Subsec. (b)(1)(C). Pub. L. 111–152, § 2303(3), substituted ''1,500,000,000'' for ''1,000,000,000''.

Subsec. (b)(1)(D). Pub. L. 111–152, § 2303(4), substituted ''2,200,000,000'' for ''1,600,000,000''.

Subsec. (b)(1)(E). Pub. L. 111–152, § 2303(5), substituted ''3,600,000,000'' for ''2,900,000,000''.

§ 254c. 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 1395x(aa) of this title.

(3) Health professional shortage area

The term ''health professional shortage area'' means a health professional shortage area designated under section 254e of this title.

(4) Medically underserved community

The term ''medically underserved community'' has the meaning given the term in section 295p(6) of this title.

(5) Medically underserved population

The term ''medically underserved population'' has the meaning given the term in section 254b(b)(3) of this title.

(c) Program

The Secretary shall establish, under section 241 of this title, 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 241 of this title 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 basic health care services, and enhance the delivery of health care, in rural areas.

(B) Types of grants

The Director may award the grants to—

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

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

(iii) 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 improving and expanding the delivery of health care services to include new and enhanced services in rural areas, through community engagement and evidence-based or innovative, evidence-informed models. The Director may award the grants for periods of not more than 5 years.

(2) Eligibility

To be eligible to receive a grant under this subsection for a project, an entity shall—

(A) be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations;

(B) represent a consortium composed of members that—

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

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

(C) 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 rural underserved populations in 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;

(E) a description of how the project will be evaluated; and

(F) other such information as the Secretary determines to be appropriate.

(f) Rural health network development grants

(1) Grants

(A) In general

The Director may award rural health network development grants to eligible entities to plan, develop, and implement integrated health care networks that collaborate in order to—

(i) achieve efficiencies;

(ii) expand access to, coordinate, and improve the quality of basic health care services and associated health outcomes; and

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

(B) Grant periods

The Director may award grants under this subsection for periods of not more than 5 years.

(2) Eligibility

To be eligible to receive a grant under this subsection, an entity shall—

(A) be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations;

(B) represent a network composed of participants that—

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

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

(C) 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 rural underserved populations in the local community or region to be served will benefit from and be involved in the development and ongoing operations of the network;

(D) a description of how the rural underserved populations in 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;

(F) a description of how the project will be evaluated; and

(G) other such information as the Secretary determines to be appropriate.

(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, including activities related to increasing care coordination, enhancing chronic disease management, and improving patient health outcomes. The Director may award the grants for periods of 1 to 5 years.

(2) Eligibility

To be eligible for a grant under this subsection, an entity shall—

(A)(i) 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) be another rural provider or network of small rural providers identified by the Secretary as a key source of local or regional care; and

(B) 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 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 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 rural underserved populations in 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;

(F) a description of how the project will be evaluated; and

(G) other such information as the Secretary determines to be appropriate.

(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.

(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, as appropriate, 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 4 years after March 27, 2020, and every 5 years thereafter, the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the activities and outcomes of the grant programs under subsections (e), (f), and (g), including the impact of projects funded under such programs on the health status of rural residents with chronic conditions.

(j) Authorization of appropriations

There are authorized to be appropriated to carry out this section $79,500,000 for each of fiscal years 2021 through 2025.

(July 1, 1944, ch. 373, title III, § 330A, as added Pub. L. 104–299, § 3(a), Oct. 11, 1996, 110 Stat. 3642; amended Pub. L. 107–251, title II, § 201, Oct. 26, 2002, 116 Stat. 1628; Pub. L. 108–163, § 2(b), Dec. 6, 2003, 117 Stat. 2021; Pub. L. 110–355, § 4, Oct. 8, 2008, 122 Stat. 3994; Pub. L. 116–136, div. A, title III, § 3213, Mar. 27, 2020, 134 Stat. 370.)

Editorial Notes

PRIOR PROVISIONS

A prior section 254c, act July 1, 1944, ch. 373, title III, § 330, as added July 29, 1975, Pub. L. 94–63, title V, § 501(a), 89 Stat. 342; amended Apr. 22, 1976, Pub. L. 94–278, title VIII, § 801(b), 90 Stat. 415; Aug. 1, 1977, Pub. L. 95–83, title III, § 304, 91 Stat. 388; Nov. 10, 1978, Pub. L. 95–626, title I, § 104(a)–(d)(3)(B), (4), (5), (e), (f), 92 Stat. 3556–3559; July 10, 1979, Pub. L. 96–32, §§ 6(b)–(d), 7(c), 93 Stat. 83, 84; Oct. 17, 1979, Pub. L. 96–88, title V, § 509(b), 93 Stat. 695; Oct. 19, 1980, Pub. L. 96–470, title I, § 106(e), 94 Stat. 2238; Aug. 13, 1981, Pub. L. 97–35, title IX, §§ 903(a), 905, 906, 95 Stat. 561, 562; Jan. 4, 1983, Pub. L. 97–414, § 8(e), 96 Stat. 2060; Apr. 24, 1986, Pub. L. 99–280, §§ 2–4, 100 Stat. 399, 400; Aug. 10, 1988, Pub. L. 100–386, §§ 3, 4, 102 Stat. 921, 923; Nov. 4, 1988, Pub. L. 100–607, title I, § 163(3), 102 Stat. 3062; Dec. 19, 1989, Pub. L. 101–239, title VI, § 6103(e)(5), 103 Stat. 2207; Nov. 6, 1990, Pub. L. 101–527, § 9(a), 104 Stat. 2332; Oct. 27, 1992, Pub. L. 102–531, title III, § 309(b), 106 Stat. 3500, related to community health centers, prior to the general amendment of this subpart by Pub. L. 104–299, § 2.

AMENDMENTS

2020—Subsec. (d)(2)(A). Pub. L. 116–136, § 3213(1)(A), substituted ''basic'' for ''essential''.

Subsec. (d)(2)(B). Pub. L. 116–136, § 3213(1)(B), inserted ''to'' after ''grants'' in introductory provisions and struck out ''to'' at beginning of cls. (i) to (iii).

Subsec. (e)(1). Pub. L. 116–136, § 3213(2)(A), inserted ''improving and'' after ''outreach by'' and '', through community engagement and evidence-based or innovative, evidence-informed models'' after ''rural areas'' and substituted ''5 years'' for ''3 years''.

Subsec. (e)(2). Pub. L. 116–136, § 3213(2)(B)(i), inserted ''shall'' after ''entity'' in introductory provisions.

Subsec. (e)(2)(A). Pub. L. 116–136, § 3213(2)(B)(ii), substituted ''be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations'' for ''shall be a rural public or rural nonprofit private entity''.

Subsec. (e)(2)(B). Pub. L. 116–136, § 3213(2)(B)(iii), (iv), struck out ''shall'' before ''represent'' and inserted ''that'' after ''members'' in introductory provisions and struck out ''that'' at beginning of cls. (i) and (ii).

Subsec. (e)(2)(C). Pub. L. 116–136, § 3213(2)(B)(iii), struck out ''shall'' before ''not previously''.

Subsec. (e)(3)(C). Pub. L. 116–136, § 3213(2)(C), substituted ''the rural underserved populations in the local community or region'' for ''the local community or region''.

Subsec. (f)(1)(A). Pub. L. 116–136, § 3213(3)(A)(i)(I), substituted ''plan, develop, and implement integrated health care networks that collaborate'' for ''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 introductory provisions.

Subsec. (f)(1)(A)(ii). Pub. L. 116–136, § 3213(3)(A)(i)(II), substituted ''basic health care services and associated health outcomes'' for ''essential health care services''.

Subsec. (f)(1)(B). Pub. L. 116–136, § 3213(3)(A)(ii), amended subpar. (B) generally. Prior to amendment, text read as follows: ''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.''

Subsec. (f)(2). Pub. L. 116–136, § 3213(3)(B)(i), inserted ''shall'' after ''entity'' in introductory provisions.

Subsec. (f)(2)(A). Pub. L. 116–136, § (3)(B)(ii), substituted ''be an entity with demonstrated experience serving, or the capacity to serve, rural underserved populations'' for ''shall be a rural public or rural nonprofit private entity''.

Subsec. (f)(2)(B). Pub. L. 116–136, § 3213(3)(B)(iii), struck out ''shall'' before ''represent'' and inserted ''that'' after ''participants'' in introductory provisions and struck out ''that'' at beginning of cls. (i) and (ii).

Subsec. (f)(2)(C). Pub. L. 116–136, § 3213(3)(B)(iv), struck out ''shall'' before ''not previously''.

Subsec. (f)(3)(C)(iii). Pub. L. 116–136, § 3213(3)(C)(i), amended cl. (iii) generally. Prior to amendment, cl. (iii) read as follows: ''how the local community or region to be served will benefit from and be involved in the activities carried out by the network;''.

Subsec. (f)(3)(D). Pub. L. 116–136, § 3213(3)(C)(ii), substituted ''the rural underserved populations in the local

community or region'' for ''the local community or region''.

Subsec. (g)(1). Pub. L. 116–136, § 3213(4)(A), inserted '', including activities related to increasing care coordination, enhancing chronic disease management, and improving patient health outcomes'' after ''quality improvement activities'' and substituted ''5 years'' for ''3 years''.

Subsec. (g)(2). Pub. L. 116–136, § 3213(4)(B)(i), inserted ''shall'' after ''entity'' in introductory provisions.

Subsec. (g)(2)(A). Pub. L. 116–136, § 3213(4)(B)(ii), (iii), struck out ''shall'' at beginning of cls. (i) and (ii), and inserted ''or regional'' after ''local'' in cl. (ii).

Subsec. (g)(2)(B). Pub. L. 116–136, § 3213(4)(B)(ii), struck out ''shall'' before ''not previously''.

Subsec. (g)(3)(D). Pub. L. 116–136, § 3213(4)(C), substituted ''the rural underserved populations in the local community or region'' for ''the local community or region''.

Subsec. (h)(3). Pub. L. 116–136, § 3213(5), inserted '', as appropriate,'' after ''the Secretary'' in introductory provisions.

Subsec. (i). Pub. L. 116–136, § 3213(6), amended subsec. (i) generally. Prior to amendment, text read as follows: ''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).''

Subsec. (j). Pub. L. 116–136, § 3213(7), substituted ''$79,500,000 for each of fiscal years 2021 through 2025'' for ''$45,000,000 for each of fiscal years 2008 through 2012''.

2008—Subsec. (j). Pub. L. 110–355 substituted ''$45,000,000 for each of fiscal years 2008 through 2012.'' for ''$40,000,000 for fiscal year 2002, and such sums as may be necessary for each of fiscal years 2003 through 2006.''

2003—Subsec. (b)(4). Pub. L. 108–163 substituted ''section 295p(6)'' for ''section 295p''.

2002—Pub. L. 107–251 amended section generally. Prior to amendment, section related to a rural health outreach, network development, and telemedicine grant program, and in subsec. (a), provided for administration by the Office of Rural Health Policy; in subsec. (b), set out the objectives of grants; in subsec. (c), set out eligibility requirements; in subsec. (d), described preferred characteristics of applicant networks; in subsec. (e), specified permitted uses of grant funds; in subsec. (f), limited the duration of grants; and in subsec. (g), authorized appropriations.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2003 AMENDMENT

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

EFFECTIVE DATE

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

RURAL ACCESS TO EMERGENCY DEVICES

Pub. L. 106–505, title IV, subtitle B, Nov. 13, 2000, 114 Stat. 2340, provided that:

''SEC. 411. SHORT TITLE.

''This subtitle may be cited as the 'Rural Access to Emergency Devices Act' or the 'Rural AED Act'.

''SEC. 412. FINDINGS.

''Congress makes the following findings:

''(1) Heart disease is the leading cause of death in the United States.

''(2) The American Heart Association estimates that 250,000 Americans die from sudden cardiac arrest each year.

''(3) A cardiac arrest victim's chance of survival drops 10 percent for every minute that passes before his or her heart is returned to normal rhythm.

''(4) Because most cardiac arrest victims are initially in ventricular fibrillation, and the only treatment for ventricular fibrillation is defibrillation, prompt access to defibrillation to return the heart to normal rhythm is essential.

''(5) Lifesaving technology, the automated external defibrillator, has been developed to allow trained lay rescuers to respond to cardiac arrest by using this simple device to shock the heart into normal rhythm.

''(6) Those people who are likely to be first on the scene of a cardiac arrest situation in many communities, particularly smaller and rural communities, lack sufficient numbers of automated external defibrillators to respond to cardiac arrest in a timely manner.

''(7) The American Heart Association estimates that more than 50,000 deaths could be prevented each year if defibrillators were more widely available to designated responders.

''(8) Legislation should be enacted to encourage greater public access to automated external defibrillators in communities across the United States.

''SEC. 413. GRANTS.

''(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Rural Health Outreach Office of the Health Resources and Services Administration, shall award grants to community partnerships that meet the requirements of subsection (b) to enable such partnerships to purchase equipment and provide training as provided for in subsection (c).

''(b) COMMUNITY PARTNERSHIPS.—A community partnership meets the requirements of this subsection if such partnership—

''(1) is composed of local emergency response entities such as community training facilities, local emergency responders, fire and rescue departments, police, community hospitals, and local non-profit entities and for-profit entities concerned about cardiac arrest survival rates;

''(2) evaluates the local community emergency response times to assess whether they meet the standards established by national public health organizations such as the American Heart Association and the American Red Cross; and

''(3) submits to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used—

''(1) to purchase automated external defibrillators that have been approved, or cleared for marketing, by the Food and Drug Administration; and

''(2) to provide defibrillator and basic life support training in automated external defibrillator usage through the American Heart Association, the American Red Cross, or other nationally recognized training courses.

''(d) REPORT.—Not later than 4 years after the date of the enactment of this Act [Nov. 13, 2000], the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report containing data relating to whether the increased availability of defibrillators has affected survival rates in the communities in which grantees under this section operated. The procedures under which the Secretary obtains data and prepares the report under this subsection shall not impose an undue burden on program participants under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $25,000,000 for fiscal years 2001 through 2003 to carry out this section.''

REPORT ON TELEMEDICINE

Pub. L. 106–129, § 6, Dec. 6, 1999, 113 Stat. 1675, provided that: ''Not later than January 10, 2001, the Secretary of

Health and Human Services shall submit to the Congress a report that—

''(1) identifies any factors that inhibit the expansion and accessibility of telemedicine services, including factors relating to telemedicine networks;

''(2) identifies any factors that, in addition to geographical isolation, should be used to determine which patients need or require access to telemedicine care;

''(3) determines the extent to which—

''(A) patients receiving telemedicine service have benefited from the services, and are satisfied with the treatment received pursuant to the services; and

''(B) the medical outcomes for such patients would have differed if telemedicine services had not been available to the patients;

''(4) determines the extent to which physicians involved with telemedicine services have been satisfied with the medical aspects of the services;

''(5) determines the extent to which primary care physicians are enhancing their medical knowledge and experience through the interaction with specialists provided by telemedicine consultations; and

''(6) identifies legal and medical issues relating to State licensing of health professionals that are presented by telemedicine services, and provides any recommendations of the Secretary for responding to such issues.''

Executive Documents

EX. ORD. NO. 13941. IMPROVING RURAL HEALTH AND TELEHEALTH ACCESS

Ex. Ord. No. 13941, Aug. 3, 2020, 85 F.R. 47881, provided:

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

SECTION 1. *Purpose*. My Administration is committed to improving the health of all Americans by improving access to better care, including for the approximately 57 million Americans living in rural communities. Americans living in rural communities face unique challenges when seeking healthcare services, such as limited transportation opportunities, shortages of healthcare workers, and an inability to fully benefit from technological and care-delivery innovations. These factors have contributed to financial insecurity and impaired health outcomes for rural Americans, who are more likely to die from five leading causes, many of which are preventable, than their urban counterparts. That gap widened from 2010 to 2017 for cancer, heart disease, and chronic lower respiratory disease.

Since 2010, the year the [Patient Protection and] Affordable Care Act [Pub. L. 111–148] was passed, 129 rural hospitals in the United States have closed. Predictably, financial distress is the strongest driver for risk of closure, and many rural hospitals lack sufficient patient volume to be sustainable under traditional healthcare-reimbursement mechanisms. From 2015 to 2017, the average occupancy rate of a hospital that closed was only 22 percent. When hospitals close, the patient population around them carries an increased risk of mortality due to increased travel time and decreased access.

During the COVID–19 public health emergency (PHE), hospitals curtailed elective medical procedures and access to in-person clinical care was limited. To help patients better access healthcare providers, my Administration implemented new flexibility regarding what services may be provided via telehealth, who may provide them, and in what circumstances, and the use of telehealth increased dramatically across the Nation. Internal analysis by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) showed a weekly jump in virtual visits for CMS beneficiaries, from approximately 14,000 pre-PHE to almost 1.7 million in the last week of April. Additionally, a recent report by HHS shows that nearly half (43.5 percent) of Medicare fee-for-service primary care visits were provided through telehealth in April, compared with far less than one percent (0.1 percent) in February before the PHE. Importantly, the report finds that telehealth visits continued to be frequent even after in-person primary care visits resumed in May, indicating that the expansion of telehealth services is likely to be a more permanent feature of the healthcare delivery system.

Rural healthcare providers, in particular, need these types of flexibilities to provide continuous care to patients in their communities. It is the purpose of this order to increase access to, improve the quality of, and improve the financial economics of rural healthcare, including by increasing access to high-quality care through telehealth.

SEC. 2. *Launching an Innovative Payment Model to Enable Rural Healthcare Transformation*. Within 30 days of the date of this order [Aug. 3, 2020], the Secretary of HHS (Secretary) will announce a new model, pursuant to section 1115A of the Social Security Act (42 U.S.C. 1315a), to test innovative payment mechanisms in order to ensure that rural healthcare providers are able to provide the necessary level and quality of care. This model should give rural providers flexibilities from existing Medicare rules, establish predictable financial payments, and encourage the movement into high-quality, value-based care.

SEC. 3. *Investments in Physical and Communications Infrastructure*. Within 30 days of the date of this order, the Secretary and the Secretary of Agriculture shall, consistent with applicable law and subject to the availability of appropriations, and in coordination with the Federal Communications Commission and other executive departments and agencies, as appropriate, develop and implement a strategy to improve rural health by improving the physical and communications healthcare infrastructure available to rural Americans.

SEC. 4. *Improving the Health of Rural Americans*. Within 30 days of the date of this order, the Secretary shall submit a report to the President, through the Assistant to the President for Domestic Policy and the Assistant to the President for Economic Policy, regarding existing and upcoming policy initiatives to:

(a) increase rural access to healthcare by eliminating regulatory burdens that limit the availability of clinical professionals;

(b) prevent disease and mortality by developing rural-specific efforts to drive improved health outcomes;

(c) reduce maternal mortality and morbidity; and

(d) improve mental health in rural communities.

SEC. 5. *Expanding Flexibilities Beyond the Public Health Emergency*. Within 60 days of the date of this order, the Secretary shall review the following temporary measures put in place during the PHE, and shall propose a regulation to extend these measures, as appropriate, beyond the duration of the PHE:

(a) the additional telehealth services offered to Medicare beneficiaries; and

(b) the services, reporting, staffing, and supervision flexibilities offered to Medicare providers in rural areas.

SEC. 6. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect:

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

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

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

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

DONALD J. TRUMP.

§ 254c–1. Grants for health services for Pacific Islanders

(a) Grants

The Secretary of Health and Human Services (hereafter in this section referred to as the ''Secretary'') shall provide grants to, or enter into contracts with, public or private nonprofit agencies that have demonstrated experience in serving the health needs of Pacific Islanders living in the Territory of American Samoa, the Commonwealth of Northern Mariana Islands, the Territory of Guam, the Republic of the Marshall Islands, the Republic of Palau, and the Federated States of Micronesia.

(b) Use of grants or contracts

Grants or contracts made or entered into under subsection (a) shall be used, among other items—

(1) to continue, as a priority, the medical officer training program in Pohnpei, Federated States of Micronesia;

(2) to improve the quality and availability of health and mental health services and systems, with an emphasis therein on preventive health services and health promotion programs and projects, including improved health data systems;

(3) to improve the quality and availability of health manpower, including programs and projects to train new and upgrade the skills of existing health professionals by—

(A) establishing dental officer, dental assistant, nurse practitioner, or nurse clinical specialist training programs;

(B) providing technical training of new auxiliary health workers;

(C) upgrading the training of currently employed health personnel in special areas of need;

(D) developing long-term plans for meeting health profession needs;

(E) developing or improving programs for faculty enhancement or post-doctoral training; and

(F) providing innovative health professions training initiatives (including scholarships) targeted toward ensuring that residents of the Pacific Basin attend and graduate from recognized health professional programs;

(4) to improve the quality of health services, including laboratory, x-ray, and pharmacy, provided in ambulatory and inpatient settings through quality assurance, standard setting, and other culturally appropriate means;

(5) to improve facility and equipment repair and maintenance systems;

(6) to improve alcohol, drug abuse, and mental health prevention and treatment services and systems;

(7) to improve local and regional health planning systems; and

(8) to improve basic local public health systems, with particular attention to primary care and services to those most in need.

No funds under subsection (b) shall be used for capital construction.

(c) Advisory Council

The Secretary of Health and Human Services shall establish a ''Pacific Health Advisory Council'' which shall consist of 12 members and shall include—

(1) the Directors of the Health Departments for the entities identified in subsection (a); and

(2) 6 members, including a representative of the Rehabilitation Hospital of the Pacific, representing organizations in the State of Hawaii actively involved in the provision of health services or technical assistance to the entities identified in subsection (a). The Secretary shall solicit the advice of the Governor of the State of Hawaii in appointing the 5 Council members in addition to the representative of the Rehabilitation Hospital of the Pacific from the State of Hawaii.

The Secretary shall be responsible for providing sufficient staff support to the Council.

(d) Advisory Council functions

The Council shall meet at least annually to—

(1) recommend priority areas of need for funding by the Public Health Service under this section; and

(2) review progress in addressing priority areas and make recommendations to the Secretary for needed program modifications.

(e) Omitted

(f) Authorization of appropriation

There is authorized to be appropriated to carry out this section $10,000,000 for each of the fiscal years 1991 through 1993.

(Pub. L. 101–527, § 10, Nov. 6, 1990, 104 Stat. 2333.)

Editorial Notes

CODIFICATION

Section was enacted as part of the Disadvantaged Minority Health Improvement Act of 1990, and not as part of the Public Health Service Act which comprises this chapter.

Subsec. (e) of this section, which required the Secretary, in consultation with the Council, to annually prepare and submit to appropriate committees of Congress a report describing the expenditure of funds authorized to be appropriated under this section, with any recommendations of the Secretary, terminated, effective May 15, 2000, pursuant to section 3003 of Pub. L. 104–66, as amended, set out as a note under section 1113 of Title 31, Money and Finance. See, also, page 95 of House Document No. 103–7.

Statutory Notes and Related Subsidiaries

TERMINATION OF ADVISORY COUNCILS

Advisory councils established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a council established by the President or an officer of the Federal Government, such council is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a council established by Congress, its duration is otherwise provided by law. See sections 1001(2) and 1013 of Title 5, Government Organization and Employees.

§ 254c–1a. Grants to nurse-managed health clinics

(a) Definitions

(1) Comprehensive primary health care services

In this section, the term ''comprehensive primary health care services'' means the pri-