ability to pay) without regard to 340B (a)(4)(L)(iii); or

''(C) a public health department; or

''(2) represent a consortium of providers and, as appropriate, related agencies or entities—

''(A) whose principal purpose is to provide a broad range of coordinated health care services in a geographic area defined in the entity's grant application;

''(B) that includes health care providers that serve such geographic area and that have traditionally provided care (beyond emergency services) to uninsured and underinsured individuals without regard to the individuals' ability to pay; and

''(C) that may include other health care providers and related agencies and organizations;

except that preference may be given to applicants that are health care providers identified in paragraph (1).

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an eligible entity shall submit to the Secretary an application, in such form and manner as the Secretary shall prescribe, that shall—

''(1) define a geographic area of uninsured and underinsured individuals;

''(2) identify the providers who will participate in the consortium's program under the grant, and specify each one's contribution to the care of uninsured and underinsured individuals in such geographic area, including the volume of care it provides to medicare and medicaid beneficiaries, to individuals served by the program under title XXI of the Social Security Act (relating to SCHIP), and to privately paid patients;

''(3) describe the activities that the applicant and the consortium propose to perform under the grant to further the purposes of this section;

''(4) demonstrate the consortium's ability to build on the current system for serving uninsured and underinsured individuals by involving providers who have traditionally provided a significant volume of care for that community;

''(5) demonstrate the consortium's ability to develop coordinated systems of care that either directly provide or ensure the prompt provision of a broad range of high-quality, accessible services, including, as appropriate, primary, secondary, and tertiary services, as well as substance abuse treatment and mental health services in a manner which assures continuity of care in the community;

''(6) provide evidence of community involvement in the development, implementation, and direction of the program that it proposes to operate;

''(7) demonstrate the consortium's ability to ensure that individuals participating in the program are enrolled in public insurance programs for which they are eligible (or know of private insurance options available to them, if any);

''(8) present a plan for leveraging other sources of revenue, which may include State and local sources and private grant funds, and integrating current and proposed new funding sources in a way to assure long-term sustainability;

''(9) describe a plan for evaluation of the activities carried out under the grant, including measurement of progress toward the goals and objectives of the program;

''(10) demonstrate fiscal responsibility through the use of appropriate accounting procedures and appropriate management systems;

''(11) include such other information as the Secretary may prescribe; and

''(12) demonstrate the commitment to serve individuals in the geographic area without regard to the ability of the individual or family to pay by arranging for or providing free or reduced charge care for the poor.

''(d) PRIORITIES.—In awarding grants under this section, the Secretary may accord priority to applicants—

''(1) whose consortium includes public hospitals, Federally qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act), and other providers that are covered entities as defined by section 340B(a)(4) of this Act (or that would be covered entities as so defined but for subparagraph (L)(iii) of such section);

''(2) that identify a geographic area has a high or increasing percentage of individuals who are uninsured;

''(3) whose consortium includes other health care providers that have a tradition of serving uninsured individuals and underinsured individuals in the community;

''(4) who show evidence that the program would expand utilization of preventive and primary care services for uninsured and underinsured individuals and families in the community, including mental health services or substance abuse services;

''(5) whose proposed program would improve coordination between health care providers and appropriate social service providers, including local and regional human services agencies, school systems, and agencies on aging;

''(6) that demonstrate collaboration with State and local governments;

''(7) that make use of non-Federal contributions to the greatest extent possible; or

''(8) that demonstrate a significant likelihood that the proposed program will continue after support under this section ceases.

''(e) USE OF FUNDS.—

''(1) USE BY GRANTEES.—

''(A) IN GENERAL.—Except as provided in paragraphs (2) and (3), a grantee may use amounts provided under this section only for—

''(i) direct expenses associated with operating the greater integration of a health care delivery system so that it either directly provides or ensures the provision of a broad range of services, as appropriate, including primary, secondary, and tertiary services, as well as substance abuse treatment and mental health services; and

''(ii) direct patient care and service expansions to fill identified or documented gaps within an integrated delivery system.

''(B) SPECIFIC USES.—The following are examples of purposes for which a grantee may use grant funds, when such use meets the conditions stated in subparagraph (A):

''(i) Increase in outreach activities.

''(ii) Improvements to case management.

''(iii) Development of provider networks.

''(iv) Recruitment, training, and compensation of necessary personnel.

''(v) Acquisition of technology for the purpose of coordinating health care.

''(vi) Identifying and closing gaps in health care services being provided.

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

''(viii) Other activities that may be appropriate to a community that would increase access to the uninsured.

''(2) RESERVATION OF FUNDS FOR NATIONAL PROGRAM PURPOSES.—The Secretary may use not more than 3 percent of funds appropriated to carry out this section for technical assistance to grantees, obtaining assistance of experts and consultants, meetings, dissemination of information, evaluation, and activities that will extend the benefits of funded programs to communities other than the one funded.

''(f) MAINTENANCE OF EFFORT.—With respect to activities for which a grant under this section is authorized, the Secretary may award such a grant only if the recipient of the grant and each of the participating providers agree that each one will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such expenditures during the year immediately preceding the fiscal year for which the applicant is applying to receive such grant.

''(g) REPORTS TO THE SECRETARY.—The recipient of a grant under this section shall report to the Secretary annually regarding—

''(1) progress in meeting the goals stated in its grant application; and

''(2) such additional information as the Secretary may require.

The Secretary may not renew an annual grant under this section unless the Secretary is satisfied that the consortium has made reasonable and demonstrable progress in meeting the goals set forth in its grant application for the preceding year.

''(h) AUDITS.—Each entity which receives a grant under this section shall provide for an independent annual financial audit of all records that relate to the disposition of funds received through this grant.

''(i) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or

contract, provide any funded entity with technical and other non-financial assistance necessary to meet the requirements of this section.

''(j) REPORT.—Not later than September 30, 2005, the Secretary shall submit to the Congress a report describing the extent to which demonstration projects under this section have been successful in improving the effectiveness, efficiency, and coordination of services for uninsured and underinsured individuals in the geographic areas served by such projects, including providing better quality health care for such individuals, and at lower costs, than would have been the case in the absence of such projects.

''(k) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.''.

SEC. 402. EXPANDING AVAILABILITY OF DENTAL SERVICES.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart X—Primary Dental Programs

''SEC. 340F. DESIGNATED DENTAL HEALTH PROFESSIONAL SHORTAGE AREA.

''In this subpart, the term 'designated dental health professional shortage area' means an area, population group, or facility that is designated by the Secretary as a dental health professional shortage area under section 332 or designated by the applicable State as having a dental health professional shortage.

''SEC. 340G. GRANTS FOR INNOVATIVE PROGRAMS.

''(a) GRANT PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, is authorized to award grants to States for the purpose of helping States develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas in a manner that is appropriate to the States' individual needs.

''(b) STATE ACTIVITIES.—A State receiving a grant under subsection (a) may use funds received under the grant for—

''(1) loan forgiveness and repayment programs for dentists who—

''(A) agree to practice in designated dental health professional shortage areas;

''(B) are dental school graduates who agree to serve as public health dentists for the Federal, State, or local government; and

''(C) agree to—

''(i) provide services to patients regardless of such patients' ability to pay; and

''(ii) use a sliding payment scale for patients who are unable to pay the total cost of services;

''(2) dental recruitment and retention efforts;

''(3) grants and low-interest or no-interest loans to help dentists who participate in the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to establish or expand practices in designated dental health professional shortage areas by equipping dental offices or sharing in the overhead costs of such practices;

''(4) the establishment or expansion of dental residency programs in coordination with accredited dental training institutions in States without dental schools;

''(5) programs developed in consultation with State and local dental societies to expand or establish oral health services and facilities in designated dental health professional shortage areas, including services and facilities for children with special needs, such as—

''(A) the expansion or establishment of a community-based dental facility, free-standing dental clinic, consolidated health center dental facility, school-linked dental facility, or United States dental school-based facility;

''(B) the establishment of a mobile or portable dental clinic; and

''(C) the establishment or expansion of private dental services to enhance capacity through additional equipment or additional hours of operation;

''(6) placement and support of dental students, dental residents, and advanced dentistry trainees;

''(7) continuing dental education, including distance-based education;

''(8) practice support through teledentistry conducted in accordance with State laws;

''(9) community-based prevention services such as water fluoridation and dental sealant programs;

''(10) coordination with local educational agencies within the State to foster programs that promote children going into oral health or science professions;

''(11) the establishment of faculty recruitment programs at accredited dental training institutions whose mission includes community outreach and service and that have a demonstrated record of serving underserved States;

''(12) the development of a State dental officer position or the augmentation of a State dental office to coordinate oral health and access issues in the State; and

''(13) any other activities determined to be appropriate by the Secretary.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each State desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

''(2) ASSURANCES.—The application shall include assurances that the State will meet the requirements of subsection (d) and that the State possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

''(d) MATCHING REQUIREMENT.—The Secretary may not make a grant to a State under this section unless that State agrees that, with respect to the costs to be incurred by the State in carrying out the activities for which the grant was awarded, the State will provide non-Federal contributions in an amount equal to not less than 40 percent of Federal funds provided under the grant. The State may provide the contributions in cash or in kind, fairly evaluated, including plant, equipment, and services and may provide the contributions from State, local, or private sources.

''(e) REPORT.—Not later than 5 years after the date of enactment of the Health Care Safety Net Improvement Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report containing data relating to whether grants provided under this section have increased access to dental services in designated dental health professional shortage areas.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for the 5-fiscal year period beginning with fiscal year 2002.''.

SEC. 403. STUDY REGARDING BARRIERS TO PARTICIPATION OF FARMWORKERS IN HEALTH PROGRAMS.

(a) IN GENERAL.—The Secretary shall conduct a study of the problems experienced by farmworkers (including their families) under Medicaid and SCHIP. Specifically, the Secretary shall examine the following:

(1) BARRIERS TO ENROLLMENT.—Barriers to their enrollment, including a lack of outreach and outstationed eligibility workers, complicated applications and eligibility determination procedures, and linguistic and cultural barriers.

(2) LACK OF PORTABILITY.—The lack of portability of Medicaid and SCHIP coverage for farmworkers who are determined eligible in one State but who move to other States on a seasonal or other periodic basis.

(3) POSSIBLE SOLUTIONS.—The development of possible solutions to increase enrollment and access to benefits for farmworkers, because, in part, of the problems identified in paragraphs (1) and (2), and the associated costs of each of the possible solution described in subsection (b).

(b) POSSIBLE SOLUTIONS.—Possible solutions to be examined shall include each of the following:

(1) INTERSTATE COMPACTS.—The use of interstate compacts among States that establish portability and reciprocity for eligibility for farmworkers under the Medicaid and SCHIP and potential financial incentives for States to enter into such compacts.

(2) DEMONSTRATION PROJECTS.—The use of multi-state demonstration waiver projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to develop comprehensive migrant coverage demonstration projects.

(3) USE OF CURRENT LAW FLEXIBILITY.—Use of current law Medicaid and SCHIP State plan provisions relating to coverage of residents and out-of-State coverage.

(4) NATIONAL MIGRANT FAMILY COVERAGE.—The development of programs of national migrant family coverage in which States could participate.

(5) PUBLIC-PRIVATE PARTNERSHIPS.—The provision of incentives for development of public-private partnerships to develop private coverage alternatives for farmworkers.

(6) OTHER POSSIBLE SOLUTIONS.—Such other solutions as the Secretary deems appropriate.

(c) CONSULTATIONS.—In conducting the study, the Secretary shall consult with the following:

(1) Farmworkers affected by the lack of portability of coverage under the Medicaid program or the State children's health insurance program (under titles XIX and XXI of the Social Security Act).

(2) Individuals with expertise in providing health care to farmworkers, including designees of national and local organizations representing migrant health centers and other providers.

(3) Resources with expertise in health care financing.

(4) Representatives of foundations and other nonprofit entities that have conducted or supported research on farmworker health care financial issues.

(5) Representatives of Federal agencies which are involved in the provision or financing of health care to farmworkers, including the Health Care Financing Administration and the Health Research and Services Administration.

(6) Representatives of State governments.

(7) Representatives from the farm and agricultural industries.

(8) Designees of labor organizations representing farmworkers.

(d) DEFINITIONS.—For purposes of this section:

(1) FARMWORKER.—The term ''farmworker'' means a migratory agricultural worker or seasonal agricultural worker, as such terms are defined in section 330(g)(3) of the Public Health Service Act (42 U.S.C. 254c(g)(3)), and includes a family member of such a worker.

(2) MEDICAID.—The term ''Medicaid'' means the program under title XIX of the Social Security Act.

(3) SCHIP.—The term ''SCHIP'' means the State children's health insurance program under title XXI of the Social Security Act.

(e) REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall transmit a report to the President and the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 404. ELIGIBILITY OF CERTAIN ENTITIES FOR GRANTS.

If under a program established in this Act (other than section 401), or if pursuant to an amendment made by this Act, a private entity that is not a nonprofit entity is eligible for an award of a grant, contract, or cooperative agreement, such an award may not be made to such private entity unless the entity is the only available provider of quality health services in the geographic area involved.

SEC. 405. CONFORMING AMENDMENTS.

(a) HOMELESS PROGRAMS.—Subsections (g)(1)(G)(ii), (k)(2), and (n)(1)(C) of section 224, and sections 317A(a)(2), 317E(c), 318A(e), 332(a)(2)(C), 340D(c)(5), 799B(6)(B), 1313, and 2652(2) of the Public Health Service Act (42 U.S.C. 233, 247b–1(a)(2), 247b–6(c), 247c–1(e), 254e(a)(2)(C), 256d(c)(5), 295p(6)(B), 300e–12, and 300ff–52(2)) are amended by striking ''340'' and inserting ''330(h)''.

(b) HOMELESS INDIVIDUAL.—Section 534(2) of the Public Health Service Act (42 U.S.C. 290cc–34(2)) is amended by striking ''340(r)'' and inserting ''330(h)(5)''.

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

The Chair recognizes the gentleman from Florida (Mr. BILIRAKIS).

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation, and to insert extraneous material on the bill.

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

There was no objection.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of H.R. 3450, the Health Care Safety Net Improvement Act. This bill reauthorizes our Nation's key health care delivery systems and creates additional efficiencies. Specifically, this bill reauthorizes the Community Health Center program, the National Health Service Corps and rural outreach grants. Each of these programs ensures that both the uninsured and the underinsured have access to quality health care services.

Since 1965, America's health centers have delivered comprehensive services to people who otherwise would face major barriers to obtaining quality, affordable health care. Health centers serve those who are hardest to reach and are required by law to make their services accessible to everyone, regardless of their ability to pay.

Our legislation increases the funding authorization for health centers to $1.293 billion. We have included language allowing health centers to provide behavioral, mental health, and substance abuse services if they choose. The legislation also creates a new program for practice management networks. These networks will improve access to care and reduce costs of delivering the high-quality care that health centers provide.

Many community health centers are located in America's inner cities, isolated rural areas, and migrant farm worker communities, which often lack adequate numbers of health professionals. H.R. 3450 ensures that health centers will have an easier process for becoming designated as a health professional shortage area. The HPSA designation is important because it will help health centers access health professionals through other Federal programs.

One of the most important programs for ensuring an adequate supply of health professionals is the National Health Service Corps. The National Health Service Corps recruits, trains, and places primary care providers in both urban and rural health care shortage areas. Program participants are health professionals who receive educational assistance in return for a period of obligated service.

Our legislation reauthorizes this vital program, which serves as a pipeline for health care facilities that have trouble attracting health professionals. The bill strengthens the service obligation requirements of the National Health Service Corps. By strengthening this provision, health care facilities using program graduates can be certain that health corps personnel will fulfill their entire service contract, something I have been concerned with for years and years.

H.R. 3450 also recognizes the importance of oral health care and authorizes the inclusion of primary dental care education. The bill creates flexibility for the HHS Secretary in administering the program to ensure that resources are maximized between the loan repayment and the scholarship programs.

Another area of focus in the Safety Net Improvement Act is in the rural health arena. Often rural communities have trouble developing capacity and maintaining health care facilities. Our bill includes programs that will help rural providers develop new service capacity and integrated health delivery networks. It will help rural facilities implement quality improvement initiatives.

A concern for many rural communities is the delivery of adequate specialty care and mental health services. Our bill consolidates programs within the Office of Telehealth to build on them to deliver services via teletechnologies. We authorize funding for the creation of programs that will expand access to, coordinate, and improve the quality of health services. These programs will also improve and expand the training of health care providers and the quality of health information available to underserved communities.

Mr. Speaker, I believe using telehealth technologies is an effective and efficient way to expand access to care for those in the most remote locations of our country. H.R. 3450 authorizes for the first time a demonstration program to coordinate the care that individuals receive in a particular geographic area. I believe that programs like this may help reduce duplicative services and lead to greater efficiencies within our systems, and I anxiously await the GAO study on this program so we may better evaluate its overall effectiveness.

As health care delivery becomes more complex, we must be sure that we have the trained professionals and the necessary infrastructure to address the increasing demand for health care services.

Mr. Speaker, given recent events and news of increasing numbers of uninsured, it is vitally important that we keep our safety net strong. I believe this bill is a good start, and I am certain it will improve services for our most vulnerable populations. I urge Members to support H.R. 3450, the Health Care Safety Net Improvement Act.

Mr. Speaker, I reserve the balance of my time.

Mr. GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 3450, the Health Care Safety Net Improvement Act, and I thank the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) for bringing this important legislation to the floor today. I would also like to thank the gentleman from Louisiana (Chairman TAUZIN) and the ranking member, the gentleman from Michigan (Mr. DINGELL), for their efforts to improve access to quality preventive and primary health care for the millions of medically underserved Americans who rely on these programs.

This important legislation strengthens our health care safety net by reauthorizing the Consolidated Health Centers program, the National Health Services Corps, certain rural health programs, and creating a new Community Access Demonstration Program.

This legislation could not come at a better time. The U.S. Census Bureau announced on Sunday that the number of uninsured people in the United States increased by 1.4 million in 2001 to more than 41 million Americans.

With the decline in the economy and escalating health care costs, the ranks of the uninsured will continue to grow. We must act now to ensure that our health care safety net is prepared for the flood of newly uninsured individuals. These programs ensure that all Americans have access to health care, regardless of their ability to pay.

I would like to take a moment to talk about the Community Access Program, or CAP program, as this is an

issue I have been working on for a number of years. The CAP program was launched as a demonstration project in fiscal year 2000, providing grants to 23 communities across the country. This program has expanded in fiscal year 2001 to 77 communities, and again in fiscal year 2002 to a total of 136 communities.

The CAP program provides grants to help agencies coordinate preventive and primary care for that 41 million Americans without insurance. The uninsured and underinsured tend to be more expensive to treat, often because they fall through the cracks in our health care system. Instead of getting checkups and having small problems looked at, the uninsured often ignore the symptoms of what might be larger problems because they simply cannot afford to go to the doctor. CAP can help fill the gaps in our health care safety net by improving infrastructure and communication among the agencies to ensure that care is continuous.

With better information, agencies can provide preventive, primary, and emergency clinical health services in an integrated and coordinated manner.

I am particularly proud of the CAP program in Houston, Texas, which has been operating for the past 2 years. Using Federal CAP funds, the Harris County Community Access Collaborative was able to grow into an organization consisting of 78 member and affiliate groups working together to coordinate and improve access to health care. In just the last year, over 9,000 persons have been assisted during the 15,000 interventions to procure access to care through navigation services.

And after-hours telephone service called Ask Your Nurse has been opened that is designed to provide health care information to 20,000 callers per year as an alternative to emergency rooms. The collaborative is also supporting the redesign of existing safety net services in order to assist them to use their resources more efficiently resulting in the increase of services to 18,000 to 24,000 additional persons. This kind of program not only helps ease some of the burdens on our health care system, but makes a tremendous difference in the quality of life for many of these patients. That is why I am pleased to support H.R. 3450, including a 3-year demonstration program for the CAP program.

However, I am concerned that H.R. 3450 limits the number of grants nationally to 35 and that the initial authorization level in the bill will not adequately support the program or provide for its growth.

Given that there are currently 136 grantees and many more prospective CAP participants, I support efforts to achieve the strongest CAP provisions possible as the bill moves forward. It is my hope in the closing days of the 107th Congress, we are able to work out the differences and produce a strong and effective CAP program.

Mr. Speaker, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to acknowledge the work of the gentleman from Texas (Mr. GREEN) on the entire issue of the Safety Net Community Health Centers, and particularly the CAP program. It sounds like a terrific concept, and we are continuing to talk on it and hopefully improve on what we have in this legislation insofar as that area is concerned. But it is important also that we have oversight, and take a look at how it is working and is it working, as we hope and dream that it is working.

Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois (Mr. SHIMKUS).

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

□ 1245

Mr. SHIMKUS. Mr. Speaker, as a cosponsor of the bill and as a proud member of the Committee on Energy and Commerce, I would like to commend the distinguished gentleman from Florida (Mr. BILIRAKIS), the Commerce Subcommittee on Health and all those who have worked to bring this legislation to the floor. This bill will improve access to quality preventative and primary health care for the medically underserved, including the millions of Americans, many who reside in Illinois, without health insurance coverage.

First and foremost, H.R. 3450 would reauthorize the critically important Community Health Centers Program for another 5 years, including reaffirmation that health centers be located in high-need areas; provide comprehensive preventive and primary health care services; governed by community boards made up of a majority of current health care center patients to assure responsiveness to local needs; and open to everyone in the communities they serve, regardless of ability to pay.

I have been in love with community health centers since I have been involved here in Washington. They are meeting a great need. That is why I wholeheartedly support what we are doing here.

This legislation also authorizes for the very first time the Community Access Program, the CAP program as has been talked about earlier before me, which supports the development of communitywide networks to organize and improve access to health care in low-income and uninsured populations. The CAP program has proven successful in improving health care access, reducing emergency room use and saving money through shared resources and economies of scale.

I have had the opportunity to observe the benefits of this important program up close when I visited Macoupin County Health Department and the Springfield and Sangamon County Comprehensive Community Health Initiative, two innovative CAP projects in my district. I am proud to report that these two projects have helped tremendously to both expand and strengthen the health care safety net in the communities I represent.

I am pleased that H.R. 3450 includes a 5-year authorization for the CAP program. However, as has been stated by the chairman and the gentleman from Texas, H.R. 3450 limits the number of grants nationally to 35. Given that there are currently 136 grantees and many more prospective CAP participants, I strongly support efforts to achieve the strongest CAP provisions possible as the bill moves forward, most importantly the elimination of the bill's limit on the number of CAP grantees.

Again, I am pleased to support passage of H.R. 3450, and I stand ready to work with my esteemed colleagues to ensure that the Health Care Safety Net Improvement Act is enacted into law. I look forward to working with the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Texas (Mr. GREEN) in the future.

Mr. GREEN of Texas. Mr. Speaker, I yield 4 minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. I thank the gentleman from Texas for yielding me this time and also for his outstanding work on this legislation.

Mr. Speaker, as a cosponsor of the bill, former president of the National Association of Community Health Centers, cochair of the Health Center Caucus, former employee of two community health centers, and with 26 community health centers in my district, I rise to add my strong support for H.R. 3450, the Health Care Safety Net Improvement Act. I would like to commend the distinguished gentleman from Florida (Mr. BILIRAKIS), chairman of the House Energy and Commerce Subcommittee on Health, and the distinguished gentleman from Ohio (Mr. BROWN), ranking member of the House Energy and Commerce Subcommittee on Health, for bringing this important legislation to the floor today. I would also like to commend the distinguished gentleman from Louisiana (Mr. TAUZIN), chairman of the Committee on Energy and Commerce and the distinguished gentleman from Michigan (Mr. DINGELL), the ranking member, for their efforts to improve access to quality preventative and primary health care for the medically underserved, including the millions of Americans without health insurance coverage.

The Federal Health Centers Program was designed as a unique public-private partnership, with Federal resources provided directly to community organizations for the development and operation of local health care systems. Under program rules, a majority of the membership on the policy boards of the local health centers must consist of individuals who receive their health care at the local center and who represent the community being served. In this way communities in need are given the

resources to address their most pressing health problems, and they are held responsible for doing so.

Mr. Speaker, community health centers are truly integral threads of America's health care safety net. That is why I am pleased to support reauthorization of this critically important program for another 5 years.

Most importantly, H.R. 3450 strongly reaffirms the four foundations of the health centers programs that, one, health centers be located in high-need areas; two, provide comprehensive preventive and primary health care services; three, be governed by community boards made up of a majority of current health center patients to assure responsiveness to local needs; and, four, be open to everyone in the communities they serve, regardless of ability to pay. It is these requirements of the Health Centers Program that have made it a model of health care delivery for more than 30 years, providing high-quality, cost-effective primary and preventive health care to all who need it.

I am pleased, Mr. Speaker, that H.R. 3450 reauthorizes the Health Centers Program so that these centers can continue their proven record of attacking some of the most challenging health problems that exist. One example of this program's effectiveness is the tenacity with which health centers have addressed the racial and ethnic disparities in health care, a growing issue highlighted by the Institute of Medicine's March 2002 report entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.'' This report found overwhelming evidence that minorities in America generally receive poor health care even when income, insurance and medical conditions are similar. The report identified a number of causes for racial health disparities, including language barriers, inadequate coverage, provider bias, and lack of minority doctors. For most of us, this is not new.

This bill also expands the availability of dental health services at community health centers, which is so greatly and vitally needed even for senior citizens who have Medicare and still cannot get dental services.

Mr. Speaker, this is an outstanding program. I commend all of those who continue to make it happen.

Mr. BILIRAKIS. Mr. Speaker, I, too, thank the gentleman for his kind remarks and endorse his remarks.

Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. FOLEY).

Mr. FOLEY. Mr. Speaker, let me thank, first of all, the gentleman from Florida (Mr. BILIRAKIS), who is known as Mr. Health in the Florida delegation for his timely passage of H.R. 3450, and urge adoption. Coming from Florida, many people think of us as a very large urban regional center. They think of Palm Beach, they think of Tampa, they think of St. Petersburg, Jacksonville. They do not recognize the small agrarian rural counties that are contained in 67 counties in the great State of Florida.

I happen to represent communities that go from the east coast to the west coast, and they include such impoverished communities as Glades and Henry, where average, hard-working families have absolutely no access to quality health care. Fortunately, due to the work of the gentleman from Florida (Mr. BILIRAKIS) and the Committee on Energy and Commerce, we have seen an outpouring and a growth, if you will, of community health centers throughout these areas.

Five years ago most of these families would have had to travel to Lee County to gain any type of health care at all. Oftentimes doctors were not even available in the communities. You could not attract or recruit them. This bill goes a long way to ensuring not only do we have a quality work force of doctors, but trained professionals to assist.

The gentleman from Illinois just mentioned another important provision in this bill, which is dental health. Dental health is part of the physical being. If we do not adequately care for the dentures, the teeth, the jaws and gums of the individuals we serve, they will have a decline, if you will, of quality of life.

The mental health coverage provided in this bill is expanded, and it brings about new innovations.

We mentioned again about providing help to migratory and seasonal agricultural workers. Oftentimes if we can catch their illnesses early, we can actually save society a great deal of money. The sicker a person becomes, whether it is pneumonia or some other disease, the more expensive it is and typically will be treated in an emergency room where the cost is that much greater for Medicaid and some of the other delivery services. Some of the hospitals in my district are going uncompensated for the care of some of these individuals.

This is the underpinnings of this very well-crafted legislation, that it reaches out and not only provides a safety net for our communities, but actually strengthens the communities through a delivery system of quality health care. Every citizen in this country is entitled to quality health care regardless of their ability to pay and regardless of their ability to speak English, because oftentimes they are the hardest working among us.

Again, I commend and salute the chairman, the ranking member, and the gentleman from Texas for his hard work on this issue. I urge all colleagues to strongly support H.R. 3450.

Mr. BARR of Georgia. Mr. Speaker, since its creation in 1972, the National Health Service Corps (NHSC) has made a significant impact both in improving the distribution of health care providers (physicians, physician assistants, nurse practitioners and dentists) in the underserved areas of our country and increasing primary care access for at-risk populations.

The NHSC operates two programs to help meet the needs of underserved communities: the scholarship program and the loan repayment program. The scholarship program provides funds to students for educational living expenses during health care practitioner training. The loan repayment program provides financial assistance to help newly graduated practitioners repay their educational loans. For each year of NHSC scholarship or loan repayment support, participants are obligated to provide one year of medical care in underserved communities.

Noteworthy research comparing the effectiveness of the NHSC scholarship and loan repayment programs was conducted by The Cecil G. Sheps Center at UNC Chapel Hill, NC and Mathematica Policy Research—''Evaluation of the Effectiveness of the National Health Service Corps'' HRSA Contract No. 240–95–0038, May 31, 2000. This research confirmed that only 20.7 percent of NHSC scholarship recipients stayed at least one month beyond their service obligation, compared to 57.2 percent of NHSC loan repayment recipients.

In addition, the General Accounting Office (GAO), in a 1995 report entitled, ''National Health Service Corp: Opportunities to Stretch Scarce Dollars and Improve Provider Placement,'' concluded that the NHSC scholarship program was significantly more expensive than the NHSC loan repayment program. The report stated that ''loan repayment recipients cost the federal government one-half to one-third less than scholarship recipients and . . . the loan repayment program offers a better long term investment of limited federal dollars.''

Given this information from both the Sheps Center/Mathematica study and the GAO report, I am a strong advocate for removing the current 30 percent set aside for NHSC scholarships. The legislation before us today, H.R. 3450, does not include a 30 percent set aside for NHSC scholarships. Instead, the legislation leaves the division of resources between the scholarship and loan repayment programs up to the experts at the Health Resources Services Administration (HRSA). This way HRSA officials can look at all of the data collected on these programs and determine the best use of taxpayer money.

We all want to see America's safety net of community health care centers, rural health care clinics, and providers for underserved areas grow stronger and more stable. The NHSC loan repayment program has proven its effectiveness in this area and I am proud to say that the House-version of this legislation will enable the fullest possible support of that program.

Mr. BROWN of Ohio. Mr. Speaker, I want to thank the Chairman of the Energy and Commerce Health Subcommittee, Mr. BILIRAKIS, for his hard work on this bill. And a special thanks to staff members Steve Tilton, Erin Okunzzi, and Pat Morissey, on the Republican side, and David Nelson and John Ford on ours.

Community Health Centers and the National Health Service Corps provide health care to an underserved and uninsured population. A population that faces poverty, hunger, poor living conditions—all of which exacerbate the need for health care and all but guarantee disenfranchisement from the private health insurance system so many of us take for granted.

Community Health Centers and the National Health Service Corps serve populations that otherwise would fall through the cracks of our

patch-work public/private healthcare system. In Ohio, over 217,000 patients receive services through Community Health Centers. Life-saving services like treatment for dehydration and for exposure to extreme heat and cold. Services as fundamental—and fundamentally important—as immunizations, child health exams, and breast and cervical cancer screening. And services as sophisticated as treatment for heart disease, diabetes, asthma and mental illness.

Since 1972, the National Health Service Act has reach millions of Americans living in areas where health care is scarce. The Corps has encouraged health professionals to go where other health professionals would not, providing access to health care and working to eliminate health disparities in underserved areas. Reauthorization of the Corps will only make this public program stronger.

Health centers and the National Health Service Corps continue to improve the quality of life for so many uninsured families. I urge my colleagues to support this popular bill.

While the committee did not report the bill, I have discussed interpretation of certain provisions with the Chairman, and the explanation follows.

We recognize the critically important role that translation and interpretation services, as well as health care services provided in a culturally competent manner, play in ensuring the delivery of appropriate health care services to patients who have limited ability to speak English, and applaud the efforts of health centers to deliver linguistically and culturally appropriate care.

We recognize that health centers serve increasing numbers of patients speaking a variety of languages and representing a variety of racial and ethnic backgrounds.

We also recognize that the particular community health centers that serve limited English proficient populations bear a disproportionate financial, administrative and clinical burden above and beyond costs associated with providing health services and other general enabling services.

It is our expectation that the Secretary will work with health centers to enable them to provide, to the maximum extent feasible, appropriate translation and interpretation services for all of the patients they serve.

Mr. CAPUANO. Mr. Speaker, I rise today in support of H.R. 3450, the Health Care Safety Net Improvement Act. As a cosponsor of this bill and Co-Chair of the Community Health Center Caucus I'd like to thank Mr. BILIRAKIS and Mr. BROWN for their leadership in bringing this legislation to the floor today.

As you know, health centers were established over 35 years ago to provide access to quality preventive and primary health care for the medically underserved—including the millions of Americans without health insurance, low income working families, members of minority groups, residents of rural areas, homeless persons, and agricultural farmworkers. Since their inception, health centers have served as a prototype for effective public-private partnerships, demonstrating an ability to meet pressing local health needs while being held accountable for meeting national performance standards.

H.R. 3450 would reauthorize the National Health Service Corps program and authorize the Community Access Program. According to the Department of Health and Human Services, over 50 million people do not have a regular health care provider, including millions with public or private health insurance coverage. This legislation is vital in light of this data, including yesterday's Census Bureau study reporting the number of Americans who lack health coverage has increased again after a two-year decline. Specifically, one-third of Latinos lack coverage, far more than any other racial or ethnic group. More than 4 in 10 residents who are not citizens are uninsured, and more than one-quarter of high school dropouts have no insurance.

Health Centers focus their efforts on these underserved and uninsured populations. H.R. 3450 continues to reaffirm the principles of health centers, by focusing on high-need areas while ensuring care to all, regardless of their ability to pay. Health centers across the nation have begun a five-year effort to expand services to millions more underserved patients. My District has over twenty-five health centers and my constituents rely on the dedicated staff to provide health care services to them and their families. We cannot jeopardize the extraordinary work of the health centers because of a lack of federal authorization.

Mr. Speaker, I urge all Members of the House to support this bill and to ensure its passage and enactment this year. The House must move quickly to ensure that health centers can continue to provide high quality health care services to vulnerable populations in underserved communities across America.

Ms. PELOSI. Mr. Speaker, I rise in strong support of H.R. 3450, the Health Care Safety Net Improvement Act. By reauthorizing the Community Health Centers program and the National Health Service Corps, this important legislation will preserve and expand access to culturally and linguistically appropriate primary health care services for the millions of uninsured and underinsured Americans who rely on these programs.

Just this week, the Census Bureau released figures showing that the number of uninsured Americans increased by 1.4 million last year to a total of 41.2 million, or 14.6 percent of the total population. Community Health Centers create a cost-effective alternative to the emergency room for those without adequate access to health care by providing comprehensive primary and preventive care to 12 million people each year, including 5 million uninsured Americans, in more than 3400 urban and rural communities. H.R. 3450 will expand the availability of cancer screening and housing service at Health Centers, and create new grants to increase access to health services in rural areas.

Existing shortages in the health professions, especially in nursing, have strained all aspects of the health care system. The National Health Services Corps helps increase the number of trained health professionals available to meet the personnel needs of safety net providers by providing scholarship and loan repayment support to 2500 health professionals, who then agree to serve in Community Health Centers and other locations in underserved communities.

H.R. 3450 also authorizes the Healthy Communities Access Program, which has demonstrated ability to strengthen our health care safety net through improved information systems, telecommunication, integrated networks, and better care management. Coordination of care is an issue that is consistently raised as one of the challenges associated with reducing the number of uninsured Americans. The Healthy Communities Access Program is the only federal program designed to address this need, and today's legislation will ensure that it is preserved.

In my district, the San Francisco Community Clinics Consortium has used these funds to build a system that will link community health centers to each other and to family planning clinics, Ryan White grantees, and all of our city's providers that serve uninsured San Franciscans. The result is a cohesive system of care that includes a common registration system, installation of electronic medical record software, standardization of referral systems, and integration of behavioral health care with primary care.

Expanding access to quality health care is one of our most important responsibilities in Congress. I urge my colleagues to vote in support of H.R. 3450.

Mr. DINGELL. Mr. Speaker, I support H.R. 3450, the ''Health Care Safety Net Improvement Act,'' an important piece of legislation. Its progress has been delayed for nearly a year by a Republican leadership that was willing to jeopardize a bill of vital importance to millions of Americans by attempting to attach an extremely controversial, yet completely non-related, amendment to this bill. Thankfully we now have an opportunity, though long overdue, to pass this legislation.

H.R. 3450 will reauthorize the National Health Service Corps (NHSC), the Community Health Centers program, and will establish a Community Access demonstration program (CAP). H.R. 3450 is vital to providing health care services to the uninsured and under-insured. Health centers are located in more than 3,400 communities in all 50 states and often are the only available source of care for uninsured and medically under served individuals.

Health centers provide primary health care services to more than 12 million people per year—nearly five million of whom have no health insurance coverage. Currently, there are over 41 million uninsured Americans and untold numbers of under-insured. Due to the slowing economy, this number is increasing rapidly. As a result, demand for health care services has increased drastically, forcing risky delays for important primary and preventive health care services.

Health centers are effective and efficient providers of care to millions of our country's most vulnerable people. Ensuring access to primary and preventive care, regardless of insurance status or income, is an important component of H.R. 3450.

While health centers provide quality care to the uninsured for nearly one dollar per patient per day, they cannot continue to expand care to the growing number of uninsured who seek their care without a significant increase in their appropriations. This legislation is valuable because it authorizes such appropriations as may be necessary for community health centers for FY 2003 through FY 2006 so that these centers may continue to serve the public and the communities that depend on them for reliable, quality health care services. We should be passing legislation that would double these programs now, but this bill authorizes needed funding to community health centers and we should therefore support its passage.

This bill, however, has two noteworthy shortcomings. The Administration has chosen

to minimize the CAP program that permits local communities to coordinate the use of scarce healthcare dollars, event though where implemented that program that has been praised by local officials. Secondly, all authorizations for construction of the physical facilities have been struck from the bill, because the Republican leadership has refused to allow vote on a bill that provides the basic labor protections found in the Davis-Bacon Act for all direct Federal construction projects. Such protections would pass if a vote were allowed, and needed construction could begin.

Though this bill is far from perfect, I urge all of my colleagues to join me in support of H.R. 3450, the ''Health Care Safety Net Improvement Act.'' This is an important piece of legislation and its passage is long overdue.

Mr. BEREUTER. Mr. Speaker, as a cosponsor of the bill, this Member wishes to add his strong support for H.R. 3450, the Health Care Safety Net Improvement Act. Furthermore, this Member would like to commend the distinguished gentleman from Florida [Mr. BILIRAKIS], the Chairman of the House Energy and Commerce Subcommittee on Health, and the distinguished gentleman from Ohio [Mr. BROWN], the ranking member of the House Energy and Commerce Subcommittee on Health, for bringing this important legislation to the House Floor today. This Member would also like to commend the distinguished gentleman from Louisiana [Mr. TAUZIN], Chairman of the House Energy and Commerce Committee, and the distinguished gentleman from Michigan [Mr. DINGELL], the ranking member of the House Energy and Commerce Committee, for their efforts to improve access to quality preventive and primary health care for the medically underserved—including the millions of Americans without health insurance coverage.

The Health Care Safety Net Improvement Act would:

(1) reauthorize the critically important Community Health Centers program for another five years, including reaffirmation that Health Centers should be: located in high-need areas; provide comprehensive preventive and primary health care services; governed by community boards made up of a majority of current health center patients to assure responsiveness to local needs; and, open to everyone in the communities they serve, regardless of ability to pay; and

(2) reauthorize the important Telehealth Programs, as well as the Rural Health Outreach and the Rural Health Network Development. In addition, H.R. 3450 would authorize a new Small Health Care Provider Quality Improvement Program. These programs would go a long way to facilitate the provision of care to vulnerable populations living in rural areas all across the country.

This Member is particularly pleased that language is included in H.R. 3450 that would provide automatic designation to Federally Qualified Health Centers (FQHC) and Federally Certified Rural Health Clinics as Health Professional Shortage Areas (HPSA) facilities for a period of six years. This Member recognizes that the National Health Service Corps plays a critical role in providing care for underserved populations by placing clinicians in urban and rural areas. However, it has come to this Member's attention that health centers and rural clinics must obtain Health Professional Shortage Area designation to become eligible for the placement of Nation Health Service Corps personnel. While this Member is pleased to see that H.R. 3450 would improve on the current HPSA designation process, he would have preferred that the bill include permanent automatic designation, which would have guaranteed that FQHCs and rural health clinics would not have to return to the current, cumbersome HPSA designation process. This is a process that certainly seems unnecessary and duplicative, and which in some cases may result in delays in the placement of needed practitioners at high-need health centers and rural health clinics. Last year, this Member sent a letter, along with several colleagues, to the Chairman of the Energy and Commerce Subcommittee on Health requesting this change on a permanent basis and greatly appreciates the inclusion of the provision—even in the short term.

In closing, Mr. Speaker, this Member looks forward to working with the Committee and Subcommittee leadership, as earlier noted, on this important issue and this important bill as H.R. 3450 moves foward.

Mr. GREEN of Texas. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. BOOZMAN). The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules and pass the bill, H.R. 3450.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

RECOGNIZING THE DEVASTATING IMPACT OF FRAGILE X

Mr. SHIMKUS. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 398) recognizing the devastating impact of fragile X, urging increased funding for research on fragile X, and commending the goals of National Fragile X Research Day, and for other purposes.

The Clerk read as follows:

H. RES. 398

Whereas fragile X is the most common inherited cause of mental retardation, affecting people of every race, income level, and nationality;

Whereas 1 in every 267 women is a carrier of the fragile X;

Whereas children born with fragile X typically require a lifetime of special care at a cost of over $2,000,000 each;

Whereas fragile X frequently remains undetected because the defect was relatively recently discovered and there is a lack of awareness about the disease, even within the medical community;

Whereas the gene causing fragile X has been discovered and is easily identified by testing;

Whereas inquiry into fragile X is a powerful research model for neuropsychiatric disorders, such as autism, schizophrenia, pervasive developmental disorders, and other forms of X-chromosome-linked mental retardation;

Whereas individuals with fragile X can provide a homogeneous research population for advancing the understanding of neuropsychiatric disorders;

Whereas with concerted research efforts, a cure for fragile X may be developed;

Whereas fragile X research, both basic and applied, has been vastly underfunded despite the prevalence of the disorder, the potential for the development of a cure, the established benefits of available treatments and interventions, and the significance that fragile X research has for related disorders;

Whereas Members of Congress are in unique positions to help raise public awareness about the need for increased funding for research and early diagnosis and treatment for fragile X; and

Whereas throughout the United States, families and friends of individuals with fragile X have designated October 5 as National Fragile X Research Day to promote efforts to find a treatment and cure for fragile X: Now, therefore, be it

Resolved, That the House of Representatives—

(1) recognizes the devastating impact of fragile X on thousands of people in the United States and their families;

(2) calls on the National Institutes of Health, the Centers for Disease Control and Prevention, and other sources of Federal and private research funds to enhance and increase their efforts and commitments to fragile X research;

(3) calls on medical schools and other health educators, medical societies and associations, and Federal, State, and local health care facilities to promote research that will lead to a treatment and cure for fragile X; and

(4) commends the goals and ideals of a National Fragile X Research Day and supports interested groups in conducting appropriate ceremonies, activities, and programs to demonstrate support for such a day.

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

The Chair recognizes the gentleman from Illinois (Mr. SHIMKUS).

GENERAL LEAVE

Mr. SHIMKUS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this legislation and to insert extraneous material on the resolution.

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

There was no objection.

Mr. SHIMKUS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased that today the House is considering House Resolution 398 introduced by the gentleman from Oklahoma (Mr. WATKINS) to recognize the impact of fragile X on thousands of people in the United States and their families. The Committee on Energy and Commerce approved this resolution unanimously last week, and I encourage my colleagues to adopt the resolution today on the floor.

Fragile X syndrome is the most common genetically inherited form of mental retardation. Patients diagnosed with fragile X may experience mental impairments that range from mild learning disabilities and hyperactivity