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MEDICARE, MEDICAID, AND SCHIP INDIAN HEALTH CARE IMPROVEMENT ACT OF 2006

JULY 12, 2006.—Ordered to be printed

Mr. GRASSLEY, from the Committee on Finance, submitted the following

R E P O R T

[To accompany S. 3524]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, having had under consideration an original bill (S. 3524), to amend titles XVIII, XIX, and XXI of the Social Security Act to improve health care provided to Indians under the Medicare, Medicaid, and State Children's Health Insurance Programs, and for other purposes, reports favorably thereon and recommends that the bill do pass.

I. LEGISLATIVE HISTORY

The Finance Committee passed S. 3524, the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006 on June 8, 2006. S. 3524 is an original bill encompassing provisions of S. 1057, the "Indian Health Care Improvement Act" (IHCIA), that fall into the Finance Committee's jurisdiction—i.e., issues related to Medicare, Medicaid, and SCHIP. The IHCIA (S. 1057) was reported favorably out of the Senate Indian Affairs Committee on March 16, 2006. It is the intention of the Committee that the provisions of S. 3524 be incorporated into S. 1057 when it is considered by the full Senate.

S. 1057 would authorize the appropriation of such sums as necessary through 2015 for the Indian Health Care Improvement Act, the primary authorizing legislation for the Indian Health Service (IHS). The bill also contains specific authorizations for a program to encourage Indians to pursue careers related to behavioral health, a demonstration project to provide suicide prevention serv-

ices, a commission on Indian health care, and administrative costs for a new nonprofit corporation. In addition, the bill also would affect direct spending, primarily through provisions affecting the Medicaid program. CBO estimates that implementing S. 1057 would cost $2.6 billion in 2007 and $30.4 billion over the period 2007–2016.

II. SECTION-BY-SECTION ANALYSIS

SECTION 1. SHORT TITLE; TABLE OF CONTENTS

Current law

No provision.

Description of provision

This act may be cited as the "Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006."

SECTION 2. EXPANSION OF PAYMENTS UNDER MEDICARE, MEDICAID AND SCHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS

(a) Medicaid

Current law

A facility of the Indian Health Service (IHS) (including hospitals, nursing facilities or any other type of facility that provides services that are coverable under the Medicaid State plan), whether operated by the IHS or by an Indian tribe (IT) or a tribal organization (TO), as defined in Section 4 of the Indian Health Care Improvement Act (IHCIA), is eligible for Medicaid reimbursement under the State Medicaid plan, if and for so long as it meets all of the conditions and requirements generally applicable to such facilities under Title XIX of the Social Security Act (SSA).

Section 1911(b) of the SSA provides that if a facility of the IHS which does not meet all of the conditions and requirements of Title XIX which are generally applicable to such a facility, that submits to the Secretary of Health and Human Services (HHS), an acceptable plan for achieving compliance with such conditions and requirements, must be deemed to meet such conditions and requirements, and to be eligible for Medicaid reimbursement, without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

Under Section 1911(c) of the SSA, the Secretary of HHS is authorized to enter into agreements with the State Medicaid agency for purpose of reimbursing such agency for Medicaid services provided in IHS facilities to Indians who are eligible for Medicaid under the State Medicaid plan.

The Medicaid statute (Section 1911(d) of the SSA) points to Section 405 of the IHCIA, which describes the provisions relating to the authority of certain ITs, TOs, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services covered by Medicaid and provided by a hospital or clinic of such entities.

Description of provision

These provisions would completely replace their counterparts (described above) in current law.

The provision would require that the IHS and ITs, TOs and Urban Indian Organizations (UIOs) be reimbursed for Medicaid items and services provided under the State plan or a waiver, if the provision of those services meets all the conditions and requirements generally applicable to the delivery of such care.

A facility of the IHS or an IT, TO, or UIO which is eligible for Medicaid reimbursement, but which does not meet all of the conditions and requirements of Medicaid under the State plan or a waiver which are generally applicable to such a facility, must make such improvements as are necessary to achieve or maintain compliance in accordance with a plan submitted to and accepted by the Secretary for meeting such conditions and requirements. The Secretary may deem a facility compliant for an initial twelve month period as under current law.

The provision would also allow the Secretary of HHS to enter into an agreement with a State for the purpose of reimbursing that State for Medicaid services provided by the IHS, an IT, TO or UIO, directly, through referral, or under contracts or other arrangements between these entities and another health care provider to Indians eligible for Medicaid under the State Medicaid plan or a waiver.

The provision would also provide a cross-reference to a special fund into which are placed payments to which a facility of the Indian Health Service is entitled under Medicaid. These provisions describe the authority of the Secretary to place Medicaid payments for which IHS facilities are eligible into a special fund, requires the Secretary to ensure that 100 percent of the payment for which facilities are eligible are paid out, and further requires facilities to use any amounts in excess of the amount necessary to achieve or maintain compliance for the purposes of improving IHS facilities. These requirements are outlined in subparagraphs (A) and (B) of Section 401(c)(1) of the IHCIA.

The provision would also point to Section 401(d) of the IHCIA for rules relating to the authority of a Tribal Health Program (THP) or UIO to elect to directly bill for, and receive payment for, health care items and services reimbursable under Medicaid.

Finally, the bill would point to Section 4 of the IHCIA for definitions of the following terms: Indian Health Program, Indian Tribe, Tribal Health Program, Tribal Organization, and Urban Indian Organization.

(b) Medicare

Current law

The Social Security Act generally prohibits payment to any Federal agency for services which would otherwise be covered under Medicare. However, Section 1880 of the Act provides an exception for IHS facilities. Section 1880(a) provides an exception for hospitals and skilled nursing facilities (SNF) whether operated by the Service or by an Indian tribe or tribal organization if and for so long as the entity meets the conditions and requirements for payments generally applicable to such facilities under Medicare. Section 1880(b) established a temporary provision for submission of an

acceptable compliance plan for a hospital or SNF not meeting all of these conditions and requirements in 1976. Section 1880(c) specifies that payments to which any hospital or SNF of the IHS is otherwise entitled is to be placed in a special fund to be held by the Secretary. The Secretary is to use the payments (to the extent provided in appropriations Acts) exclusively for the purpose of making improvements in hospitals and SNFs which may be needed to achieve compliance with Medicare conditions and requirements. The provision would cease to apply when the Secretary determined and certified that substantially all the hospitals and SNFs of the IHS are in compliance. Section 1880(d) specifies that the annual report of the Secretary (required by the Indian Health Care Improvement Act) is to include a detailed statement of the status of hospitals and SNFs in terms of their compliance and of their progress toward achievement of such compliance.

Section 1880(e) extends payment, effective July 1, 2001, to certain services furnished in hospitals and ambulatory care clinics (whether provider-based or free-standing) operated by the IHS or by an Indian tribe (IT) or tribal organization (TO). The specified services are those provided by physicians, nonphysician practitioners, and physical and occupational therapists and which are paid for under the physician fee schedule. Effective for the 5–year period beginning January 1, 2005, the authority is extended to all services for which payment may be made under Medicare Part B.

Section 1880(f) provides a cross-reference to Section 405 of the IHCIA for provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native Health organizations to elect to directly bill for and receive payments for health care services provided by a hospital or clinic of such tribe or organization.

Description of provision

The provision would rewrite Section 1880 of the Social Security Act. New Section 1880(a) would specify that the Indian Health Service, and an Indian Tribe, Tribal Organization, or an Urban Indian Organization would be eligible for Medicare payments for services furnished by such entities, provided such services met all the conditions and requirements generally applicable to the furnishing of such services under Medicare. Application of the provision would be subject to the revised Section 1880(e).

New Section 1880(b) would require facilities of the Indian Health Service, or an Indian Tribe, Tribal Organization, or an Urban Indian Organization, which are eligible for reimbursement under Medicare, but which do not meet all of the conditions and requirements generally applicable to such facilities, to make improvements. The improvements would be in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements. The Secretary may deem a facility compliant for initial 12–month period as under current law.

New Section 1880(c) would provide a cross reference to the special fund established under Section 401(c)(1) of the IHCIA for provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is entitled under Medicare in a special fund. It would provide a further cross ref-

erence to section 401(c)(1) (A) and (B) of the IHCIA, which require the Secretary to ensure that 100 percent of the payment for which facilities are eligible are paid out, and further requires facilities to use any amounts in excess of the amount necessary to achieve or maintain compliance for the purposes of improving IHS facilities.

New Section 1880(d) would provide a cross reference to Section 401(d) of the IHCIA for provisions relating to the authority of a Tribal Health Program (THP) or Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such program or organization for which payment would be made under Medicare.

The provision would make a conforming change to the existing Section 1880(e) to specify that Section 401(c)(1) of the IHCIA, as well as new Section 1880(c), would not apply to payments made under Section 1880(e).

New Section 1880(f) would specify that the following terms have the meanings given to these terms in Section 4 of the IHCIA: Indian Health Program, Indian Tribe, Service Unit, Tribal Health Program, Tribal Organization, and Urban Indian Organization.

(c) Application to SCHIP

Current law

No provision.

Description of provision

This provision would apply all but one subsection of these Medicaid provisions to the SCHIP program, including: (1) the provision regarding eligibility of Indian entities to receive reimbursement (as defined in the new Section 1911(a)); (2) the provision regarding compliance with conditions and requirements (as defined in the new Section 1911(b)); (3) the provision regarding the authority of the Secretary of HHS to enter into agreements with States to provide Medicaid reimbursement to Indian entities (as defined in the new Section 1911(c)); (4) the provision regarding direct billing (as defined in the new Section 1911(e); and (5) the provision defining terms referring to Indian entities (as defined in the new Section 1911(f)). The provision regarding the special fund for improving IHS facilities (as defined in the new Section 1911(d)) would not apply to SCHIP.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 401, which revises Section 401 of the Indian Health Care Improvement Act Amendments of 2005, as reported (S. 1057), would amend parts of Sections 401, 402, and 405 of the Indian Health Care Improvement Act. Section 401(a), which is identical to Section 401(a) of S. 1057, would expand to SCHIP the prohibition in IHCIA on any Medicare and Medicaid payments received by a hospital or skilled nursing facility (SNF) of IHS (whether operated by the IHS, a tribe, or tribal organization under a Indian Self-Determination Act contract) for services provided to eligible Indians from being considered in determining appropriations for health care and services to Indians. Section 401(a) would also expand the prohibition to cover any such payments received by an Urban In-

dian Organization, and to cover payments for any services provided, not just services from hospitals or SNFs.

Section 401(b), which is identical to Section 401(b) of S. 1057, would include an amendment to the IHCIA that nothing in the law authorizes the Secretary to provide services to Indian Medicare and Medicaid or SCHIP beneficiaries in preference to those without such coverage.

Section 401(c), which is nearly identical to Section 401(c) of S. 1057, would expand current law, which directs that IHS put all Medicaid payments to IHS facilities in a special fund to be held by the Secretary, and to require that reimbursements from Medicare also be deposited in the special fund. It would expand allowable uses of the special fund to cover improvements in all IHS programs to comply with conditions of Medicare (as well as Medicaid) programs, and would require that reimbursed amounts in excess of the amount necessary to meet such compliance conditions be used, subject to the consultation with tribes being served by the IHS service unit, for reducing the health resource deficiencies of the tribes. It would increase to 100 percent (from 80 percent) the proportion of any SSA reimbursement (to which an IHS service unit is entitled) that the Secretary must ensure goes to that service unit. Section 401(c) would further provide that the requirement for placement of reimbursements in the special fund shall not apply to Tribal Health Programs, as well as Urban Indian Organizations (added by this amendment to S. 1057), that elect under Section 401(d) to receive reimbursements directly, but would allow no payments from the special fund during the period the Tribal Health Program or Urban Indian Organization elects to receive reimbursements directly. Tribal Health Programs are defined in Section 4 of S. 1057, as reported, as tribes or tribal organizations that operate health programs under a self-determination funding agreement.

Section 401(d) would amend provisions in current law authorizing the option of direct billing of Medicare, Medicaid, and third-party payors for health care services by Tribal Health Programs operating hospitals and clinics. It would revise S. 1057 to make that bill's provisions parallel to similar provisions in Section 2 of the proposed "Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006," as reported (see new Sections 1911(c) and 1880(c)); it would drop S. 1057 language allowing direct billing for SCHIP services; it would drop language that only direct billing participants who also receive self-determination or urban Indian health program funding need to give IHS their provider enrollment numbers or other identifiers; it retains a current law provision (dropped in S. 1057) requiring that amounts paid to a Tribal Health Program or Urban Indian Organization under a Social Security Act program be subject to the auditing requirements applicable to that program's payments; and it would add language stating nothing in the auditing provision may be construed as limiting the application of Medicare, Medicaid, and SCHIP auditing requirements; it would add a requirement that IHS provide the CMS Administrator with provider enrollment numbers and enrollment data regarding patients served by the Service (and, to the extent such data are available, by Tribal Health Programs and Urban Indian Organizations) and other information the CMS Administrator may require if the tribe receives funding from the Service under the In-

dian Self-Determination and Education Assistance Act or an Urban Program receives funding from the Service under Title V of this Act and receives reimbursements or payments under Title XVIII, XIX, or XXI of the Social Security Act; and it would add a provision authorizing the Secretary to terminate a Tribal Health Program's or Urban Indian Organization's participation in the direct billing program if the Secretary determined that the program or organization failed to comply with the direct billing program's requirements, if the Secretary provided advance notice and a reasonable opportunity to correct the noncompliance.

Section 401(d) would expand the current direct billing program to include Urban Indian Organizations, would require that reimbursements be used for compliance improvements and additional health care, health facilities, and other broad health-care-related purposes, but would delete the current law prioritization of spending on compliance improvements. It would delete provisions directing the Secretary to monitor participating hospitals and clinics and require annual reports from them, and it would delete participation criteria and application requirements. As in current law, participants in the direct billing program may withdraw from the program under the same conditions as retrocession from a contracted program occurs under the Indian Self-Determination Act (although all cost accounting and billing authority must be returned to the Secretary when the withdrawal is accepted), and the Secretary through IHS, and with assistance from the CMS Administrator, is directed to examine and implement any administrative changes that would facilitate direct billing, including agreements with States.

New Section 401(e) would add a cross-reference to Sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act for provisions related to Section 401(c) and (d).

SECTION 3. INCREASED OUTREACH TO INDIANS UNDER MEDICAID AND SCHIP AND IMPROVED COOPERATION IN THE PROVISION OF ITEMS AND SERVICES TO INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS

Current law

No provision in Social Security Act.

Section 404(a) of the IHCIA requires the Secretary to make grants or enter into contracts with Tribal Organizations for establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages. The purpose of the programs is to assist individual Indians to enroll in Medicare, apply for Medicaid and pay monthly premiums for coverage due to financial need of such individuals. Section 404(b) of the IHCIA directs the Secretary, through the IHS, to set conditions for any grant or contract. The conditions include, but are not limited to: (1) determining the Indian population that is, or could be, served by Medicare and Medicaid; (2) assisting individual Indians to become familiar with and use benefits; (3) providing transportation to Indians to the appropriate offices to enroll or apply for medical assistance; and (4) developing and implementing both an income schedule to determine premium payment levels for coverage of needy individuals and methods to improve Indian participation

in Medicare and Medicaid. Section 404(c) of the IHCIA authorizes the Secretary, acting through the IHS, to enter into agreements with tribes, Tribal Organizations, and Urban Indian Organizations to receive and process applications for medical assistance under Medicaid and benefits under Medicare at facilities administered by the IHS, or by a tribe, Tribal Organization or Urban Indian Organization under the Indian Self-Determination Act.

Description of provision

The provision would add a new Section 1139 to the Social Security Act (replacing the current Section 1139 provision dealing with an expired National Commission on Children).

The new Section 1139(a) would encourage States to take steps to provide for enrollment of Indians residing on or near a reservation in Medicaid and SCHIP. The steps could include outreach efforts such as: outstationing of eligibility workers; entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach; education regarding eligibility and benefits; and translation services. Nothing could be construed as affecting arrangements between States and the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations for them to conduct administrative activities under Medicaid or SCHIP.

The new Section 1139(b) would require the Secretary, acting through CMS, to take such steps as necessary to facilitate cooperation with and agreements between States, and the IHS, Indian Tribes, Tribal Organizations, or Urban Indian Organizations relating to the provision of benefits to Indians under Medicare, Medicaid, and SCHIP.

The New Section 1139(c) would specify that the following terms have the meanings given to these terms in Section 4 of the Indian Health Care Improvement Act: Indian Tribe, Indian Health Program, Tribal Organization, and Urban Indian Organization.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 402, which revises Section 402 of S. 1057, as reported, would amend Section 404 of the IHCIA, concerning assistance to Indians to enroll in Medicare, Medicaid, and SCHIP. Section 402(a) would expand current law—which requires the Secretary to make grants or contracts with tribal organizations for programs on or near reservations, trust areas, and Alaska Native villages to assist individual Indians to enroll in Medicare and apply for Medicaid [and to pay monthly premiums due to such Indians' financial need—to cover enrollment in SCHIP, make tribes eligible recipients, and allow the tribes or tribal organizations to determine financial need based on a schedule of income levels developed or implemented by the tribes]. Section 402(a) would limit appropriations for such grants and contracts to those authorized under Title IV of the IHCIA. Section 402(a) would expand current law and S. 1057 to cover payment not only of premiums but also of cost sharing, but unlike current law and S. 1057 would limit such payment to those programs for which the charging of premiums and cost sharing is not prohibited. New Section 402(f) would define "premium" as any

enrollment fee or similar charge and "cost sharing" as any deduction, deductible, copayment, coinsurance, or similar charge.

Section 402(b) would continue current law requiring the Secretary, acting through the IHS, to set conditions for grants or contracts under Section 402. The conditions would include requirements that the tribe or tribal organization determine the population eligible for Medicare, Medicaid, or SCHIP benefits, educate Indians about benefits available under the programs, provide transportation for individual Indians to the appropriate offices for enrollment or application for benefits, and develop and implement methods of improving Indian participation in these programs. New Section 402(c), identical to Section 402(e) in S. 1057, would apply this section's provisions on agreements to Urban Indian Organizations for the populations that they serve, and would require that agreements with the Organizations include requirements that are consistent with those in subsection (b), appropriate to urban Indians and such Organizations, and necessary to effect the purposes of Section 402.

New Section 402(d) would require the Secretary, acting through CMS, to facilitate cooperation with and agreements between the States and IHS, tribes, tribal organizations, and Urban Indian Organizations, but would revise S. 1057 by limiting the cooperation and agreements to the provision of health care to Indians under Medicare, Medicaid, or SCHIP.

New Section 402(e) would drop the authorization in Section 402(c) of current law, and in S. 1057, for tribal processing of Indians' applications for Medicare and Medicaid, and drop S. 1057's extension of that authority to SCHIP. Section 402(e) instead adds a cross-reference to new Section 1139(a) of the Social Security Act added by the proposed "Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006."

SECTION 4. ADDITIONAL PROVISIONS TO INCREASE OUTREACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID

(a) Nonapplication of 10-percent limit on outreach and certain other expenditures

Current law

Title XXI of the Social Security Act provides States with annual Federal SCHIP allotments based on a formula set in law. State SCHIP payments are matched by the Federal Government at an enhanced rate that builds on the base rate applicable to Medicaid. The SCHIP statute also specifies that Federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP statute specifies that payments for these four other specific health care activities cannot exceed 10 percent of the total amount of expenditures for

benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

Description of provision

The provision would exclude from the 10 percent cap on SCHIP payments (for the four specific health care activities described above) the following activities: (1) expenditures for outreach activities to families of Indian children likely to be eligible for separate SCHIP programs or Medicaid expansions under SCHIP authority, or under related waivers, and (2) related informing and enrollment assistance activities for Indian children under such programs, expansions, or waivers, including such activities conducted under grants, contracts, or agreements entered into under the new grant program delineated in the Section 1139(a) of this Act (described in Section 3 above).

(b) Assurance of payments to Indian health care providers for child health assistance

Current law

Among other assurances, the State SCHIP plan must include a description of the procedures to be used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in Section 4(c) of the IHCIA).

Description of provision

The provision would strike the reference to Section 4(c) of the IHCIA, and would expand this assurance to include how the State will ensure that payments are made to IHPs and UIOs providing SCHIP benefits in the State.

(c) Inclusion of other Indian financed health care programs in exemption from prohibition on certain payments

Current law

To prevent duplicative payments, the SCHIP statute specifies that no payments shall be made to a State for expenditures for child health assistance when that payment has been made or can reasonably be expected to be made promptly under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the IHS, as identified by the Secretary.

Description of provision

This provision would add ITs, TOs and UIOs, to the exemption from the prohibition on SCHIP payments in the same manner currently applicable to the IHS.

(d) Satisfaction of Medicaid documentation requirements

Current law

Under the Deficit Reduction Act of 2005 (DRA), States are prohibited from receiving Federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. Satisfactory evidence includes one docu-

ment (from a list specified in the law) that provides reliable documentation of identity and proof of U.S. citizenship or nationality. Satisfactory evidence also includes one document (from a list specified in the law) that provides proof of U.S. citizenship or nationality and one document (also from a list specified in the law) that provides reliable documentation of identity.

Section 6036(a)(2) of DRA specifies that the requirements do not apply to an alien who is (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on the basis of receiving Supplemental Security Income (SSI) benefits, or (3) eligible for Medicaid on such other basis as the Secretary of HHS may specify that satisfactory evidence had been previously presented.

The provision applies to initial determinations and to redeterminations of eligibility for Medicaid made on or after July 1, 2006.

Description of provision

For the purpose of establishing Medicaid eligibility, this provision would add "a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe" to the list of accepted documents that provide reliable documentation of identity and proof of U.S. citizenship or nationality. The provision would also make a technical correction to a reference to a subparagraph in Section 1903(i) of the Medicaid statute.

With respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by paragraph (1)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.

(e) Definitions

Current law

Under SCHIP statute, definitions of specific terms are provided, including for example, "child," "creditable health coverage," "low-income," etc.

Description of provision

For SCHIP purposes, the provision would specify that the terms "Indian," "Indian Health Program," "Indian Tribe," "Tribal Organi-

zation," and "Urban Indian Organization" have the same meanings given those terms in Section 4 of the IHCIA.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 410, which replaces Section 410 of S. 1057, as reported, would add a new Section 410 to the Indian Health Care Improvement Act, concerning expenditures for SCHIP outreach to Indians and SCHIP payments to Indian health programs. Section 410(1) would add a cross-reference to Sections 2105(c)(2) and 1139 of the Social Security Act, as amended by the proposed "Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006," concerning outreach to families whose Indian children may be eligible for SCHIP. Section 410(2) adds a cross-reference to Sections 2101(b)(3)(D) and 2105(c)(6)(B) of the Social Security Act, as amended, concerning targeting of SCHIP assistance to low-income Indian children and SCHIP payments to Indian Health Programs to include IHS, tribal, and tribal organizations' health programs) and Urban Indian Organizations.

SECTION 5. PREMIUMS AND COST SHARING PROTECTIONS UNDER MEDICAID, ELIGIBILITY DETERMINATIONS UNDER MEDICAID AND SCHIP, AND PROTECTION OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY

(a) Premiums and cost sharing protection under Medicaid

Current law

Under Medicaid, premiums and enrollment fees are generally prohibited for most beneficiaries classified as categorically needy. Nominal premiums and enrollment fees specified in regulations can be collected from persons classified as medically needy, certain families qualifying for transitional medical assistance, and pregnant women and infants with income over 150 percent of the Federal poverty level. Premiums and enrollment fees can exceed these nominal amounts for persons classified as workers with disabilities (up to other specified limits), and for individuals covered under Section 1115 waivers.

Service-related cost-sharing (e.g., deductibles, copayments, and coinsurance) is prohibited for children under 18, for pregnant women, and for selected services (i.e., in a hospital, long-term care facility or other institution if spend-down is required; for hospice care; for emergency services; and for family planning services and supplies) provided to individuals classified as categorically needy or medically needy. For most other groups and services, nominal cost-sharing amounts are allowed as specified in regulations. For individuals classified as workers with disabilities, and those covered under Section 1115 waivers, service-related cost-sharing can exceed these nominal amounts.

Finally, the DRA of 2005 added a new State option for alternative premiums and cost-sharing, effective as of March 31, 2006. Generally, this new option provides States with additional flexibility to apply premiums and service related cost-sharing for certain Medicaid subgroups. Special cost-sharing rules apply to prescription drugs and to non-emergency services delivered in an emergency room.

Description of provision

The provision would add a new subsection specifying that no enrollment fee, premium or similar charge, and no deduction, co-payment, cost-sharing, or similar charge shall be imposed against an Indian who receives Medicaid-coverable services or items directly from the IHS, an IT, TO, or UIO, or through referral under the contract health service. In addition, Medicaid payments due to the IHS, an IT, TO, or UIO, or to a health care provider through referral under the contract health service for providing services to a Medicaid-eligible Indian, could not be reduced by the amount of any enrollment fee, premium or similar charge, or by the amount of any cost-sharing or similar charge that would otherwise be due from an Indian, if such charges were permitted.

Nothing in this provision shall be construed as restricting the application of any other limitations on the imposition of premiums or cost-sharing that may apply to a Medicaid-enrolled Indian.

This provision would stipulate that the terms "contract health service," "Indian," "Indian Tribe," "Tribal Organization," and "Urban Indian Organization" have the meanings given those terms in Section 4 of the IHCIA.

Finally, the provision would stipulate that these provisions would not be superseded by the new State option for alternative premiums and cost-sharing added by the DRA of 2005.

(b) Treatment of certain property for Medicaid and SCHIP eligibility

Current law

The Federal Medicaid statute defines more than 50 eligibility pathways. For some pathways, States are required to apply an assets test. For other pathways, assets tests are a State option. When assets tests apply, some pathways give States flexibility to define specific assets that are to be counted and which can be disregarded. For other pathways, primarily for people qualifying on the basis of having a disability or who are elderly, assets tests are required. Assets under those tests are specifically defined in the Supplemental Security Income (SSI) statute in Title XVI of the Social Security Act. Under SSI law, several types of assets are excluded, including: (1) any land held in trust by the United States for a member of a federally-recognized tribe, or any land held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the Federal Government; and (2) certain distributions (including land or an interest in land) received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act. All other property, except for the applicant's primary residence, is required to be counted.

There is no similar provision in current SCHIP law.

Description of provision

Notwithstanding any other Federal or State law, the provision would prohibit consideration of four different classes of property in determining Medicaid eligibility. These classes include: (1) property located on a reservation, including any federally-recognized Indian

Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act (ANCSA), and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs; (2) for any federally-recognized Tribe not described in the first class, property located within the most recent boundaries of a prior Federal reservation; (3) ownership interests in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights; and (4) ownership interest in or usage rights to items not covered in the previous classes that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

The provision would also apply this new language to SCHIP in the same manner in which it applies to Medicaid.

(c) Continuation of current law protections of certain Indian property from Medicaid estate recovery

Current law

Under Medicaid, the Secretary is allowed to specify standards for a State hardship waiver of asset criteria for Medicaid estate recovery purposes.

Description of provision

The provision would provide that certain income, resources, and property would remain exempt from Medicaid estate recovery if they were exempted under Section 1917(b)(3) of the Social Security Act (allowing the Secretary to specify standards for a State hardship waiver of asset criteria) under instructions regarding Indian tribes and Alaskan Native Villages as of April 1, 2003. The provision would also allow the Secretary to provide for additional estate recovery exemptions for Indians under Medicaid.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 412, which replaces Section 412 of S. 1057, as reported, would add a new Section 412 to the Indian Health Care Improvement Act, concerning Indian cost sharing and treatment of Indian property under Medicaid and SCHIP. Section 412(1) adds a cross-reference to Sections 1916(j) and 1916A(a)(1) of the Social Security Act, as amended by proposed "Medicare, Medicaid, and SCHIP Health Care Improvement Act of 2006," concerning Medicaid premiums and cost sharing protections for health care provided Indians by Indian Health Programs, either directly or through referral. Section 412(2) adds a cross-reference to Sections 1902(e)(13) and 2107(e)(1)(B) of the Social Security Act, as amended by the bill, for rules concerning treatment of certain kinds of Indian property in determining Medicaid eligibility. Section 412(3) adds a cross-reference to Section 1917(b)(3)(B) of the Social Security Act, as amended by the bill, concerning protection of certain types of Indian property from Medicaid estate recovery provisions.

Section 412(a) of S. 1057, as reported, would exempt Indians from Medicaid, SCHIP, and IHS deductibles, coinsurance, and co-payments, and would prohibit reducing the Medicaid or SCHIP payment or reimbursement due to IHS, a tribe, a tribal organization, or an Urban Indian Organization by the amount of the deductible, co-payment, or coinsurance that would have been due from the Indian. Section 412(b) would exempt eligible Indians from Medicaid or SCHIP premiums, enrollment fees, or similar charges. Section 412(c) would exclude certain reservation, Alaskan, trust, restricted, cultural, and subsistence Indian property, and rights-based natural resource ownership interests, from the Medicaid eligibility determinations. Section 412(d) would provide similar protections of Indian property from Medicaid estate recovery.

SECTION 6. NONDISCRIMINATION IN QUALIFICATIONS FOR PAYMENT FOR SERVICES UNDER FEDERAL HEALTH PROGRAMS

Current law

No provision.

Description of provision

The provision would add an additional subsection to New Section 1139, as added by Section 3 of this bill. New Section 1139(c) would require a Federal health care program to accept an entity that is operated by the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment or reimbursement on the same basis as any other provider qualified to participate as a provider under the program. This requirement would apply if the entity met generally applicable State or other requirements for participation as a provider of health care services under the program. Any requirement that an entity be licensed or recognized under State or local law where the entity is located would be deemed to be met in the case of an entity operated by the IHS, Indian Tribe, Tribal Organization, or Urban Indian Organization, if the entity met all applicable standards for such licensure or recognition. Under certain circumstances, the fact that a health care professional employed by the entity did not have licensure under the State or local law where the entity was located would not be taken into account for purposes of determining whether the entity met the standards. Specifically, the absence of such licensure would not be taken into account if the professional was licensed in another State. This would be in accordance with Section 221 of the IHCIA.

The provision would prohibit payments under Federal health care programs for services to Indians to any entity operated by the IHS, Indian Tribe, Tribal Organization, or Urban Indian Organization, if the entity was excluded from participation in any Federal health care program. The prohibition would also apply if the entity's State license was either under suspension or revoked. Further, no individual excluded from participation in any Federal health care program or whose State license was under suspension or revoked would be eligible to receive payment or reimbursement under any Federal health care program for services furnished to an Indian.

The provision would define the term Federal health care program as the term is defined under Section 1128B(f) of the Social Security Act, except that the exclusion of the Federal employees health benefits program would not apply. Section 1128B(f) specifies that the term means any plan or program that provides health benefits directly, through insurance or otherwise, which is funded directly in whole or in part by the U.S. Government. Section 1128B(f) specifies that the term also includes the following State health care programs; Medicaid, any program receiving funds under the maternal and child health services block grant program or from an allotment to a State under such program, any program receiving funds under the social services block grant program or from an allotment to a State under such program, or a State child health plan approved under the SCHIP program.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 408, which revises Section 408 of the Indian Health Care Improvement Act Amendments of 2005, as reported (S. 1057), would add a new Section 408 to the Indian Health Care Improvement Act, concerning eligibility of IHS and Indian entities to become providers and receive payments under Federal health care programs. Section 408 would divide the same section in S. 1057, as reported, into two subsections. Section 408(a) would require that a Federal health care program accept an entity operated by IHS, a tribe, tribal organization, or Urban Indian Organizations as a provider eligible to receive payments or reimbursements on the same basis as other qualified providers if the entity meets generally applicable State or other requirements. Section 408(b) would deem entities operated by IHS, a tribe, tribal organization, or Organization to have met State or local licensing or recognition requirements if the entities met all applicable licensing or recognition standards, regardless of whether an entity has obtained the license or other documentation, and regardless of whether a health care professional employed by the entity has a State or local license as long as the professional is licensed in another State. A new subsection, Section 408(c), would add a cross-reference to Section 1139(c) of the Social Security Act, as added by the bill, regarding nondiscrimination against IHS, tribal, tribal organization, or Urban Indian Organization providers.

SECTION 7. CONSULTATION ON MEDICAID, SCHIP AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS

Current law

There are no provisions in current Medicaid or SCHIP statutes regarding a Tribal Technical Advisory Group (T-TAG) within the Centers for Medicare and Medicaid Services (CMS), the Federal agency that oversees the Medicare, Medicaid and SCHIP programs. Current Federal guidance requires States submitting waivers under Section 1915 or 1115 of the Social Security Act to engage in the following activities related to consultation with Tribal Governments in their State: (1) notify in writing all federally-recognized

Tribal Governments maintaining a primary office in the State at least 60 days before submitting the waiver or renewal of the State's intent to submit such waiver or renewal to CMS; (2) ensure the notice to the tribal Government describes the purpose of the waiver or renewal and anticipates the impact on tribal members; (3) ensure the notice also describes a method for appropriate Tribal representatives to provide official written comments and questions in a timeframe allowing State analysis and consideration and discussion between the States and the Tribes responding to the notice; (4) provide Tribal Governments with a reasonable period of at least 30 days in which to respond to the notice; and (5) provide an opportunity for an in-person meeting with Tribal representatives to discuss issues.

Description of provision

The provision would require the Secretary to maintain within CMS a Tribal TAG, previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TAG include a representative of the UIOs and IHS. The UIO representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act for certain meetings with Federal officials.

The provision would also require certain States to establish a process for obtaining advice on a regular, on-going basis from designees of IHPs and UIOs on matters relating to the application of Medicaid law likely to have a direct effect on those entities. Applicable States would include those in which the IHS operates or funds health programs, or in which one or more IHPs or UIOs provide health care for which Medicaid can be billed. This process would include seeking advice prior to submission of State Medicaid plan amendments, waiver requests or proposed demonstrations likely to directly affect Indians, IHPs, or UIOs. This process could include appointment of an advisory panel and of a designee of IHPs and UIOs to the Medicaid medical care advisory committee advising the State on its State Medicaid plan.

The provision would also apply this new language to SCHIP in the same manner in which it applies to Medicaid.

Finally, the provision would prohibit construing these amendments as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary or any State with respect to the provision of health care to Indians.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 409, which replaces Section 409 of the Indian Health Care Improvement Act Amendments of 2005, as reported (S. 1057), would add a new Section 409 to the Indian Health Care Improvement Act, making a cross-reference to Section 1139(d) of the Social Security Act, as amended by the bill, concerning consultation with Indian Health Programs and Urban Indian Organizations on the Medicare, Medicaid, and SCHIP programs.

Section 409(a) of S. 1057, as reported, would require the Secretary to maintain the Tribal Technical Advisory Group established under a CMS charter and to include an Urban Indian Organization representative. Section 409(b) would require a State to establish a process to seek advice on relevant Medicaid matters from Indian Health Programs and Urban Indian Organizations; the process would include solicitation of advice on proposed Medicaid plan amendments, waiver requests, and demonstration projects, creation of an advisory committee, or appointment of an Indian designee to the State's medical care advisory committee. Section 409(c) would direct that nothing in Section 409 superseded any existing advisory procedures, guidance, committees, or groups established by the Secretary or a State.

SECTION 8. SANCTIONS UNDER THE SOCIAL SECURITY ACT

Current law

The Social Security Act establishes sanctions for certain prohibited activities in connection with Medicare, Medicaid, and SCHIP. Under certain circumstances, primarily in cases of access issues, waivers may be requested.

Section 1128B(b) of the Social Security Act authorizes criminal penalties for anyone knowingly and willfully soliciting or receiving remuneration in return for: (1) referring any individual for services for which Federal health program payment may be made; or (2) purchasing, leasing, or ordering or arranging for purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made under a Federal health care program.

Description of provision

The provision would add an additional subsection to New Section 1139, as added by Section 3, and amended by Sections 6 and 7, of this bill. New Section 1139(e) would establish a process for requesting waivers of sanctions imposed against a health care provider under Title XI of the Social Security Act (General Administrative provisions). The process would apply insofar as the provider provided services through an Indian Health Program. The administrator of the affected Indian Health Program would petition the Secretary directly for a waiver.

The provision would specify that certain transactions involving Indian Health Care Programs would not be deemed remuneration for purposes of applying Section 1128B(b) of the Social Security Act. Safe harbors would be established for certain transfers between or among an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization that were made for the purpose of providing necessary health care items and services to patients served by such Program, Tribe, or Organization. Covered transfers would be services in connection with the collection, transport, analysis, and/or interpretation of diagnostic specimens or test data, inventory or supplies, staff, or a waiver of all or part of premiums or cost sharing.

Safe harbors would also be established for certain transfers between an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization and any patient served or eligible for services from such entity, including any patient served or

eligible for service pursuant to Section 807 of the IHCIA. A safe harbor would only exist if one of the following three criteria was met. First, the transfer was for the purpose of providing transportation for the patient for the provision of necessary health care items or services; and the provision of such services could not be advertised, nor considered an incentive of which the value is disproportionately large in relationship to the value of the care service. Second, the transfer was for the purpose of providing housing to the patient (including a pregnant patient) and immediate family members or an escort necessary to assuring the timely provision of health services to the patient; and the provision of such services could not be advertised, nor considered an incentive of which the value is disproportionately large in relationship to the value of the care service. The third permissible type of transfer would be for the purpose of paying premiums or cost sharing on behalf of a patient; the payment could not be subject to conditions other than those under a contract for the delivery of contract health services.

A safe harbor would be established for a transfer negotiated as part of a contract entered into between Indian Health Program, Indian Tribe, Tribal Organization, Urban Indian Organization, or the Indian Health Service, and a contract care provider, provided that the transfer is not tied to the volume or value of referrals or other business generated by the parties, and any such transfer be limited to the fair market value of the services provided.

Additional safe harbors would be established for other transfers involving an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization or patient served or eligible for service from such an entity. Such additional safe harbors would occur only if the Secretary, in consultation with the Attorney General, determined that they were appropriate given the special circumstances of Indian Health Programs, Indian Tribes, Tribal Organizations, or Urban Indian Organizations and of the patients served by such entities.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 411, which replaces Section 411 of the Indian Health Care Improvement Act Amendments of 2005, as reported (S. 1057), would add a new Section 411 to the Indian Health Care Improvement Act, making a cross-reference to Section 1139(e) of the Social Security Act, as amended by this bill, concerning sanctions against providers of services through Indian Health Programs.

Section 411(a) of S. 1057, as reported, would allow an Indian Health Program to request from the Secretary a waiver of sanctions imposed against one of its health care provider if the State does not seek the waiver after the Program's request. Section 411(b) would specify that certain exchanges of items or services of value are not to be treated as remuneration, in violation of anti-kickback provisions in Section 1128B of the Social Security Act, if they are exchanged between or among Indian Health Programs and Urban Indian Organizations, or if they are exchanged between tribes, tribal organizations, Programs, or Organizations and patients served or eligible to be served and are for health-related transportation, housing, cost sharing, or low-value items or services provided as incentives, or if the exchanges are between or among

programs, organizations, tribes, or tribal organizations and meet standards deemed appropriate by the Secretary (in consultation with the Attorney General) that take into account the special circumstances of the programs, organizations, tribes, tribal organizations, and their patients.

SECTION 9. RULES APPLICABLE UNDER MEDICAID AND SCHIP TO MANAGED CARE ENTITIES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES

(a) In general (for Medicaid)

Current law

Section 1903(m)(1) of Title XIX defines: (1) the term Medicaid managed care organization, (2) requirements regarding accessibility of services for Medicaid managed care organizations (MCO) beneficiaries vis-à-vis non-MCO Medicaid beneficiaries within the area served by the MCO; (3) solvency standards in general and specific to different types of organizations; and (4) the duties and functions of the Secretary with respect to the status of an organization as a Medicaid MCO.

Section 1902(w) of Title XIX specifies requirements for advance directives applicable to Medicaid managed care organizations, institutional providers (e.g., hospitals, nursing facilities), providers of home health care or personal care services, and hospice programs.

Title XIX contains a number of additional provisions regarding managed care under Medicaid. Section 1932(a)(5) specifies rules regarding the provision of information about managed care to beneficiaries and potential enrollees. Such information must be in an easily understood form, and must address the following topics: (1) who providers are and where they are located, (2) enrollee rights and responsibilities, (3) grievance and appeal procedures, (4) covered items and services, (5) comparative information for available MCOs regarding benefits, cost-sharing, service area and quality and performance, and (6) information on benefits not covered under managed care arrangements. In addition, Section 1932(d)(2)(B) requires managed care entities to distribute marketing materials to their entire service areas.

Sections 1903(m) and 1932 provide cross-referencing definitions for the term "Medicaid managed care organization."

In general, Federally Qualified Health Centers (FQHCs) are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services. When an FQHC is a participating provider with a Medicaid managed care entity (MCE), the State must make supplemental payments to the center in an amount equal to any difference between the rate paid by the MCE and the per visit amount determined under the prospective payment system under Section 1902(bb)(5). In addition, some Indian Health Care providers currently receive an encounter rate payment under a Memorandum of Agreement between CMS and the Indian Health Service effective July 11, 1996.

Title XIX includes specific provisions limiting mandatory enrollment of Indians in Medicaid MCEs in Section 1932(a)(2)(C).

Description of provision

The provision would require that Indians enrolled in a non-Indian Medicaid managed care entity (MCE) with an IHP or UIO participating as a primary care provider within the MCE's network be allowed to choose such an IHP or UIO as their primary care provider when the Indian is otherwise eligible to receive services from such a provider and the IHP or UIO has the capacity to provide primary care services to that Indian. Contracts between the State and such MCEs must reflect this requirement, and Medicaid payments to the MCE are conditional on meeting this requirement.

The provision would stipulate that contracts with Medicaid MCEs must require those MCEs with a significant percentage of Indian enrollees (as determined by the Secretary), to meet other requirements as a condition of receiving Medicaid payments. These conditions include: (1) such MCEs must demonstrate that the number of participating Indian health care providers is sufficient to ensure timely access to covered Medicaid managed care services for those enrollees who are eligible to receive services from such providers; or (2) such MCEs must agree to pay non-participating Indian health care providers (except for non-participating FQHCs and non-FQHC Indian Health providers that have a Memorandum of Agreement between CMS and the Indian Health Service) at a rate equal to the rate negotiated between such entity and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE would make for services rendered by a participating non-Indian health care provider. Special Medicaid payment rules would apply to an Indian health care provider that is an FQHC that does not participate with a Medicaid managed care entity. Payments to such non-participating FQHCs would be at rates otherwise applicable to FQHCs that are participating providers with the MCE. These provisions do not waive the existing requirement that States make supplemental payments due to a FQHC for services rendered under a contract with an MCE to bring the payment rate up to the rate owed under the prospective payment system. Indian health providers that are not federally qualified health care centers, and that elect to receive payment under Title XIX as an Indian Health provider under the Memorandum of Agreement between CMS and the Indian Health Service effective July 11, 1996 will also be eligible to receive a supplemental payment for that service in the same manner as a federally qualified health center under 1902(bb)(5).

In addition, such MCEs must agree to make prompt payment (in accordance with rules applicable to MCEs) to participating Indian health care providers or, in the case of a non-participating Indian health care provider (excluding non-participating FQHCs), the second condition listed above must apply. The provision also stipulates that the submission of a claim or other documentation for services by the IHP or UIO (consistent with Section 403(h) of the IHCIA) would be deemed to satisfy any requirement for an enrollee to submit a claim or other documentation. The provision would also require that as a condition of payment for covered services, the IHP or UIO comply with all generally applicable Medicaid requirements

to the extent that these requirements do not conflict with other requirements or prohibitions imposed on the IHP or UIO through other statutes. The IHP or UIO shall only need to comply with those generally applicable requirements of a managed care entity as a condition of payment that are necessary for the entity's compliance with the State plan such as those related to care management, quality assurance and utilization management.

The provision would also prohibit waiving requirements relating to assurances that payments are consistent with efficiency, economy and quality.

Under this provision States must offer to enter into an agreement with Indian Medicaid MCEs to serve eligible Indians if: (1) the State elects to provide services through Medicaid MCEs under its Medicaid managed care program, and (2) an Indian health care provider that is funded in whole or in part by the IHS, or a consortium composed of one or more tribes, TOs, or UIOs as well as the IHS (if applicable), has established an Indian Medicaid MCE in the State that meets all generally applicable standards required for such an entity under the State's Medicaid managed care program.

The provision also contains a number of special rules that would be applicable to Indian MCEs. With respect to enrollment, Indian Medicaid MCEs could restrict enrollment to Indians and to members of specific tribes in the same manner as IHPs may restrict the delivery of services to such Indians and tribal members. Also, among Medicaid MCEs, the State could not limit the choice of an Indian only to Indian Medicaid MCEs, and the provision does not allow States to be more restrictive in the choice of MCEs offered to Indian versus non-Indian beneficiaries. Also, if enrollment of an Indian in a Medicaid MCE is mandatory, the provision would require such States to enroll Indians who are not otherwise enrolled in an MCE to be enrolled in an Indian Medicaid MCE. Such enrollment must be consistent with the Indian's eligibility for enrollment with such an entity based on the service area and capacity of the entity, and must take into consideration maintaining existing provider-individual relationships or relationships with providers that have traditionally served Medicaid beneficiaries. Finally, under procedures specified by the Secretary, the provision would also require States to grant requests by Indians enrolled with a non-Indian Medicaid MCE to switch to an Indian Medicaid MCE.

Additional special rules would apply to flexibility in application of solvency standards for Indian Medicaid MCEs. The provision would specify that such entities must demonstrate, to the satisfaction of the Secretary (rather than the State), that they have made adequate provision against the risk of insolvency, and as with other Medicaid MCEs, must assure that individuals eligible for benefits are in no case held liable for debts of the entity in case of the organization's insolvency. The provision would also deem Indian Medicaid MCEs to be public entities, and thus, exempt these MCEs from requirements to meet solvency standards established by the State for private health maintenance organizations, and from requirements that such MCEs be licensed or certified by the State as risk-bearing entities. The provision would continue to apply other rules in Section 1903(m)(1) to Indian Medicaid MCEs.

With respect to special rules for Indian Medicaid MCEs and advance directives, the provision would allow the Secretary to modify

or waive requirements related to maintenance of written policies and procedures for such directives, if the Secretary finds that these requirements are not an appropriate or effective way to communicate such information to Indians.

With respect to special rules for Indian Medicaid MCEs and flexibility in information and marketing, the provision would allow the Secretary to modify requirements defined in Section 1932(a)(5) to ensure that information provided to enrollees and potential enrollees of Indian Medicaid MCEs is delivered in a culturally appropriate and understandable manner that clearly communicates individual rights, protections, and benefits. Also, in the case of an Indian Medicaid MCE that distributes appropriate materials only to those Indians potentially eligible to enroll with the entity in its service area, the requirements of Section 1932(d)(2)(B), with respect to distribution of marketing material to an entire service area, must be deemed to be satisfied.

In general, the provision specifies that under a Medicaid managed care program, if a health care provider is required to have medical malpractice insurance as a condition of contracting with a Medicaid MCE, an Indian health care provider that is either (1) a FQHC that is covered under the Federal Tort Claims Act; (2) a provider that delivers services pursuant to a contract under the Indian Self-Determination and Education Assistance Act, would be deemed to satisfy such a requirement; or (3) the Indian Health Service, which is covered under the Federal Tort Claims Act.

Finally, the provision provides definitions for several terms. An "Indian health care provider" means an IHP or UIO. The terms "Indian," "Indian Health Program," "Service," "Tribe, Tribal Organization," and "Urban Indian Organization" all have the meanings given such terms in Section 4 of the IHCIA. The term "Indian Medicaid managed care entity" means a MCE that is controlled by the IHP, a Tribe, TO, or UIO, or a consortium, which may be composed of one or more tribes, TOs, or UIOs, and which also may include the IHS, for which the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent. The term "non-Indian Medicaid managed care entity" means a MCE that is not an Indian Medicaid MCE. The term "covered Medicaid managed care services" means the items and services that are within the scope of benefits available under the contract between the entity and the State involved. The term "Medicaid managed care program" means a program under Sections 1903(m) and 1932, and includes a managed care program operating under a waiver under Sections 1915(b) or 1115 or otherwise.

(b) Application to SCHIP

Current law

Under Title XIX, Section 1932(a)(2)(C) stipulates the rules regarding Indian enrollment in Medicaid managed care. A State may not require an Indian (as defined in Section 4(c) of the IHCIA) to enroll in a managed care entity unless the entity is one of the following (and only if such entity is participating under the plan): (1)

the IHS, (2) an IHP operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or (3) an urban IHP operated by a UIO pursuant to a grant or contract with the IHS pursuant to Title V of the IHCIA.

Description of provision

The provision would apply specific sections of the Medicaid provisions to the SCHIP program, including: (1) Section 1932(a)(2)(C) regarding enrollment of Indians in Medicaid managed care, and (2) the new Section 1932(h) as added by Section 9 of this bill and described above.

For informational purposes only, background on provision contained in amendment of S. 1057

Section 413, which replaces Section 413 of the Indian Health Care Improvement Act Amendments of 2005, as reported (S. 1057), would add a new Section 413 to the Indian Health Care Improvement Act, making a cross-reference to Section 1932(h) of the Social Security Act, as amended by the bill, concerning treatment of Indians enrolled in Medicaid managed care entities and Indian Health Programs and Urban Indian Organizations providing services to the Indian enrollees. Section 413 would also strike Section 4 of S. 1057, as reported, which included amendments to Sections 1911, 1932, 2105, and 2107 of the Social Security Act that are covered by previous sections of this bill.

Section 413(a) of S. 1057, as reported, would establish payment rules and provider options for Indians enrolled in non-Indian Medicaid managed care entities with respect to Indian Health Programs and Urban Indian Organizations. It would require that if an Indian is enrolled in a non-Indian Medicaid managed care plan and receives covered health services from an Indian Health Program or a UIO, then either (1) the managed care entity shall pay the program furnishing the service either at an established rate (that is not less than the rate for preferred providers) or at another rate negotiated between the entity and the Program or Organization, or (2) the State shall provide for payment to the Program or Organization at the rate that is otherwise applicable (and will make an appropriate adjustment of the capitation payment made to the Medicaid managed care entity to take into account such payment). It would also require the Program or Organization to comply with generally applicable Medicaid requirements as a condition of payment, would deem any claim submission requirements to be satisfied if the Program or Organization submits a claim or documentation, and would allow eligible Indian enrollees of a non-Indian Medicaid managed care entity to choose a participating Program or Organization as their primary care provider if the Program or Organization has the capacity.

Section 413(b) of S. 1057, as reported, would require a State (if it elects to offer Medicaid through managed care organizations) to offer to make an agreement with an Indian Health Program or Urban Indian Organization to serve as the managed care organization for eligible Indians the Program or Organization serves, if the Program or Organization has established a managed care entity that meets applicable quality standards.

Section 413(c) of S. 1057, as reported, would establish special rules for Indian Medicaid managed care entities, including allowing the Indian entity to restrict enrollment to Indians or members of specific tribes, prohibiting a State from limiting an Indian's choice of managed care entities to Indian entities, and requiring a State to provide default enrollment to eligible Indians in an Indian entity and to allow an Indian to switch from a non-Indian entity to an Indian entity despite State lock-in rules. Section 413(c) would also provide for flexibility in Medicaid solvency requirements, advance directives, communications with enrollees, and marketing to service areas.

Section 413(d) of S. 1057, as reported, would deem requirements that Medicaid managed care programs' health care providers have medical malpractice insurance coverage, as a condition for contracting with a managed care entity, to be satisfied if the Indian Health Program, or an Urban Indian Organization that is a federally qualified health center, is covered by the Federal Tort Claims Act. Section 413(e) would define certain terms for the section.

SECTION 10. ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS

Current law

No provision.

Description of provision

The bill would further amend new Section 1139 to add a new subsection 1139(f). Beginning January 1, 2007, the Secretary, acting through the Administrator of CMS and the Director of the IHS, would be required to submit an annual report to Congress. The report would cover the enrollment and health status of Indians receiving items or services under the health benefit programs funded under the Social Security Act during the preceding year. The report would include information on: (1) total number of Indians enrolled in or receiving items or services under each such program, (2) the number of such Indians also receiving benefits under programs funded by the IHS; (3) general information regarding the health status of these Indians, disaggregated with respect to specific diseases or conditions, presented consistent with privacy of individually identifiable health information; (4) a detailed statement on the status of facilities of the Indian Health Service, or an Indian Tribe, Tribal Organization, or Urban Indian Organization with respect to the facilities' compliance with the applicable terms and conditions under Medicare, Medicaid and SCHIP (and, in the case of Medicaid and SCHIP, under the State plan or waiver authority) and of the progress being made by such facilities (under plans submitted under the new Sections 1880(b) and 1911(b) added by Section 2 of this bill, or otherwise) toward achievement and maintenance of compliance; and (5) such other information the Secretary determined appropriate.

SECTION 11. EFFECTIVE DATE

Current law

No provision.

Description of provision

The provision would specify that the effective date of this Act would be the same as that for the amendments made by the Indian Health Care Improvement Act Amendments of 2006.

III. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 10, 2006.

Hon. CHARLES E. GRASSLEY,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 3524, the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Eric Rollins.

Sincerely,

DONALD B. MARRON,
Acting Director.

Enclosure.

S. 3524—Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006

Summary: S. 3524 would make several changes to Medicaid and the State Children's Health Insurance Program (SCHIP) that would affect both Indians who are enrolled in those programs and the Indian Health Service (IHS). Those changes would include exempting Indians from paying cost sharing or premiums for certain services and making it easier for IHS and related health programs to receive Medicaid payments for services provided through managed care arrangements.

CBO estimates that enacting S. 3524 would increase direct spending by $8 million in 2007, by $65 million over the 2007–2011 period, and by $159 million over the 2007–2016 period. Enacting the bill would have no effect on revenues.

S. 3524 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Some provisions of the bill, however, would result in additional spending by states to comply with new conditions for participating in the Medicaid and SCHIP programs. CBO estimates that state spending for Medicaid and SCHIP would increase by about $93 million over the 2007–2016 period to comply with those new requirements. The bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 3524 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
CHANGES IN DIRECT SPENDING										
Exclude Outreach Spending from Limit on Administrative Costs:										
Budget Authority	0	0	0	0	0	0	0	0	0	0

	By fiscal year, in millions of dollars—									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
Exemption from Cost Sharing and Premiums:										
Medicaid										
Estimated Budget Authority	5	10	10	10	10	10	10	15	15	15
Estimated Outlays	5	10	10	10	10	10	10	15	15	15
SCHIP										
Budget Authority	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	1	1	*	−1	*	*	*	*	*	*
Consultation with Indian Health Programs:										
Estimated Budget Authority	*	*	1	1	1	1	1	1	.....	.....
Estimated Outlays	*	*	1	1	1	1	1	1	.....	.....
Medicaid Managed Care Provisions:										
Estimated Budget Authority	2	3	3	4	4	4	5	5	5	6
Estimated Outlays	2	3	3	4	4	4	5	5	5	6
Total Changes in Direct Spending:										
Estimated Budget Authority	7	13	14	15	15	15	16	21	21	22
Estimated Outlays	8	14	13	14	15	15	16	20	21	22

* = Costs or savings of less than $500,000.
NOTES: Components may not sum to totals because of rounding. SCHIP = State Children's Health Insurance Program.

Basis of estimate: For the purpose of this estimate, CBO assumes that S. 3524 will be enacted near the start of fiscal year 2007.

Health programs funded by the Indian Health Service are commonly divided into three groups: those operated directly by the Indian Health Service, those operated by tribes and tribal organizations under self-governance agreements, and those operated by urban Indian organizations. For this estimate, they are referred to collectively as Indian health programs.

Exclude outreach spending from limit on administrative costs

Under current law, spending by SCHIP programs on administration and certain other activities cannot exceed 10 percent of overall spending. Section 4 would exclude spending on outreach activities to enroll additional Indian children from the 10 percent limit.

CBO estimates that this provision would increase or decrease SCHIP spending by less than $500,000 in any fiscal year. Federal funding for SCHIP is capped, and we anticipate that most states with a significant Indian population would spend all of their SCHIP funds under current law. In addition, some of the states with unspent funds are not currently constrained by the 10 percent limit and thus would not be affected by the provision.

Exemption from cost sharing and premiums

Section 5 would prohibit Medicaid and SCHIP programs from charging cost sharing or premiums to Indians for services that are provided directly or upon referral by Indian health programs. The provision also would prohibit states from reducing payments to providers for those services by the amount of cost sharing that Indians otherwise would pay.

Medicaid: CBO anticipates that this provision's budgetary effect would stem largely from eliminating cost sharing for referral services. Current law already prohibits Indian health programs from charging cost sharing to Indians who use their services. In addition, Medicaid pays almost all facilities operated by IHS and tribes based on an all-inclusive rate that is not reduced to account for any cost sharing that Indians would otherwise have to pay. Finally, very few states charge premiums to their Medicaid enrollees.

Using Medicaid administrative data, CBO estimates that about 270,000 Indians are Medicaid recipients who also use IHS, and that federal Medicaid spending on affected services would be about $275 per person annually in 2007. The amount of affected spending would be relatively low because Medicaid already prohibits cost sharing in many instances, such as long-term care services, emergency services, and services for many children and pregnant women. For the affected spending, CBO assumes that cost sharing paid by individuals equals 2 percent of total spending—Medicaid law limits the extent to which states can impose cost sharing—and that eliminating cost sharing would increase total spending by about 5 percent as individuals consume more services. Overall, CBO estimates that the provision would increase federal Medicaid spending by $5 million in 2007 and by $110 million over the 2007–2016 period.

State Children's Health Insurance Program: SCHIP regulations already prohibit states from charging cost sharing or premiums to Indian children enrolled in the program. As a result, the provision's impact on SCHIP spending largely reflects higher payments to providers and the use of additional services by adult enrollees that a handful of states cover in waiver programs. CBO estimates that the additional spending would total $2 million over the 2007–2016 period. The provision's effects would be limited in later years because total funding for the program is capped.

Consultation with Indian health programs

Section 7 would encourage state Medicaid administrators to consult regularly the administrators of Indian health programs on outstanding Medicaid issues by allowing states to receive federal matching funds for the cost of those consultations. Those costs would be treated as an administrative expense under Medicaid and divided equally between the federal government and the states. CBO anticipates that a small number of states would take advantage of this provision, increasing federal Medicaid spending by less than $500,000 in 2007 and by $7 million over the 2007–2016 period.

Medicaid managed care provisions

Section 9 would make several changes to improve the ability of Indian health programs to receive payments for Indians who receive Medicaid benefits through managed care arrangements. Those changes include:

- Managed care organizations (MCOs) would have to pay Indian health programs at least the rates used for participating providers. States also would have the option of making those payments directly to Indian health programs.
- MCOs would have to accept claims submitted by Indian health programs instead of requiring enrollees to submit claims personally.
- Some requirements that MCOs must now meet to participate in Medicaid would be waived or modified for Indian health programs that seek to operate as MCOs. (For example, MCOs run by Indian health programs would be able to limit enrollment to Indians only.)

• States would be required to offer contracts to Indian health programs seeking to operate their own MCOs.

Based on administrative data on Medicaid enrollment and spending for Indians who receive benefits via managed care, CBO estimates that those provisions would increase federal Medicaid spending by $2 million in 2007 and $41 million over the 2007–2016 period. We anticipate that the additional costs would be relatively modest because some states already use similar rules in their Medicaid managed care programs and Indian health programs would have a limited interest in participating as MCOs.

Estimated impact on State, local, and tribal governments: S. 3524 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act. Some provisions of the bill, however, would result in additional spending by states to comply with new conditions for participating in the Medicaid and SCHIP programs. CBO estimates that state spending for Medicaid and SCHIP would increase by about $93 million over the 2007–2016 period to comply with those new requirements.

Estimated impact on the private sector: The bill contains no private-sector mandates as defined in UMRA.

Previous CBO estimate: On April 26, 2006, CBO transmitted a cost estimate for S. 1057, the Indian Health Care Improvement Act Amendments of 2005, as reported by the Senate Committee on Indian Affairs on March 16, 2006. That bill contains provisions that would affect direct spending that are very similar to those in S. 3524; we estimated that enacting S. 1057 would increase direct spending by $27 million in 2007 and by $398 million over the 2007–2016 period. The estimated costs for S. 1057 are higher largely because that bill would exempt all Indians enrolled in Medicaid or SCHIP from any cost sharing or premiums. By comparison, the exemption in S. 3524 would apply to fewer individuals (Medicaid or SCHIP recipients who also use IHS) and to a narrower range of services (those provided directly or upon referral by Indian health programs).

Estimate prepared by: Federal costs: Eric Rollins and Jeanne De Sa; Impact on State, local, and tribal governments: Leo Lex; Impact on the private sector: Jennifer Doleac.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

IV. REGULATORY IMPACT AND OTHER MATTERS

A. REGULATORY IMPACT

Pursuant to paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of the bill as amended.

Impact on individuals and businesses

The provisions of the bill are not expected to impose additional administrative requirements or regulatory burdens on individuals or businesses.

Impact on personal privacy and paperwork

The provisions of the bill do not reduce personal privacy.

B. UNFUNDED MANDATES STATEMENT

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (P.L. 104–4).

The Committee has determined that the provisions of the bill contain no Federal private sector mandates.

The Committee has determined that the provisions of the bill do not impose a Federal intergovernmental mandate on State, local, or tribal governments.

V. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the following statements are made concerning the votes taken on the Committee's consideration of the bill.

Motion to report the bill

The bill was ordered favorably reported by voice vote, a quorum being present, on June 8, 2006.

Votes on amendments

No amendments were offered and voted upon.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

Pursuant to the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

PART A—GENERAL PROVISION

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any Federal health care program (as defined in section 1128B(f)):

* * * * * * *

(k) ADDITIONAL EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS.—In addition to the authority granted the Secretary under subsections (c)(3)(B) and (d)(3)(B) to waive an exclusion under subsection (a)(1), (a)(3), (a)(4), or (b), the Secretary may, in the case of an Indian Health Program, waive such an exclu-

sion upon the request of the administrator of an affected Indian Health Program (as defined in section 4 of the Indian Health Care Improvement Act) who determines that the exclusion would impose a hardship on individuals entitled to benefits under or enrolled in a Federal health care program.

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f)),

* * * * * * *

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

* * * * * * *

(4) Subject to such conditions as the Secretary may promulgate from time to time as necessary to prevent fraud and abuse, for purposes of paragraphs (1) and (2) and section 1128A(a), the following transfers shall not be treated as remuneration:

(A) TRANSFERS BETWEEN INDIAN HEALTH PROGRAMS, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—Transfers of anything of value between or among an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, that are made for the purpose of providing necessary health care items and services to any patient served by such Program, Tribe, or Organization and that consist of—

(i) services in connection with the collection, transport, analysis, or interpretation of diagnostic specimens or test data;

(ii) inventory or supplies;

(iii) staff; or

(iv) a waiver of all or part of premiums or cost sharing.

(B) TRANSFERS BETWEEN INDIAN HEALTH PROGRAMS, INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS AND PATIENTS.—Transfers of anything of value between an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization and any patient served or eligible for service from an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, including any patient served or eligible for service pursuant to section 807 of the Indian Health Care Improvement Act, but only if such transfers—

(i) consist of expenditures related to providing transportation for the patient for the provision of necessary health care items or services, provided that the provision of such transportation is not advertised, nor an incentive of which the value is disproportionately large in

relationship to the value of the health care item or service (with respect to the value of the item or service itself or, for preventative items or services, the future health care costs reasonably expected to be avoided);

(ii) consist of expenditures related to providing housing to the patient (including a pregnant patient) and immediate family members or an escort necessary to assuring the timely provision of health care items and services to the patient, provided that the provision of such housing is not advertised nor an incentive of which the value is disproportionately large in relationship to the value of the health care item or service (with respect to the value of the item or service itself or, for preventative items or services, the future health care costs reasonably expected to be avoided); or

(iii) are for the purpose of paying premiums or cost sharing on behalf of such a patient, provided that the making of such payment is not subject to conditions other than conditions agreed to under a contract for the delivery of contract health services.

(C) CONTRACT HEALTH SERVICES.—A transfer of anything of value negotiated as part of a contract entered into between an Indian Health Program, Indian Tribe, Tribal Organization, Urban Indian Organization, or the Indian Health Service and a contract care provider for the delivery of contract health services authorized by the Indian Health Service, provided that—

(i) such a transfer is not tied to volume or value of referrals or other business generated by the parties; and

(ii) any such transfer is limited to the fair market value of the health care items or services provided or, in the case of a transfer of items or services related to preventative care, the value of the future health care costs reasonably expected to be avoided.

(D) OTHER TRANSFERS.—Any other transfer of anything of value involving an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, or a patient served or eligible for service from an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, that the Secretary, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, and of patients served by such Programs, Tribes, and Organizations.

* * * * * * *

[NATIONAL COMMISSION ON CHILDREN

[SEC. 1139. (a)(1) There is hereby established a commission to be known as the National Commission on Children (in this section referred to as the "Commission").

[(b)(1) The Commission shall consist of—

[(A) 12 members to be appointed by the President,

[(B) 12 members to be appointed by the Speaker of the House of Representatives, and

[(C) 12 members to be appointed by the President pro tempore of the Senate.

[(2) The President, the Speaker, and the President pro tempore shall each appoint as members of the Commission—

[(A) 4 individuals who—

[(i) are representatives of organizations providing services to children,

[(ii) are involved in activities on behalf of children, or

[(iii) have engaged in academic research with respect to the problems and needs of children,

[(B) 4 individuals who are elected or appointed public officials (at the Federal, State, or local level) involved in issues and programs relating to children, and

[(C) 4 individuals who are parents or representatives of parents or parents' organizations.

[(3) The appointments made pursuant to subparagraphs (B) and (C) of paragraph (1) shall be made in consultation with the chairmen of committees of the House of Representatives and the Senate, respectively, having jurisdiction over relevant Federal programs.

[(c)(1) It shall be the duty and function of the Commission to serve as a forum on behalf of the children of the Nation and to conduct the studies and issue the report required by subsection (d).

[(2) The Commission (and any committees that it may form) shall conduct public hearings in different geographic areas of the country, both urban and rural, in order to receive the views of a broad spectrum of the public on the status of the Nation's children and on ways to safeguard and enhance the physical, mental, and emotional well-being of all of the children of the Nation, including those with physical or mental disabilities, and others whose circumstances deny them a full share of the opportunities that parents of the Nation may rightfully expect for their children.

[(3) The Commission shall receive testimony from individuals, and from representatives of public and private organizations and institutions with an interest in the welfare of children, including educators, health care professionals, religious leaders, providers of social services, representatives of organizations with children as members, elected and appointed public officials, and from parents and children speaking in their own behalf.

[(d) The Commission shall submit to the President, and to the Committees on Finance and Labor and Human Resources of the Senate and the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives, an interim report no later than March 31, 1990, and a final report no later than March 31, 1991, setting forth recommendations with respect to the following subjects:

[(1) Questions relating to the health of children that the Commission shall address include—

[(A) how to reduce infant mortality,

[(B) how to reduce the number of low-birth-weight babies,

[(C) how to reduce the number of children with chronic illnesses and disabilities,

[(D) how to improve the nutrition of children,

[(E) how to promote the physical fitness of children,

[(F) how to ensure that pregnant women receive adequate prenatal care,

[(G) how to ensure that all children have access to both preventive and acute care health services, and

[(H) how to improve the quality and availability of health care for children.

[(2) Questions relating to social and support services for children and their parents that the Commission shall address include—

[(A) how to prevent and treat child neglect and abuse,

[(B) how to provide help to parents who seek assistance in meeting the problems of their children,

[(C) how to provide counseling services for children,

[(D) how to strengthen the family unit,

[(E) how children can be assured of adequate care while their parents are working or participating in education or training programs,

[(F) how to improve foster care and adoption services,

[(G) how to reduce drug and alcohol abuse by children and youths, and

[(H) how to reduce the incidence of teenage pregnancy.

[(3) Questions relating to education that the Commission shall address include—

[(A) how to encourage academic excellence for all children at all levels of education,

[(B) how to use preschool experiences to enhance educational achievement,

[(C) how to improve the qualifications of teachers,

[(D) how schools can better prepare the Nation's youth to compete in the labor market,

[(E) how parents and schools can work together to help children achieve success at each step of the academic ladder,

[(F) how to encourage teenagers to complete high school and remain in school to fulfill their academic potential,

[(G) how to address the problems of drug and alcohol abuse by young people,

[(H) how schools might lend support to efforts aimed at reducing the incidence of teenage pregnancy, and

[(I) how schools might better meet the special needs of children who have physical or mental handicaps.

[(4) Questions relating to income security that the Commission shall address include—

[(A) how to reduce poverty among children,

[(B) how to ensure that parents support their children to the fullest extent possible through improved child support collection services, including services on behalf of children whose parents are unmarried, and

[(C) how to ensure that cash assistance to needy children is adequate.

[(5) Questions relating to tax policy that the Commission shall address include—

[(A) how to assure the equitable tax treatment of families with children,

[(B) the effect of existing tax provisions, including the dependent care tax credit, the earned income tax credit, and the targeted jobs tax credit, on children living in poverty,

[(C) whether the dependent care tax credit should be refundable and the effect of such a policy,

[(D) whether the earned income tax credit should be adjusted for family size and the effect of such a policy, and

[(E) whether there are other tax-related policies which would reduce poverty among children.

[(6) In addition to addressing the questions specified in paragraphs (1) through (5), the Commission shall—

[(A) seek to identify ways in which public and private organizations and institutions can work together at the community level to identify deficiencies in existing services for families and children and to develop recommendations to ensure that the needs of families and children are met, using all available resources, in a coordinated and comprehensive manner, and

[(B) assess the existing capacities of agencies to collect and analyze data on the status of children and on relevant programs, identify gaps in the data collection system, and recommend ways to improve the collection of data and the coordination among agencies in the collection and utilization of data.

[The reports required by this subsection shall be based upon the testimony received in the hearings conducted pursuant to subsection (c), and upon other data and findings developed by the Commission.

[(e)(1)(A) Members of the Commission shall first be appointed not later than 60 days after the date of the enactment of this section, for terms ending on March 31, 1991.

[(B) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the vacant position was first filled.

[(2) The Commission shall elect one of its members to serve as Chairman of the Commission. The Chairman shall be a non-voting member of the Commission.

[(3) A majority of the members of the Commission shall constitute a quorum for the transaction of business.

[(4)(A) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission.

[(B) The Commission shall meet not less than 4 times during the period beginning with the date of the enactment of this section and ending with September 30, 1990.

[(5) Decisions of the Commission shall be according to the vote of a simple majority of those present and voting at a properly called meeting.

[(6) Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

[(f)(1) The Commission shall appoint an Executive Director of the Commission. In addition to the Executive Director, the Commission may appoint and fix the compensation of such personnel as

it deems advisable. Such appointments and compensation may be made without regard to title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

[(2) The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

[(g) In carrying out its duties, the Commission, or any duly organized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which it has a responsibility under this section, as the Commission or committee may deem advisable.

[(h)(1) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities.

[(2) Upon request of the Commission, any such department or agency shall furnish any such data or information.

[(i) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Commission may request.

[(j) There are authorized to be appropriated through fiscal year 1991, such sums as may be necessary to carry out this section for each of fiscal years 1989 and 1990.

[(k)(1) The Commission is authorized to accept donations of money, property, or personal services. Funds received from donations shall be deposited in the Treasury in a separate fund created for this purpose. Funds appropriated for the Commission and donated funds may be expended for such purposes as official reception and representation expenses, public surveys, public service announcements, preparation of special papers, analyses, and documentaries, and for such other purposes as determined by the Commission to be in furtherance of its mission to review national issues affecting children.

[(2) For purposes of Federal income, estate, and gift taxation, money and other property accepted under paragraph (1) of this subsection shall be considered as a gift or bequest to or for the use of the United States.

[(3) Expenditure of appropriated and donated funds shall be subject to such rules and regulations as may be adopted by the Commission and shall not be subject to Federal procurement requirements.

[(1) The Commission is authorized to conduct such public surveys as it deems necessary in support of its review of national issues affecting children and, in conducting such surveys, the Commission shall not be deemed to be an "agency" for the purpose of section 3502 of title 44, United States Code.]

SEC. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XVIII, XIX, AND XXI.

(a) AGREEMENTS WITH STATES FOR MEDICAID AND SCHIP OUTREACH ON OR NEAR RESERVATIONS TO INCREASE THE ENROLLMENT OF INDIANS IN THOSE PROGRAMS.—

(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the

Medicaid and State children's health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide out-reach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

(2) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such titles.

(b) REQUIREMENT TO FACILITATE COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI.

(c) NONDISCRIMINATION IN QUALIFICATIONS FOR PAYMENT FOR SERVICES UNDER FEDERAL HEALTH CARE PROGRAMS.—

(1) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

(A) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

(B) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221 of the Indian Health Care Improvement Act, the absence of the licensure of a health care professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

(2) PROHIBITION ON FEDERAL PAYMENTS TO ENTITIES OR INDIVIDUALS EXCLUDED FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS OR WHOSE STATE LICENSES ARE UNDER THE SUSPENSION OR HAVE BEEN REVOKED.—

(A) EXCLUDED ENTITIES.—No entity operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment under any such program for health care services furnished to an Indian.

(B) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension or has been revoked shall be eligible to receive payment under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

(C) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, "Federal health care program" has the meaning given that term in section 1128B(f), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

* * * * * * *

(d) CONSULTATION WITH TRIBAL TECHNICAL ADVISORY GROUP (TTAG).—The Secretary shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group, establishd in accordance with requirements of the charter dated September 30, 2003, and in such group shall include a representative of the Urban Indian Organizations and the Service. The representative of the Urban Indian Organization shall be deemed to be an elected officer of a tribal government for purposes of applying section 204(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534(b)).

(e) ANNUAL REPORT ON INDIANS SERVED BY HEALTH BENEFIT PROGRAMS FUNDED UNDER THIS ACT.—Beginning January 1, 2007, and annually thereafter, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service, shall submit a report to Congress regarding the enrollment and health status of Indians receiving items or services under health benefit programs funded under this Act during the preceding year. Each such report shall include the following:

(1) The total number of Indians enrolled in, or receiving items or services under, such programs, disaggregated with respect to each such program.

(2) The number of Indians described in paragraph (1) that alos received health benefits under programs funded by the Indian Health Service.

(3) General information regarding the health status of the Indians described in paragraph (1), disaggregated with respect to specific diseases or conditions and presented in a manner that

is consistent with protections for privacy of individually identifiable health information under sction 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(4) A detailed statement of the status of facilities of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization with respect to such facilities' compliance with the applicable conditions and requirements of titles XVIII, XIX, and XXI, and, in the case of title XIX or XXI, under a State plan under such title or under waiver authority, and of the progress being made by such facilities (under plans submitted under section 1880(b), 1911(b) or otherwise) toward the achievement and maintenance of such compliance.

(5) Such other information as the Secretary determines is appropriate.

(f) DEFINITION OF INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms "Indian Tribe", "Indian Health Program", "Tribal Organization", and "Urban Indian Organization" have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

Part E—Miscellaneous Provisions

* * * * * * *

[INDIAN HEALTH SERVICE FACILITIES

[SEC. 1880.] (a) A hospital or skilled nursing facility 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), shall be eligible for payments under this title, notwithstanding sections 18149c) and 1835(d), if and for so long as it meets standing sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

[(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

[(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to

such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

[(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.]

SEC. 1880. INDIAN HEALTH PROGRAMS.

(a) ELIGIBILITY FOR PAYMENTS.—Subject to subsection (e), the Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization shall be eligible for payments under this title with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title.

(b) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—Subject to subsection (e), a facility of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization which is eligible for payment under subsection (a) with respect to the furnishing of items and services, but which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, shall make such improvements as are necessary to achieve or maintain compliance with such conditions and requirements in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements, and shall be deemed to meet such conditions and requirements (and to be eligible for payment under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submittal.

(c) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

(d) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program or an Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such Program or Organization for which pay-

ment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.

(e)(1)(A) Notwithstanding section 1835(d), subject to subparagraph (B), the Secretary shall make payment under part B to a hospital or an ambulatory care clinic (whether provider-based or freestanding) that is operated by te Indian Health Service or by an Indian tribe or tribal organization (as defined for purposes of subsection (a)) for services described in paragraph (2) (and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B) furnished in or at the direction of the hospital or clinic under the same situations, terms, and conditions as would apply if the services were furnished in or at the direction of such a hospital or clinic that was not operated by such Service, tribe, or organization.

* * * * * * *

(3) Subsection (c) *and section 401(c)(1) of the Indian Health Improvement Act* shall not apply to payments made under this subsection.

[(f) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organziations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).**]**

(f) DEFINITIONS.—In this section, the terms "Indian Health Program," "Indian Tribe", "Service Unit", "Tribal Health Program", "Tribal Organization", and "Urban Indian Organization", have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

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(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936; **[**and**]**

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

* * * * * * *

(B) may be conducted under contract with a broker who—

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

* * * * * * *

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate)**[**.**]** *; and*

(71) in the case of any State in which the Indian Health Service operates or funds health care programs, or in which 1 or more Indian Health Programs or Urban Indian Organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act) provide health care in the State for which medical assistance is available under such title, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title.

(e)(1)(A) * * *

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

(13) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property for purposes of determining eligibility for medical assistance under this title:

(A) Property, including real property and improvements, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated

and approved by the Bureau of Indian Affairs of the Department of the Interior.

(B) For any federally recognized Tribe not described in subparagraph (A), property located within the most recent boundaries of a prior Federal reservation.

(C) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(D) Ownership interests in or usage rights to items not covered by subparagraphs (A) through (C) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1996—

* * * * * * *

(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

* * * * * * *

(3)(A) For purposes of this subsection, the term "satisfactory documentary evidence of citizenship or nationality" means—

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph.

(i) A United States passport.

* * * * * * *

(v)(I) Except as provided in subclause (II), a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe.

(II) With respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satis-

factory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

[(v)]*(vi)* Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

* * * * * * *

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

* * * * * * *

[INDIAN HEALTH SERVICE FACILITIES

[SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), 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), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

[(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.

[(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.

[(d) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provides by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).]

SEC. 1911. INDIAN HEALTH PROGRAMS.

(a) ELIGIBILITY FOR PAYMENT FOR MEDICAL ASSISTANCE.—The Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization shall be eligible for payment for medical assistance provided under a State plan or under waiver authority with respect to items and services furnished by the Indian

Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title and under such plan or waiver authority.

(b) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—A facility of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization which is eligible for payment under subsection (a) with respect to the furnishing of items and services, but which does not meet all of the conditions and requirements of this title and under a State plan or waiver authority which are applicable generally to such facility, shall make such improvements as are necessary to achieve or maintain compliance with such conditions and requirements in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements, and shall be deemed to meet such conditions and requirements (and to be eligible for payment under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided by the Indian Health Service, and Indian Tribe, Tribal Organization, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan or under waiver authority.

(d) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

(e) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program or an Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such Program or Organization for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.

(f) DEFINITIONS.—In this section, the terms "Indian Health Program", "Indian Tribe", "Tribal Health Program", "Tribal Organization", and "Urban Indian Organization" have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

* * * * * * *

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. (a) Subject to subsections (g) [and (i)], *(i), and (j)*, the State plan shall provide that in the case of individuals described

in subparagraph (A) or (E)(i) of section 1902(a)(10) who are eligible under the plan—

* * * * * * *

(j) NO PREMIUMS OR COST SHARING FOR INDIANS FURNISHED ITEMS OR SERVICES DIRECTLY BY INDIAN HEALTH PROGRAMS OR THROUGH REFERRAL UNDER THE CONTRACT HEALTH SERVICE.—

(1) NO COST SHARING FOR ITEMS OR SERVICES FURNISHED TO INDIANS THROUGH INDIAN HEALTH PROGRAMS.—

(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who 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 the contract health service for which payment may be made under this title.

(B) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under the contract health service for the furnishing of an item or service to an Indian who is eligible for assistance under such title, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.

(3) DEFINITIONS.—In this subsection the terms "contract health services", "Indian,", "Indian Tribe", "Tribal Organization", and "Urban Indian Organization" have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING

SEC. 1916A. (a) STATE FLEXIBILITY.—

(1) IN GENERAL.—Notwithstanding sections 1916 and 1902(a)(10)(B), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) [section 1916(g)]*subsections (g), (i), or (j) of section 1916*.

* * * * * * *

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. (a)(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

* * * * * * *

(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

* * * * * * *

(3) *(A)* The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.

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PROVISIONS RELATING TO MANAGED CARE

SEC. 1932. (a) STATE OPTION TO USE MANAGED CARE.—

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(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or

(2) to include a sponsorship code in the identification card issued to individuals covered under this title in order that a hospital may identify a patient as being entitled to benefits under this title.

(h) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

(1) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH CARE PROVIDER AS PRIMARY CARE PROVIDER.—In the case of a non-Indian Medicaid managed care entity that—

(A) has an Indian enrolled with the entity; and

(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity that has a significant percentage of Indian enrollees (as determined by the Secretary), as a condition of receiving payment under such contract to satisfy the following requirements.

(A) DEMONSTRATION OF PARTICIPATING INDIAN HEALTH CARE PROVIDERS OR APPLICATION OF ALTERNATIVE PAYMENT ARRANGEMENTS.—Subject to subparagraph (E), to—

(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those enrollees who are eligible to receive services from such providers; or

(ii) agree to pay Indian health care providers who are not participating providers with the entity for covered Medicaid managed care services provided to those enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

(B) PROMPT PAYMENT.—To agree to make prompt payment (in accordance with rules applicable to managed care entities) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (E) applies, that the entity is required to pay in accordance with that subparagraph.

(C) SATISFACTION OF CLAIM REQUIREMENT.—To deem any requirement for the submission of a claim or other documentation for services covered under subparagraph (A) by the enrollee to be satisfied through the submission of a claim or other documentation by an Indian health care provider that is consistent with section 403(h) of the Indian Health Care Improvement Act.

(D) COMPLIANCE WITH GENERALLY APPLICABLE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), as a condition of payment under subparagraph (A), an Indian health care provider shall comply with the generally applicable requirements of this title, the State plan, and such entity with respect to covered Medicaid managed care services provided by the Indian health care provider to the same extent that non-Indian providers participating with the entity must comply with such requirements.

(ii) LIMITATIONS ON COMPLIANCE WITH MANAGED CARE ENTITY GENERALLY APPLICABLE REQUIREMENTS.—An Indian health care provider—

(I) shall not be required to comply with a generally applicable requirement of a managed care entity described in clause (i) as a condition of payment under subparagraph (A) if such compliance would conflict with any other statutory or regulatory requirements applicable to the Indian health care provider; and

(II) shall only need to comply with those generally applicable requirements of a managed care entity described in clause (i) as a condition of payment under subparagraph (A) that are necessary for the entity's compliance with the State plan, such as those related to care management, quality assurance, and utilization management.

(E) APPLICATION OF SPECIAL PAYMENT REQUIREMENTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND ENCOUNTER RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—

(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

(I) MANAGED CARE ENTITY PAYMENT REQUIREMENT.—To agree to pay any Indian health care provider that is a federally-qualified health center but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the federally-qualified health center is or is not a participating provider with the entity).

(ii) CONTINUED APPLICATION OF ENCOUNTER RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN

HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center and that has elected to receive payment under this title as an Indian Health Service provider under the July 11, 1996, Memorandum of Agreement between the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) and the Indian Health Service for services provided by such provider to an Indian enrollee with the managed care entity is less than the encounter rate that applies to the provision of such services under such memorandum, the State plan shall provide for payment to the Indian health care provider of the difference between the applicable encounter rate under such memorandum and the amount paid by the managed care entity to the provider for such services.

(F) CONSTRUCTION.—Nothing in this paragraph shall be construed as waiving the application of section 1902(a)(30)(A) (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(3) OFFERING OF MANAGED CARE THROUGH INDIAN MEDICAID MANAGED CARE ENTITIES.—If—

(A) a State elects to provide services through Medicaid managed care entities under its Medicaid managed care program; and

(B) an Indian health care provider that is funded in whole or in part by the Indian Health Service, or a consortium composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Indian Health service, has established an Indian Medicaid managed care entity in the State that meets generally applicable standards required of such an entity under such Medicaid managed care program,

the State shall offer to enter into an agreement with the entity to serve as a Medicaid managed care entity with respect to eligible Indians served by such entity under such program.

(4) SPECIAL RULES FOR INDIAN MANAGED CARE ENTITIES.—The following are special rules regarding the application of a Medicaid managed care program to Indian medicaid managed care entities:

(A) ENROLLMENT.—

(i) LIMITATION TO INDIANS.—An Indian medicaid managed care entity may restrict enrollment under such program to Indians and to members of specific Tribes in the same manner as Indian Health Programs may restrict the delivery of services to such Indians and tribal members.

(ii) NO LESS CHOICE OF PLANS.—Under such program the state may not limit the choice of an Indian among Medicaid managed care entities only to Indian Medicaid managed care entities or to be more restric-

tive than the choice of managed care entities offered to individuals who are not Indians.

(iii) DEFAULT ENROLLMENT.—

(I) IN GENERAL.—If such program of a state requires the enrollment of Indians in a medicaid managed care entity in order to receive benefits, the state, taking into consideration the criteria specified in sub-section (a)(4)(D)(ii)(I), shall provide for the enrollment of Indians described in subclause (II) who are not otherwise enrolled with such an entity in an Indian Medicaid managed care entity described in such clause.

(II) INDIAN DESCRIBED.—An Indian described in this subclause, with respect to an Indian Medicaid managed care entity, is an Indian who, based upon the service area and capacity of the entity, is eligible to be enrolled with the entity consistent with subparagraph (A).

(iv) EXCEPTION TO STATE LOCKIN.—A request by an Indian who is enrolled under such program with a non-Indian Medicaid managed care entity to change enrollment with that entity to enrollment with an Indian Medicaid managed care entity shall be considered cause for granting such request under procedures specified by the Secretary.

(B) FLEXIBILITY IN APPLICATION OF SOLVENCY.—In applying section 1903(m)(1) to an Indian medicaid managed care entity—

(i) any reference to a "State" in subparagraph (A)(ii) of that section shall be deemed to be a reference to the "Secretary"; and

(ii) the entity shall be deemed to be a public entity described in subparagraph (C)(ii) of that section.

(C) EXCEPTIONS TO ADVANCE DIRECTIVES.—The Secretary may modify or waive the requirements of section 1902(w) (relating to provision of written materials on advance directives) insofar as the Secretary finds that the requirements otherwise imposed are not an appropriate or effective way of communicating the information to Indians.

(D) FLEXIBILITY IN INFORMATION AND MARKETING.—

(i) MATERIALS.—The Secretary may modify requirements under subsection (a)(5) to ensure that information described in that subsection is provided to enrollees and potential enrollees of Indian medicaid managed care entities in a culturally appropriate and understandable manner that clearly communicates to such enrollees and potential enrollees their rights, protections, and benefits.

(ii) DISTRIBUTION OF MARKETING MATERIALS.—The provisions of subsection (d)(2)(B) requiring the distribution of marketing materials to an entire service area shall be deemed satisfied in the case of an Indian medicaid managed care entity that distributes appropriate materials only to those Indians who are poten-

tially eligible to enroll with the entity in the service area.

(5) MALPRACTICE INSURANCE.—Insofar as, under a Medicaid managed care program, a health care provider is required to have medical malpractice insurance coverage as a condition of contracting as a provider with a Medicaid managed care entity, an Indian health care provider that is—

(A) a federally-qualified health center that is covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.);

(B) providing health care services pursuant to a contract or compact under the Indian Self-Determinatin and education Assistance Act (25 U.S.C. 450 et seq.) that are covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.); or

(C) the Indian Health Service providing health care services that are covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.

are deemed to satisfy such requirement.

(6) DEFINITIONS.—For purposes of this subsection:

(A) INDIAN HEALTH CARE PROVIDER.—The term "Indian health care provider" means an Indian Health Program or an Urban Indian Organization.

(B) INDIAN; INDIAN HEALTH PROGRAM; SERVICE; TRIBE, TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms "Indian", "Indian Health Program", "Service", "Tribe", "tribal organization", "Urban Indian Organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement act.

(C) INDIAN MEDICAID MANAGED CARE ENTITY.—The term "Indian Medicaid managed care entity" means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C)) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(D) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term "non-Indian Medicaid managed care entity" means a managed care entity that is not an Indian Medicaid managed care entity.

(E) COVERED MEDICAID MANAGED CARE SERVICES.—The term "covered Medicaid managed care services" means, with respect to an individual enrolled with a managed care entity, items and services that are within the scope of items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(F) MEDICAID MANAGED CARE PROGRAM.—The term "Medicaid managed care program" means a program under sections 1903(m) and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.

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TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH

SEC. 2102 (a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

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(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.—

(1) ELIGIBILITY STANDARDS.—

* * * * * * *

(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS.—The plan shall include a description of procedures to be used to ensure—

(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

* * * * * * *

(D) the provision of child health assistance to targeted low-income children in the State who are Indians, **[**(as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c))**]**, *including how the State will ensure that payments are made to Indian Health Program and Urban Indian Organization operating in the State for the provision of such assistance*; and

* * * * * * *

PAYMENTS TO STATES

SEC. (a) Payments.—

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(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

(1) GENERAL LIMITATIONS.—Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE.—

(A) IN GENERAL.—Except as provided in this paragraph, the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the total amount of expenditures for

which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection.

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(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF INDIAN CHILDREN UNDER THIS TITLE AND TITLE XIX.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(1)(D) shall not apply in the case of expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waive of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1139(a).

(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

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(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care [insurance program, other than an insurance program operated or financed by the Indian Health Service] *program, other than a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization,* as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

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STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION

SEC. 2107. (a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

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(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

(1) TITLE XIX PROVISIONS.—

(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

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(B) Section 1902(a)(71) (relating to the option of certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).

(C) Section 1902(c)(13) (relating to disregard of certain property for purposes of making eligibility determinations).

[(B)]*(D)* Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

[(C)]*(E)* Section 1903(w) (relating to limitations on provider taxes and donations).

(F) Section 1911 (relating to Indian Health Programs, other than subsection (d) of such section).

[(D)]*(G)* Section 1920A (relating to presumptive eligibility for children).

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(H) Subsections (a)(2)(C) and (h) of section 1932.

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DEFINITIONS

SEC. 2110. (a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term "child health assistance" means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(1)(D)(i), payment for the part or all of the cost of providing any of the following), as specified under the State plan:

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(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) CHILD.—The term child means an individual under 19 years of age.

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(9) INDIAN; INDIAN HEALTH PROGRAM; INDIAN TRIBE; ETC.—*The terms "Indian", "Indian Health Program", "Indian Tribe", "Tribal Organization", and "Urban Indian Organization" have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.*

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