Summary of Indian Provisions in the Patient Protection and Affordable Care Act – H.R. 3590

P.L. 111-148 (Enacted March 23, 2010)

Over the past year the Congress and Administration have been working to pass a health insurance reform bill that is intended to lowers costs, guarantees choices, and enhances quality health care for all Americans. Building on that year-long effort, the President signed into law this historic national health care legislation on March 23, 2010. The *Patient Protection and Affordable Care Act* (P.L. 111-148) is expected to provide health coverage to approximately 32 million Americans who currently do not have any. It aims to reform the health insurance system in a number of ways, including banning pre-existing condition exemptions, capping out-of-pocket expenses, increasing competition and providing increased government oversight.

The newly enacted health care legislation includes several important provisions pertaining to Indian health programs and the reauthorization of the Indian Health Care Improvement Act (IHCIA). The legislation reauthorized the IHCIA (S. 1790) with no sunset date thereby making the IHCIA permanent.

The Indian specific health care reform provisions are intended to ensure that the Indian health system will be effectively integrated with many of the program and services that will be afforded under the new health reform legislation. The provisions will modernize, strengthen, and preserve the ability of the Indian health system to participate in the sweeping changes that will be brought by health reform. The following provides an overview of these provisions.

Summary of Key Indian Provisions

The health reform legislation (P.L. 111-148) is organized into ten different titles that amongst other requirements, establish a mandate for most residents of the United States to obtain health insurance. It will set up insurance exchanges through which individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage. The legislation will expand Medicaid eligibility considerably, while also reducing the growth of Medicare's payment rates for most services (as compared to growth rates under current law). The new law will also impose an excise tax on insurance plans with high premiums and make various other changes to the federal tax code, Medicare, Medicaid, and other programs.

The key Indian provisions are contained in Titles I, II, IX, and X (IHCIA). The following is a short summary of those items with more detailed information explained under each title below.

- Individual Mandate: (Title I, Section 1501(b)). The new law makes most Americans responsible to carry some form of health insurance coverage. Compliance with this requirement will be enforced through the use of tax penalties by the Internal Revenue Service. The law *exempts members of Indian Tribes* on the basis of the federal trust relationship.
- Insurance Exchange: (Title II, Section 1402). Individuals who do not have health coverage through their employer would be able to purchase coverage through state-based insurance exchanges by 2014. Three *Indian specific provisions will protect Indians from cost sharing requirements* at or below 300% of FPL, a second protects Indians from any cost sharing for service delivered through an IHS program, and Indians will be allowed to enroll in Exchange plans on a monthly basis.
- Medicare Part B: (Title II, Section 2902). Removes sunset date of December 31, 2009, to allow IHS programs permanent authority to receive reimbursement of some Part B services. Provision initially passed in Medicare Modernization Act of 2003 limited authority to a five-year period.
- Medicare Part D "TrOOP fix: (Title III, Section 3314). Effective January 1, 2011, the value of drugs provided by IHS programs will now count toward "true out of pocket" costs.
- Tax Exemption on Tribal-provided Insurance: (Title IX, Section 9021). Effective March 23, 2010, the law excludes from an individual Tribal member's gross income the value of health benefits, care, or coverage provided by IHS programs, a Tribe, or tribal organization.

Title I. Quality, Affordable Health Care for All Americans

Includes provisions to make immediate improvements in health care coverage such as expanding preventive care, extends dependent care coverage, and makes measures to prevent loss of insurance coverage. Other provisions prohibit insurance companies from discriminating on basis of preexisting conditions, establish reinsurance for early retirees, and create Internet portals for beneficiaries to easily access affordable and comprehensive coverage options.
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Indian Provisions:

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS. Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses.

Sec. 1311(D). special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

- State exchange coverage – American Indians and Alaska Natives would be allowed a choice of health care providers, including the Indian Health Service, tribes, tribal organizations and urban Indian health organizations. Monthly special enrollment periods for American Indians and Alaska Natives would be authorized for state exchanges.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS**.** The standard out-of-pocket maximum limits ($5,950 for individuals and $11,900 for families) would be reduced to one-third for those between 100-200 percent of poverty, one-half for those between 200-300 percent of poverty, and to two-thirds for those between 300-400 percent of poverty. The plan's share of total allowed costs of benefits would be increased to 90 percent for those between 100-150 percent of poverty (i.e., the individual's liability is limited to 10 percent on average) and to 80 percent for those between 150-200 percent of poverty (i.e., the individual's liability is limited to 20 percent on average). The cost-sharing assistance does not take into account benefits mandated by States.

Sec. 1402(d) SPECIAL RULES FOR INDIANS.—

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS. The Secretary shall establish a program for determining whether an individual applying for coverage in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, is a citizen or national of the United States or an alien lawfully present in the United States and meets the income and coverage requirements; whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable; and whether to grant a certification attesting that, for purposes of the individual responsibility requirement, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

Sec. 1411(d)(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE. Contains findings of Congress related to the individual responsibility requirement. Requires individuals to maintain minimum essential coverage beginning in 2014. As amended by Section 10106, Failure to maintain coverage will result in a penalty of the greater of $95 in 2014, $495 in 2015 and $750 in 2016, or up to two percent of income by 2016, up to a cap of the national average bronze plan premium. Families will pay half the amount for children up to a cap of $2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment. Exceptions to the individual responsibility requirement to maintain minimum essential coverage are made for religious objectors, individuals not lawfully present, and incarcerated individuals. Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.

Sec. 1501(b) amends Subtitle D of the Internal Revenue Code of 1986 by adding a new chapter, Maintenance of Minimum Essential Coverage, which includes a requirement to maintain health insurance coverage. The new chapter includes a provision at Section 5000A(e)(3) that exempts members of Indian tribes from penalties for not carrying health insurance.

Sec. 5000A. Requirement to Maintain Minimum Essential Coverage. (New IRS Chapter)

Section 5000A(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

Section 5000A(e)(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

Title II. The Role of Public Programs

This title includes provisions that extend Medicaid coverage at State option to cover non-elderly and non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for individuals with income at or below 133 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Effective January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100 percent FPL to 133 percent FPL. Newly-eligibles (described above) would receive benchmark or benchmark-equivalent coverage consistent with the requirements of section 1937 of the Social Security Act. Benchmark and benchmark-equivalent coverage would be required to provide at least essential benefits (as defined for the Exchange) and prescription drugs and mental health services would be added to the list of services that must be covered at actuarial equivalence.

From 2014 through 2016, the Federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, States that initially covered less of the newly-eligible population (called "Other States") would receive more assistance than those States that covered at least some non-elderly, non-pregnant individuals ("Expansion States"). Other States would receive a FMAP increase for services provided to newly-eligible individuals. Expansion States would receive FMAP increases in 2017 and 2018, respectively. Beginning in 2019 and thereafter, all States would receive an FMAP increase for such services.

States will be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This "maintenance of effort" (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. Between January 1, 2011 and January 1, 2014, a State would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133 percent of FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.

Prohibits cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market through a State Exchange. Also, facilities operated by the Indian Health Service (IHS) and Indian, Tribal, and Urban Indian facilities (I/T/Us) would be added to the list of agencies that could serve as an "Express Lane" agency able to determine Medicaid and CHIP eligibility. Removes the sunset provision, allowing IHS and I/T/U services to continue to be reimbursed by Medicare Part B.

Indian Provisions

Subtitle K—Protections for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

(b) PAYER OF LAST RESORT.—Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.—Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended—

(1) in the clause heading, by inserting ''AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS'' after ''AGENCIES''; and

(2) by adding at the end the following:

''(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).''

(d) TECHNICAL CORRECTIONS.—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)) is amended by striking ''In this section'' and inserting ''For purposes of this section, title XIX, and title XXI''.

SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking ''during the 5-year period beginning on'' and inserting ''on or after''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS. Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.

Section 2951(h) OTHER PROVISIONS.—

Sec. 2951(h)(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

Section 2951(j) APPROPRIATIONS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

(A) $100,000,000 for fiscal year 2010;
(B) $250,000,000 for fiscal year 2011;
(C) $350,000,000 for fiscal year 2012;
(D) $400,000,000 for fiscal year 2013; and
(E) $400,000,000 for fiscal year 2014.

(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

Section 2951(k) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—

(A) IN GENERAL.—The term ‘eligible entity’ means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ‘Indian Tribe’ and ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.’’

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION. Provides $75 million per year through FY2014 for Personal Responsibility Education grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research and evaluation, training, and technical assistance.

Sec. 2953(c)(2)(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

Sec. 2953(e)(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms 'Indian tribe' and 'Tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

Title III. Improving the Quality and Efficiency of Health Care

Title III provisions set out to improve the quality and efficiency of health care by linking payment to performance and quality outcome measures in the Medicare program. It makes improvements in the physician quality reporting and directs the HHS Secretary to establish value-based payments that are tied to outcome measures. Sets a National Strategy to Improve Health Quality that will include such activities to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Also encourages development of new patient care models, such as a Center for Medicare & Medicaid Innovation to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Subtitle B provisions are to improve Medicare for patients and providers by ensuring access to physician care and other services. These provisions preserve and extend certain types of Medicare payments. It preserves certain Medicare rural health provisions by including hold-harmless protections or extends them in the Act.

Sets Medicare Advantage payments based on average bids from Medicare Advantage plans in each market and creates performance bonus payments based on a plan's level of care coordination and care management and achievement on quality rankings. Prohibits Medicare Advantage plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program and makes other improvements to improve beneficiary access to services. Title III also makes improvements for Medicare Part D programs.

Indian Provisions

SEC. 3015. DATA COLLECTION; PUBLIC REPORTING: Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. As amended by Section 10305, requires the Secretary of HHS to develop a plan for the collection and public reporting of quality measures. Indian health programs are eligible to receive grants under this section.

SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

(a) IN GENERAL.—The Secretary shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

(b) GRANTS OR CONTRACTS FOR DATA COLLECTION.—

(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing,

efforts to collect and aggregate quality and resource use measures described under subsection (c).

(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

(A) be—

(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information;

(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act);

SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D. Allows drugs provided to beneficiaries by AIDS Drug Assistance Programs or the Indian Health Service to count toward the annual out-of-pocket threshold, section amends current law.

SEC. 3314(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

(3) by inserting after clause (ii) the following new clause:

(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

(I) under section 1860D–14;
(II) under a State Pharmaceutical Assistance Program;
(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or
(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE. Builds on the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to support research, technical assistance and process implementation grants. Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services. Amends PHSA to make IHS programs eligible to receive a grant.

SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health

Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME. Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. Section 10321 clarifies that nurse practitioners and other primary care providers can participate in community care teams.

Sec. 3502(b). ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE. Provides funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Requires the HHS Secretary to support emergency medicine research, including pediatric emergency medical research.

SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

(b) ELIGIBLE ENTITY; REGION.—In this section:

(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means—

(A) a State or a partnership of 1 or more States and 1 or more local governments; or

(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY. Reauthorizes and improves the trauma care program, providing grants administered by the HHS Secretary to States and trauma centers to strengthen the nation’s trauma system. Grants are targeted to assist trauma care centers in underserved areas susceptible to funding and workforce shortages.

SEC. 3505(a) TRAUMA CARE CENTERS.—

(1) GRANTS FOR TRAUMA CARE CENTERS.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a) and (b) and inserting the following:

(a) IN GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

(1) to assist in defraying substantial uncompensated care costs;

(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

(3) to provide emergency relief to ensure the continued and future availability of trauma services.

Title IV. Prevention of Chronic Disease and Improving Public Health

Title IV promotes prevention of chronic disease and public health by directing the creation of a national prevention and health promotion strategy by incorporating effective and achievable methods to improve the health status. The Act relies on the small businesses and state and local governments to find the best ways to improve wellness in the workplace and communities. The Act establishes an interagency council to promote healthy policies at the Federal level. It also establishes a Prevention and Public Health Investment Fund. The goal of the Investment Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

Subtitle B will increase access to clinical preventive services by authorizing a grant program for the operation and development of School-Based Health Clinics, which will provide comprehensive and accessible preventive and primary health care services to medically underserved children and families. Also, established is an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women. Creates demonstration programs on oral health delivery and strengthens surveillance capacity. The provisions also remove barriers to receiving preventive care and wellness visits in Medicare by removing co-payment requirements and increasing Medicaid optional services for adults by providing increased FMAP payments to states. There are additional provisions that set out to create healthier communities and support for prevention and public health innovation. Grant programs will award competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Funding will be provided for research to examine best practices relating to prevention, analyzing the translation of interventions from academic institutions to clinics and communities, and identifying effective strategies for delivering public health services in real world settings.

Indian Provisions

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL. Creates an interagency council dedicated to promoting healthy policies at the Federal level. The Council shall consist of representatives of Federal agencies that interact with Federal health and safety policy, including the departments of HHS, Agriculture, Education, Labor, Transportation, and others. The Council will establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. The Council will report annually to Congress on the health promotion activities of the Council and progress in meeting goals of the national strategy.

> Sec. 4001(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the ''National Prevention, Health Promotion and Public Health Council'' (referred to in this section as the ''Council'').
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> Sec. 4001(c). COMPOSITION.—The Council shall be composed of—
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> Sec. 4001(c)(11). the Assistant Secretary for Indian Affairs
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> Sec. 4001(d). PURPOSES AND DUTIES.—The Council shall—
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> Sec. 4001(d) (5). establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES. Expands the efforts of, and improves the coordination between, two task forces which provide recommendations for preventive interventions. The U.S. Preventive Services Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services such as colorectal cancer screening or aspirin to prevent heart disease, and develops recommendations for their use. The Community Preventive Services Task Force uses a public health perspective to review the evidence of effectiveness of

population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use.

SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policymakers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS. Directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. The Secretary will conduct a national media campaign on health promotion and disease prevention focusing on nutrition, physical activity, and smoking cessation using science-based social research. The Secretary shall also maintain a web-based portal that provides informational guidelines on health promotion and disease prevention to health care providers and the public as well as a personalized prevention plan tool for individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention.

Sec. 4004(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and Medicare and Medicaid.

SEC. 4102. ORAL HEALTHCARE PREVENTION ACTIVITIES. Establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women. Creates demonstration programs on oral health delivery and strengthens surveillance capacity.

Sec. 4102(b) REQUIREMENTS.—In establishing the campaign, the Secretary shall—
(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

SEC. 399LL–1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT. [Emphasis added] The CDC Director shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities. Eligible entities include "a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)."

SEC. 399LL–2. AUTHORIZATION OF APPROPRIATIONS. [Emphasis added] Provides authorization for appropriation to "carry out school based sealant program" and amends relevant section by striking ''may award grants to States and Indian tribes'' and inserting "shall award a grant to each of the 50 States and territories and

to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)".

(d). Oral Health Infrastructure.

(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID. The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

SEC. 4108(a)(3)(D). FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS. This section authorizes the Secretary to award competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Communities can carry out programs to prevent and reduce the incidence of chronic diseases associated with overweight and obesity, tobacco use, or mental illness; or other activities that are consistent with the goals of promoting healthy communities. Section 10403 ensures that 20 percent of the Community Transformation Grants are awarded to rural and frontier areas.

SEC. 4201(b) ELIGIBILITY.—To be eligible to receive a grant under subsection

(a), an entity shall—

(1) be—
(A) a State governmental agency;
(B) a local governmental agency;
(C) a national network of community-based organizations;
(D) a State or local non-profit organization; or
(E) an Indian tribe; and

SEC. 4202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES. The goal of this program is to improve the health status of the pre-Medicare-eligible population to help control chronic disease and reduce Medicare costs. The CDC would provide grants to States or large local health departments to conduct pilot programs in the 55-to-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. Pilot programs would be evaluated for success in controlling Medicare costs in the community. Additionally, the Centers for Medicare & Medicaid Services (CMS) would conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary would then develop a plan for improving access to such services for Medicare beneficiaries.

SEC. 4202(a) HEALTHY AGING, LIVING WELL.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary"), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

SEC. 4302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS. Ensures that any ongoing or new Federal health program achieve the collection and reporting of data by race, ethnicity, primary language and any other indicator of disparity. The Secretary shall analyze data collected to detect and monitor trends in health disparities and disseminate this information to the relevant Federal agencies. Amends the Public Health Services Act to make data available to IHS and Tribal Epidemiology Centers.

SEC. 3101(c). DATA REPORTING AND DISSEMINATION.—

(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

(A) the Office of Minority Health;

(B) the National Center on Minority Health and Health Disparities;

(C) the Agency for Healthcare Research and Quality;

(D) the Centers for Disease Control and Prevention;

(E) the Centers for Medicare & Medicaid Services;

(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

Sec. 4304. Epidemiology-Laboratory Capacity Grants**.** Establishes a program that awards grants to assist State, local, and tribal public health agencies in improving surveillance for and responses to infectious diseases and other conditions of public health importance. Amounts received under the grants shall be used to strengthen epidemiologic capacity, enhance laboratory practices, improve information systems, and develop outbreak control strategies.

Title V. Health Care Workforce

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations. The provisions seek to increase the number of primary care providers with a comprehensive approach focusing on retention and enhanced education opportunities. The bill proposes to buildup the health care workforce by funding scholarships and loan repayment programs for doctors, physician assistants, nurse practitioners, dentists, and other health providers. The Act provides state and local governments flexibility and resources to develop health workforce recruitment strategies. It also helps to expand critical and timely access to care by funding the expansion, construction, and operation of community health centers throughout the United States.

Indian Provisions

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION. Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is

to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. As amended by Section 10501, adds representation from small businesses to the Commission membership; adds an examination of the barriers of entering and remaining in primary care careers as a high-priority area for the Commission; and includes optometrists and ophthalmologists as members of the health care workforce.

> SEC. 5101(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—
> (1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS. Offers loan repayment to public health students and workers in exchange for working at least 3 years at a federal, state, local, or tribal public health agency.

SEC. 5205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS. Offers loan repayment to allied health professionals employed at public health agencies or in settings providing health care to patients, including acute care facilities, ambulatory care facilities, residences, and other settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations. The term, "allied The term 'allied health professional' includes a health professional "employed with a Federal, State, local or tribal public health agency." [Emphasis added]

SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT. Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities.

> SEC. 340G–1(a). DEMONSTRATION PROGRAM. Establishes a demonstration program for which the Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities. The term 'alternative dental health care providers' includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.
>
> SEC. 340G-1(c) Eligible Entities.—include include "Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act)." [Emphasis added]
>
> SEC. 340G-1(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—
> Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

SEC. 5405. PRIMARY CARE EXTENSION PROGRAM. Creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. AHRQ will award planning and program grants to State hubs including, at a minimum, the State health department, State-level entities administering Medicare and Medicaid, and at least one health professions school. These State hubs may also include Quality Improvement

Organizations, AHECs, and other quality and training organizations. The Act requires Secretary to consult with IHS when carrying out this section.

SEC. 399W. PRIMARY CARE EXTENSION PROGRAM. Authorizes AHRQ shall establish a Primary Care Extension Program. The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors.

SEC. 399(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS. Establishes a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. The demonstration grant is to serve low-income persons including recipients of assistance under State Temporary Assistance for Needy Families (TANF) programs. Also establishes a demonstration program to competitively award grants for up to six States for three years to develop core training competencies and certification programs for personal and home care aides. Extends funding for family-to-family health information centers at $5 million for FY2010 through FY2012.

SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

SEC. 2008(a)(2)(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—
The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

SEC. 2008(a)(4) DEFINITIONS.—In this subsection.

(A) ELIGIBLE ENTITY.—The term 'eligible entity' meansa State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

SEC. 5508. INCREASING TEACHING CAPACITY. Directs the Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for FY2010, $50 million for FY2011 and FY2012 and such sums as may be necessary for each fiscal year thereafter to carry out such program. Also provides $230 million in funding under the Public Health Service Act to cover the indirect and direct expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs.

SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS. Authorizes the Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs. The term 'teaching health center' means an entity that includes a health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

Title VI. Transparency and Program Integrity

The Title VI provisions set out to bring transparency and program integrity by improving Medicare provider participation, referral, and reporting requirements. It brings greater transparency to nursing homes to help families find the right place for their loved ones and enhances training for nursing home staff so that the quality of care continuously improves. The Act promotes nursing home safety by encouraging self corrections of errors, requiring background checks for employees who provide direct care and by encouraging innovative programs that prevent and eliminate elder abuse. It will provide doctors access to medical research to help them make decisions regarding patient care. This title includes provisions to rein in waste, fraud and abuse by imposing tough new disclosure requirements to identify high-risk providers who have defrauded the American taxpayer. It gives states new authority to crack down on providers who have been penalized in one state from setting up in another.

Indian Provisions

SEC. 6301. Patient-Centered Outcomes Research. Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. Fees will be imposed on specified health insurance policies and paid by issuer. Certain government programs are exempt including, "any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act)." [Emphasis added]

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS. Requires CMS to include in the integrated data repository (IDR) claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS). The Secretary would be required to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of the IHS to help identity fraud, waste, and abuse. The Committee Bill would grant the HHS OIG and the Department of Justice (DOJ) access to the IDR for the purposes of conducting law enforcement and oversight activities consistent with applicable privacy, security, and disclosure laws. Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) DATA MATCHING.—

(1) INTEGRATED DATA REPOSITORY.—

(A) INCLUSION OF CERTAIN DATA.—

(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).
(II) The program under title XXI.
(III) Health-related programs administered by the Secretary of Veterans Affairs.
(IV) Health-related programs administered by the Secretary of Defense.
(V) The program of old-age, survivors, and disability insurance benefits established under title II.
(VI) The Indian Health Service and the Contract Health Service program.

(B) DATA SHARING AND MATCHING.—

(i) IN GENERAL.—The Secretary shall enter into agreements with the individuals described in clause

(ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

(I) The Commissioner of Social Security.
(II) The Secretary of Veterans Affairs.
(III) The Secretary of Defense.
(IV) The Director of the Indian Health Service

SEC. 6703. ELDER JUSTICE. Requires the Secretary of HHS, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and certain employees of these facilities would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would also be required to submit to the Secretary and to the State written notification of an impending closure of a facility within 60 days prior to the closure. In the notice, the owner or operator would be required to include a plan for transfer and adequate relocation of all residents.

Sec. 2011. Definitions. The amended language here adds ‘‘Subtitle A—Block Grants to States for Social Services’’; and (C) by adding at the end the following: ‘‘Subtitle B—Elder Justice. The definitions include as an eligible entity Indian Tribe and tribal organizations.

Section 2011(A)(7). (7) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

Section 2011(A)(12) INDIAN TRIBE.—

(A) IN GENERAL.—The term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term ‘Indian tribe’ includes any Pueblo or Rancheria

Title VII. Improving Access to Innovative Medical Therapies

The short title for the provisions under this title is, the “Biologics Price Competition and Innovation Act of 2009.” This title establishes a process under which the Secretary is required to license a biological product that is shown to be bio-similar to or interchangeable with a licensed biological product, commonly referred to as a reference product. The title prohibits the approval of an application as either bio-similar or interchangeable until 12 years from the date on which the reference product is first approved. Subtitle B promotes more affordable medicines for children and under-served communities. The provisions extend the 340B discounts to inpatient drugs and also extends participation to certain children’s hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers. The bill establishes new auditing, reporting, and other compliance requirements for the Secretary,

and for pharmaceutical manufacturers and 340B covered entities. It also requires the GAO to make recommendations to Congress within 18 months on improvements to the 340B program.

Title VIII. Community Living Assistance Services and Supports Act (CLASS Act)

This Title provides a new option to finance long-term services and care in the event of a disability. It establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision.

Title IX. Revenue Provisions

This title lays out the financing scheme for the bill. It includes revenue off-set provisions that include excise tax on high cost employer sponsored health coverage, requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2, limits the amount of contributions to health FSAs to $2,500, imposes an annual fee on the health insurance sector, as well as proposals. Additional provisions provide an exclusion from gross income for the value of specified Indian tribal health benefits provisions, establishes simple cafeteria plans that ease participation restrictions so that small businesses can provide tax-free benefits to their employees, includes a health professionals state loan repayment or forgiveness program intended to provide for the increased availability of health care services in underserved or health professional shortage areas. Other financing provisions are also included.

Indian Provisions

SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.
Provides an exclusion from gross income for the value of specified Indian tribal health benefits. Section 9021, amends the Internal Revenue Code to include as a general rule that gross income does not include the value of any qualified Indian health care benefit. This exclusion rule will apply to health care benefits and coverage provided to tribal citizens after the date of the enactment on March 23, 2010. The law contains a double benefit exclusion, which means this rule will not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of the tax code, or to the amount of any such benefit for which a deduction is allowed to that beneficiary. This provision is important in that the new language closes an important "gap" in the tax code and thereby honors tribal government sovereignty and treaty rights.

> SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.
>
> (a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:
>
> SEC. 139D. INDIAN HEALTH CARE BENEFITS.
>
> (a) GENERAL RULE.—Except as otherwise provided in this section, gross income does not include the value of any qualified Indian health care benefit.
>
> (b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—For purposes of this section, the term 'qualified Indian health care benefit' means—
>
> (1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,

(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,

(3) coverage under accident or health insurance (or an arrangement having the effect of accident or health insurance), or an accident or health plan, provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, include a spouse or dependent of such a member, and

(4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for a program or service relating to medical care provided by the Federal government to Indian tribes or members of such a tribe.

(c) DEFINITIONS.—For purposes of this section—

(1) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given such term by section 45A(c)(6).

(2) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term by section 4(l) of the Indian Self-Determination and Education Assistance Act.

(3) MEDICAL CARE.—The term 'medical care' has the same meaning as when used in section 213.

(4) ACCIDENT OR HEALTH INSURANCE; ACCIDENT OR HEALTH PLAN.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in section 105.

(5) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

(d) DENIAL OF DOUBLE BENEFIT.—Subsection (a) shall not apply to the amount of any qualified Indian health care benefit which is not includible in gross income of the beneficiary of such benefit under any other provision of this chapter, or to the amount of any such benefit for which a deduction is allowed to such beneficiary under any other provision of this chapter.''.

(b) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 139C the following new item:

''Sec. 139D. Indian health care benefits.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits and coverage provided after the date of the enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and

(2) benefits provided prior to the date of the enactment of this Act.

Title X. Reauthorization of the Indian Health Care Improvement Act

Included in the health reform legislation is the reauthorization of the Indian Health Care Improvement Act (IHCIA), which is made permanent in the Act. The IHCIA provisions will improve the Indian health care system in several ways. The legislation sets to improve workforce development and recruitment of health professionals in Indian country. It also provides new authorities to fund facilities construction as well as maintenance and improvement funds to address priority facility needs. It will create opportunities to improve access and financing of health care services for Indians. For example, the law now allows IHS to carry out long term care related services and be reimbursed for them, such as home and community based services. The bill makes a marked improvement at modernizing the delivery of health services provided by IHS.

The text of S. 1790 is not included in the health reform legislation. For copy of the IHCIA reauthorization language please see S. 1790 as reported out of the Senate Indian Affairs Committee on December 2009. Section 10221 of the health reform bill made the follow changes to S. 1790:

Title X Amendments to S. 1790

PART III—INDIAN HEALTH CARE IMPROVEMENT SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.

(a) IN GENERAL.—Except as provided in subsection (b), S. 1790 entitled ''A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.'', as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law.

(b) AMENDMENTS.—

(1) Section 119 of the Indian Health Care Improvement Act (as amended by section 111 of the bill referred to in subsection

(a)) is amended—

(A) in subsection (d)—

(i) in paragraph (2), by striking ''In establishing'' and inserting ''Subject to paragraphs (3) and (4), in establishing''; and

(ii) by adding at the end the following:

(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.

(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist; and

(B) by adding at the end the following:

(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law.''.

(2) The Indian Health Care Improvement Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by striking section 125 (relating to treatment of scholarships for certain purposes).

(3) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676) is amended—

(A) by striking ''Any limitation'' and inserting the following:

(a) HHS APPROPRIATIONS.—Any limitation''; and

(B) by adding at the end the following:

(b) LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions.''.

(4) The bill referred to in subsection (a) is amended by striking section 201.

Additional Indian Provisions in Title X

PART II—SUPPORT FOR PREGNANT AND PARENTING TEENS AND WOMEN

SEC. 10211. DEFINITIONS. Defines "eligible institution of higher learning" as having the same meaning as in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001). The terms "accompaniment", "community service center", "high school", "intervention service", "Secretary", "State", "supportive social service", and "violence" are also defined.

> SEC. 10211(7) STATE.—The term ''State'' includes the District of Columbia, any commonwealth, possession, or other territory of the United States, and any Indian tribe or reservation.

SEC. 10306. IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION. This section would make minor modifications to the Centers for Medicare and Medicaid Innovation, Accountable Care Organization program, and bundling pilot program with seemingly no direct impact on hospitals and health systems. It addresses telehealth services in medically under-served areas and in IHS programs. Amends Section 1115 of the Social Security Act.

> SEC. 3021(a)(5)(B)(xix). Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—
>
> (I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and
>
> (II) to improve the capacity of non-medical providers and non-specialized medical providers to

SEC. 10323. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS. Provides Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health determination under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

> SEC. 2009. PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS. Authorizes Secretary to establish a program in accordance with this section to make competitive grants to eligible entities for the purpose of screening at-risk individuals, developing and disseminating public information and education about the availability of screening under the program, and detection, prevention, and treatment of environmental health conditions. A "facility of the Indian Health Service" is an eligible entity to receive a grant under this section.

SEC. 10501. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT, THE SOCIAL SECURITY ACT, AND TITLE V OF THIS ACT. Creates a interagency task force to access and improve access to health care in the State of Alaska to be the, "Interagency Access to Health Care in Alaska Task Force." The task force shall include as a member the Indian Health Service.

For questions or corrections please contact:

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