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114TH CONGRESS
2D SESSION

H. R. 5406

To amend the Indian Health Care Improvement Act to improve access to tribal health care by providing for systemic Indian Health Service workforce and funding allocation reforms, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 8, 2016

Mrs. NOEM (for herself, Mr. ASHFORD, Mr. SMITH of Nebraska, Mr. FORTENBERRY, Mr. CRAMER, and Ms. MCCOLLUM) introduced the following bill; which was referred to the Committee on Natural Resources, and in addition to the Committees on Energy and Commerce and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Indian Health Care Improvement Act to improve access to tribal health care by providing for systemic Indian Health Service workforce and funding allocation reforms, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare Act'' or the ''HEALTTH Act''.

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

SEC. 2. FINDINGS.

Congress finds the following:

(1) The United States Government has a treaty obligation to provide health care to American Indians and Alaska Natives.

(2) The Indian Health Service is the Federal agency that is entrusted to carry out this obligation.

(3) Access to high quality health care is critical for strong and vibrant tribal communities in the

Great Plains Area and throughout the United States.

(4) In 2010, the Senate Committee on Indian Affairs published a report titled ''In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area'', which detailed deficiencies, abuses, and malfeasance within the Aberdeen Area of the Indian Health Service, now called the Great Plains Area.

(5) In 2015 and 2016, the Centers for Medicare & Medicaid Services conducted surveys of Indian Health Service hospitals in the Great Plains Area and found serious structural deficiencies that put patients' health and safety in immediate jeopardy.

(6) The Indian Health Service's failures in the Great Plains Area have resulted in a severe reduction in access to emergency care, needlessly long wait times, patient suffering, low quality of life, and several tragic deaths.

(7) The Indian Health Service is in need of comprehensive reform that will hold its management and employees accountable, foster strong and capable agency leadership, and restore tribal members' trust in the care it delivers.

TITLE I—EXPANDING AUTHORITIES AND IMPROVING ACCESS TO CARE

SEC. 101. SERVICE HOSPITAL LONG-TERM CONTRACT PILOT PROGRAM.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671) is amended by adding at the end the following new section:

"SEC. 833. SERVICE HOSPITAL LONG-TERM CONTRACT PILOT PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall implement a 7-year pilot program to test the viability and advisability of entering into long-term contracts for the operation of eligible Service hospitals with governance structures that include tribal input.

''(b) ELEMENTS.—Under such pilot program, subject to subsection (e), the following shall apply:

''(1) The Secretary shall select three eligible Service hospitals in rural areas to participate in the pilot program.

''(2) For each such participating hospital, the Secretary shall enter into a long-term contract.

''(3) At each such participating hospital, the Secretary, in consultation with the primary Indian tribes served by the hospital, shall install a gov-

erning board described in subsection (d), which shall be responsible for overseeing the local operation of the hospital.

''(c) ELIGIBLE SERVICE HOSPITAL.—For purposes of this section, the term 'eligible Service hospital' means a Service hospital that furnishes services in a rural area to direct services tribes and with respect to which the Secretary has obtained the permission of the primary Indian tribes served by the hospital for the hospital to participate under the pilot program under this section.

''(d) GOVERNANCE BOARD DESCRIBED.—For purposes of subsection (b), a governance board described in this subsection, with respect to a Service hospital participating in the pilot program, is a board that satisfies the following criteria:

''(1) COMPOSITION.—

''(A) IN GENERAL.—The governance board is composed, in accordance with the best practices specified under paragraph (3), of the following individuals:

''(i) Representatives of the Service, who shall be selected by the Secretary.

''(ii) Representatives of the Service hospital.

"(iii) Representatives of each primary Indian tribe served by the hospital, who shall be selected by the respective Indian tribe.

"(iv) Experts in health care administration and delivery, who shall—

"(I) be selected by the Secretary and respective Indian tribe; and

"(II) to the extent possible, located in the State in which the hospital is located or otherwise familiar with such State.

"(B) VOTING RIGHTS.—In determining the composition of the board with respect to voting rights on the board—

"(i) the number of voting members representing the Service shall be equal to the number of voting members representing the Indian tribes involved; and

"(ii) the number of voting members representing the hospital may not be greater than the number of voting members representing the Service or the Indian tribes involved.

''(2) DUTIES.—The governance board shall perform duties in accordance with the best practices specified under paragraph (3) and shall include developing financial and quality metrics and standards for salaries, recruitment, retention, training, and dismissal of employees of such hospital.

''(3) BEST PRACTICES.—The Secretary shall specify best practices for the governance board described in this subsection, including best practices relating to the number of members of such board, the authorities of the board, and the duties of the board.

''(e) TREATMENT OF ELIGIBLE SERVICE HOSPITALS CURRENTLY UNDER CONTRACT.—In the case of an eligible Service hospital that is under a current contract with the Secretary as of the initiation of the selection process period for the pilot program, in order for such hospital to participate in the pilot program the Secretary, with the agreement of the hospital, may—

''(1) notwithstanding any other provision of law, modify or terminate such contract and in order for such hospital to enter into a long-term contract under the pilot program; or

''(2) enter into a long-term contract under the pilot program (and begin the pilot program) begin-

ning on the date after the last date of such current contract.

''(f) LONG-TERM CONTRACT DEFINED.—For purposes of this section, the term 'long-term contract' means a contract for a period of at least 5 years.

''(g) CLARIFICATION.—Nothing in this section shall be construed to inhibit a tribe's authority to enter into a compact or contract under the Indian Self-Determination and Education Assistance Act.

''(h) REPORTS.—For each year of the pilot program, the Secretary shall submit a report to Congress on the results of the program demonstrated during the respective year. Each such report shall include the following:

''(1) Information related to the financial health of each eligible hospital participating in the pilot program.

''(2) Information on the affect the pilot program has on access to care.

''(3) Information on patient satisfaction with services provided at such hospitals.

''(4) The number of readmissions at such hospitals.

''(5) The number of hospital-acquired conditions at such hospitals.

''(6) Recommendations on the viability and advisability of the long-term contracts and hospital governance structure under such pilot program.

''(7) Any other information the Secretary considers necessary for a proper analysis of the pilot program.''.

SEC. 102. EXPANDED HIRING AUTHORITY FOR THE INDIAN HEALTH SERVICE.

Section 601(d) of the Indian Health Care Improvement Act (25 U.S.C. 1661(d)) is amended—

(1) in paragraph (1)(A), by inserting ''and subject to paragraph (4)'' after ''paragraph (2)''; and

(2) by adding at the end the following:

''(4) EMPLOYMENT AUTHORITY.—

''(A) IN GENERAL.—The Secretary may, with respect to any employee described in subparagraph (B), provide that one or more provisions of chapter 74 of title 38, United States Code (other than subchapter V of such chapter or of regulations promulgated under such chapter other than under such subchapter), shall apply—

''(i) in lieu of any provision of title 5 of the United States Code (other than as applied pursuant to section 834); or

''(ii) notwithstanding any lack of specific authority for a matter with respect to which title 5 of the United States Code relates.

''(B) APPLICABILITY TO EMPLOYEES.—Authority under this paragraph may be exercised with respect to any employee in the Service holding a position—

''(i) to which chapter 51 of title 5 of the United States Code applies, excluding any senior executive service position; and

''(ii) which involves health care responsibilities.

''(C) DEFINITION.—For purposes of this paragraph, 'health care' means direct patient-care services or services incident to direct patient-care services.''.

SEC. 103. REMOVAL OR DEMOTION OF EMPLOYEES.

(a) IN GENERAL.—Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.), as amended by section 101, is further amended by adding at the end the following new section:

''SEC. 834. REMOVAL OR DEMOTION OF EMPLOYEES.

''(a) IN GENERAL.—The Secretary may remove or demote an individual who is an employee of the Service

if the Secretary determines the performance or misconduct of the individual warrants such removal or demotion. If the Secretary so removes or demotes such an individual, the Secretary may—

''(1) remove the individual from the Service; or

''(2) demote the individual by means of—

''(A) a reduction in grade for which the individual is qualified and that the Secretary determines is appropriate; or

''(B) a reduction in annual rate of pay that the Secretary determines is appropriate.

In the case of an individual who is removed under paragraph (1) or demoted under paragraph (2), the Secretary may require such individual take unpaid administrative leave for not longer than 10 consecutive work days.

''(b) PAY OF CERTAIN DEMOTED INDIVIDUALS.—(1) Notwithstanding any other provision of law, any individual subject to a demotion under subsection (a)(2)(A) shall, beginning on the date of such demotion, receive the annual rate of pay applicable to such grade.

''(2) An individual so demoted may not be placed on administrative leave or any other category of paid leave during the period during which an appeal (if any) under this section is ongoing, and may only receive pay if the

individual reports for duty. If an individual so demoted does not report for duty, such individual shall not receive pay or other benefits pursuant to subsection (e)(5).

''(c) NOTICE TO SECRETARY.—Not later than 30 days after removing or demoting an individual under subsection (a), the Service shall submit to the Secretary notice in writing of such removal or demotion and the reason for such removal or demotion.

''(d) PROCEDURE.—(1) The procedures under section 7513(b) of title 5 and chapter 43 of such title shall not apply to a removal or demotion under this section.

''(2)(A) Subject to subparagraph (B) and subsection (e), any removal or demotion under subsection (a) may be appealed to the Merit Systems Protection Board under section 7701 of title 5.

''(B) An appeal under subparagraph (A) of a removal or demotion may only be made if such appeal is made not later than seven days after the date of such removal or demotion.

''(e) EXPEDITED REVIEW BY ADMINISTRATIVE JUDGE.—(1) Upon receipt of an appeal under subsection (d)(2)(A), the Merit Systems Protection Board shall refer such appeal to an administrative judge pursuant to section 7701(b)(1) of title 5. The administrative judge shall expedite any such appeal under such section and, in any such

case, shall issue a decision not later than 45 days after the date of the appeal.

''(2) Notwithstanding any other provision of law, including section 7703 of title 5, the decision of an administrative judge under paragraph (1) shall be final and shall not be subject to any further appeal.

''(3) In any case in which the administrative judge cannot issue a decision in accordance with the 45-day requirement under paragraph (1), the removal or demotion is final. In such a case, the Merit Systems Protection Board shall, within 14 days after the date that such removal or demotion is final, submit to Congress a report that explains the reasons why a decision was not issued in accordance with such requirement.

''(4) The Merit Systems Protection Board or administrative judge may not stay any removal or demotion under this section.

''(5) During the period beginning on the date on which an individual appeals a removal from the Service under subsection (d) and ending on the date that the administrative judge issues a final decision on such appeal, such individual may not receive any pay, awards, bonuses, incentives, allowances, differentials, student loan repayments, special payments, or benefits.

''(6) To the maximum extent practicable, the Secretary shall provide to the Merit Systems Protection Board, and to any administrative judge to whom an appeal under this section is referred, such information and assistance as may be necessary to ensure an appeal under this subsection is expedited.

''(f) TERMINATION OF INVESTIGATIONS BY OFFICE OF SPECIAL COUNSEL.—Notwithstanding any other provision of law, the Special Counsel (established by section 1211 of title 5) may terminate an investigation of a prohibited personnel practice alleged by an employee or former employee of the Department after the Special Counsel provides to the employee or former employee a written statement of the reasons for the termination of the investigation. Such statement may not be admissible as evidence in any judicial or administrative proceeding without the consent of such employee or former employee.

''(g) RELATION TO TITLE 5.—The authority provided by this section is in addition to the authority provided by subchapter V of chapter 75 of title 5 and chapter 43 of such title.

''(h) DEFINITIONS.—In this section:

''(1) The term 'individual' means an individual occupying a position at the Service but does not include—

"(A) an individual, as that term is defined in section 713(g)(1); or

"(B) a political appointee.

"(2) The term 'grade' has the meaning given such term in section 7511(a) of title 5.

"(3) The term 'misconduct' includes neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of function.

"(4) The term 'political appointee' means an individual who is—

"(A) employed in a position described under sections 5312 through 5316 of title 5 (relating to the Executive Schedule);

"(B) a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of section 3132(a) of title 5; or

"(C) employed in a position of a confidential or policy-determining character under schedule C of subpart C of part 213 of title 5 of the Code of Federal Regulations.".

(b) CONFORMING.—Section 4303(f) of title 5, United States Code, is amended—

(1) by striking ''or'' at the end of paragraph (2);

(2) by striking the period at the end of paragraph (3) and inserting '', or''; and

(3) by adding at the end the following:

''(4) any removal or demotion under section 834 of the Indian Health Care Improvement Act.''.

SEC. 104. IMPROVING TIMELINESS OF CARE.

Title III of the Indian Health Care Improvement Act (25 U.S.C. 1631 et seq.) is amended by adding at the end the following new section:

''SEC. 314. STANDARDS TO IMPROVE TIMELINESS OF CARE.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall—

''(1) establish, by regulation, standards to measure the timeliness of the provision of health care services in Service facilities; and

''(2) make such standards available to all Service areas and Service facilities.

''(b) DATA COLLECTION.—The Secretary, acting through the Service, shall develop a process for Service facilities to submit to the Secretary data with respect to the standards established under subsection (a).''.

TITLE II—INDIAN HEALTH SERVICE RECRUITMENT AND WORKFORCE

SEC. 201. EXCLUSION FROM GROSS INCOME FOR PAYMENTS MADE UNDER INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

(a) IN GENERAL.—Section 108(f)(4) of the Internal Revenue Code of 1986 is amended by inserting ''under section 108 of the Indian Health Care Improvement Act,'' after ''338I of such Act,''.

(b) CLERICAL AMENDMENT.—The heading for section 108(f)(4) of such Code is amended by striking ''AND CERTAIN'' and inserting '', INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM, AND CERTAIN''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts received after the date of the enactment of this Act.

SEC. 202. CLARIFYING THAT CERTAIN DEGREES QUALIFY INDIVIDUALS FOR ELIGIBILITY IN THE INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

Section 108 of the Indian Health Care Improvement Act (25 U.S.C. 1616a) is amended—

(1) in subsection (b)(1)(B)—

(A) in clause (i), by inserting ''(including a degree business administration with an emphasis in health care management, as defined by the Secretary, or a degree in health administration, hospital administration, or public health)'' before the semicolon; and

(B) in clause (ii), by inserting ''or a license or certification to practice in the field of health administration, hospital administration, business administration, or public health, as applicable, in a State'' before the semicolon;

(2) in subsection (f)(1)(B)(iii), by striking ''2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession'' and inserting ''2 years or such longer period as the individual may agree to serve in the full-time practice of such individual's profession (or 4 years or such longer period as the individual may agree to serve in the half-time practice of such individual's profession)''; and

(3) in subsection (g)(2)(A), in the first sentence—

(A) by inserting '', in the case of an individual agreeing to serve in the full-time practice

of such individual's profession,'' before ''up to $35,000''; and

(B) by inserting ''(or, in the case of an individual agreeing to serve in the half-time practice of such individual's profession, up to $17,500)'' before ''on behalf of''.

SEC. 203. CULTURAL COMPETENCY PROGRAMS.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) is amended by adding at the end the following new section:

''SEC. 125. CULTURAL COMPETENCY PROGRAMS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall, not later than one year after the date of the enactment of this section and for each Service area, develop and implement training programs for cultural competency for employees of the Service, locum tenens medical providers, and other contracted employees who work at Service hospitals or other Service facilities and whose employment requires regular direct patient access.

''(b) REQUIRED PARTICIPATION.—Notwithstanding any other provision of law, beginning with years beginning after (and for contracts entered into on or after) the date of implementation of the training programs under subsection (a), annual participation in such a program shall be a condition of employment (or of providing services in

the capacity as a locum tenen medical provider or of the terms of the contracted employment, as applicable), and continued employment (or provision of such services in such capacity or contracted employment, as applicable), for each employee of the Service, locum tenens medical provider, and contracted employee described in such subsection. For purposes of the previous sentence, an individual shall not be considered as participating in such a program, with respect to a year, unless such individual satisfies such requirements, including testing, included in such program for such year, as specified by the Secretary.

''(c) CONSULTATION.—In developing a training program under subsection (a) for a Service area, the Secretary shall consult with representatives of each Indian tribe served in such area.''.

SEC. 204. RELOCATION REIMBURSEMENT.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.), as amended by section 203, is further amended by adding at the end the following new section:

''SEC. 126. RELOCATION REIMBURSEMENT.

''(a) IN GENERAL.—In the case of an employee of the Service who relocates to serve in a different capacity or position as an employee of the Service, the Secretary shall, subject to subsection (b), offer such employee reim-

bursement for reasonable costs associated with such relocation, as determined by the Secretary, incurred by such employee if—

''(1) such relocation is to fill a position that—

''(A) is at a Service facility that is located in a rural area or medically underserved area; and

''(B) had not been filled by a full-time non-contractor for a period of at least 6 months; or

''(2) such relocation is to fill a position that is for hospital management or administration, as determined by the Secretary.

''(b) AMOUNT FOR RELOCATION.—

''(1) IN GENERAL.—The amount of reimbursement to an employee under subsection (a) shall be in an amount that is at least 50 percent, but not more than 75 percent, of the specified pay amount (as described in paragraph (2)) of the employee.

''(2) SPECIFIED PAY AMOUNT.—For purposes of paragraph (1), the specified pay amount, with respect to an employee, is the annual rate of basic pay of the employee in effect at the beginning of the service period of such employee multiplied by the number of years (including fractions of a year) in the service period, not to exceed 4 years.

''(c) CLARIFICATION.—Nothing in this section shall be construed as limiting the authority of the Secretary, as in existence before the enactment of this section, to offer reimbursement for travel or relocation.''.

SEC. 205. AUTHORITY TO WAIVE INDIAN PREFERENCE LAWS.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) is amended by adding at the end the following new section:

''SEC. 605. AUTHORITY TO WAIVE INDIAN PREFERENCE LAWS.

''To enhance recruitment and retention of employees of the Service, the Secretary may waive the requirements of the Indian preference laws (as defined in section 2(e) of Public Law 96–135 (25 U.S.C. 472a(e))) with respect to a personnel action with respect to a Service unit with the written request or resolution of an Indian tribe located within the applicable Service unit—

''(1) if such personnel action is with respect to a facility that has a personnel vacancy rate of at least 20 percent; or

''(2) in the case such personnel action is with respect to a former employee of the Service or former tribal employee who was removed from such former employment or demoted for misconduct that

occurred during the five years prior to the date of such personnel action.''.

SEC. 206. STREAMLINING MEDICAL VOLUNTEER CREDENTIALING PROCESS.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.), as amended by sections 203 and 204, is further amended by adding at the end the following new section:

''SEC. 128. STREAMLINING MEDICAL VOLUNTEER CREDENTIALING PROCESS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall, in accordance with subsection (b), implement a Service-wide centralized credentialing system to credential licensed health professionals who seek to volunteer at a Service facility.

''(b) REQUIREMENTS.—The credentialing system implemented under subsection (a) shall be in accordance with the following:

''(1) Credentialing of licensed health professionals who seek to volunteer at a Service facility shall occur at the Service level.

''(2) Credentialing procedures under such system shall be uniform throughout the Service.

''(3) Under such system, in the case that such a licensed health professional has successfully com-

pleted the credentialing procedures under such system, such professional shall be authorized to treat patients at any Service facility or other facility within a Service area.

''(c) REGULATIONS.—The Secretary may promulgate regulations to implement this section.

''(d) CONSULTATION.—The Secretary may consult with public and private associations of medical providers in the development of the credentialing system under this section.

''(e) APPLICATION.—The credentialing system under this section shall apply with respect to licensed health professionals seeking to volunteer with respect to—

''(1) providing direct health care services at a Service facility; and

''(2) providing services at facilities operated or contracted by a tribe, tribal organization, or urban Indian organization under the Indian Self-Determination and Education Assistance Act.

''(f) CLARIFICATION.—Nothing in this section shall be construed to inhibit a tribe's authority to enter into a compact or contract under the Indian Self-Determination and Education Assistance Act.''.

TITLE III—PURCHASED/REFERRED CARE PROGRAM REFORMS

SEC. 301. CODIFICATION OF LIMITATION ON CHARGES FOR HEALTH CARE PROFESSIONAL SERVICES AND NON-HOSPITAL-BASED CARE SOURCE.

(a) APPLICABILITY.—The requirements of this section shall apply to—

(1) health programs operated by the Indian Health Service;

(2) health programs operated by an urban Indian organization through a contract or grant under title V of the Indian Health Care Improvement Act, Public Law 94–437, as amended; and

(3) health programs operated by an Indian tribe or tribal organization pursuant to a contract or compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), provided that the Indian tribe or tribal organization has agreed in such contract or compact to be bound by this section pursuant to section 108 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450l) and section 517(e) of such Act (25 U.S.C. 458aaa–16(e)), as applicable.

(b) DEFINITIONS.—For purposes of this section, the following definitions apply:

(1) The term ''notification of a claim'' means, the submission of a claim, with respect to services for an individual, that meets the requirements of section 136.24 of title 42, Code of Federal Regulations, in accordance with the following:

(A) Such claim is submitted within the applicable period specified under such section 136.24, or if applicable, section 406 of the Indian Health Care Improvement Act (25 U.S.C. 1646), and includes information necessary to determine the relative medical need for the services and the individual's eligibility.

(B) The information submitted with the claim is sufficient to—

(i) identify the individual as eligible for Indian Health Service services (such as name, address, home or referring service unit, tribal affiliation);

(ii) identify the medical care provided (such as the date of service and description of services); and

(iii) verify prior authorization by the Indian Health Service for services provided

(such as the IHS purchase order number or medical referral form) or exemption from prior authorization (such as copies of pertinent clinical information for emergency care that was not prior-authorized).

(C) To be considered sufficient notification of a claim, a claim submitted by a provider or supplier for payment shall be in a format that complies with the format required for submission of claims under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or recognized under section 1175 of such Act (42 U.S.C. 1320d–4).

(2) The term ''provider'' means a provider of services not governed by or subject to subpart D of part 136 of title 42, Code of Federal Regulations, and may include a skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program.

(3) The term ''referral'' means an authorization for medical care by the appropriate ordering official in accordance with subpart C of part 136 of title 42, Code of Federal Regulations.

(4) The term ''repricing agent'' means an entity that offers the Indian Health Service or a tribe, trib-

al organization, or urban Indian organization discounted rates from public and private providers that are not the Indian Health Service or a tribe, tribal organization, or urban Indian organization as a result of existing contracts that the public or private provider other than the Indian Health Service or a tribe, tribal organization, or urban Indian organization may have within the commercial health care industry.

(5) The term ''supplier'' means a physician or other practitioner, a facility, or other entity (other than a provider) not already governed by or subject to subpart D of part 136 of title 42, Code of Federal Regulations, that furnishes items or services under this section.

(c) PAYMENT FOR PROVIDER AND SUPPLIER SERVICES PURCHASED BY INDIAN HEALTH PROGRAMS.—

(1) IN GENERAL.—Payment to providers and suppliers for any level of care authorized under subpart C of part 136 of title 42, Code of Federal Regulations, by a Purchased/Referred Care program of the Indian Health Service, authorized by a tribe or tribal organization carrying out such a program of the Indian Health Service under the Indian Self-Determination and Education Assistance Act (25

U.S.C. 450 et seq.), authorized for purchase under section 136.31 of such title 42, Code of Federal Regulations, by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter collectively referred to as the ''I/T/U''), shall, subject to subsection (e), be determined based on one of the methods described in the following subparagraphs, as applicable:

(A) MFC RATE METHOD.—

(i) IN GENERAL.—The method described in this subparagraph is that, subject to clause (ii), in the case a specific amount for an item or service has been negotiated with a specific provider or supplier or its agent by the I/T/U, the I/T/U shall pay that amount for such item or service.

(ii) LIMITATION.—The amount applied under clause (i) for an item or service shall be an amount that is at least the amount of the provider's or supplier's most favored customer rate, as defined by the Secretary of Health and Human Services, for an item or service, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to

ensure that the I/T/U is receiving a fair and reasonable price. The limitation under the previous sentence shall not apply with respect to an item or service if—

(I) the amount offered to the I/T/U under the negotiation under clause (i) is fair and reasonable, as determined by the I/T/U, even though comparable discounts were not negotiated; and

(II) the amount is otherwise in the best interest of the I/T/U, as determined by the I/T/U.

(B) MEDICARE RATES.—The method described in this subparagraph is that, in the case that an amount for an item or service has not been negotiated in accordance with subparagraph (A), the I/T/U will pay the lowest of the following amounts for the item or service:

(i) The amount that is the applicable payment amount under the Medicare program under title XVIII of the Social Security Act for such item or service, including payment according to a fee schedule, a prospective payment system or based on

reasonable cost for the period in which the service was provided, or in the event of a Medicare waiver, the payment amount will be calculated in accordance with such waiver. For purposes of this paragraph, the amount described in this clause shall be referred to as the ''Medicare rate''.

(ii) An amount negotiated by a repricing agent if the provider or supplier is participating within the repricing agent's network and the I/T/U has a pricing arrangement or contract with that repricing agent.

(iii) An amount not to exceed the provider or supplier's most favored customer rate described in subparagraph (A)(ii) for such item or service, as evidenced by commercial price lists or paid invoices and other related pricing and discount data to ensure that the I/T/U is receiving a fair and reasonable price, but only to the extent such evidence is reasonably accessible and available to the I/T/U.

(C) OTHER.—The method described in this subparagraph is that, in the case that a Medicare rate does not exist for an item or service,

and no other method described in a previous subparagraph is accessible or available, the amount shall be deemed to be 65 percent of authorized charges for such item or service.

(2) COORDINATION OF BENEFITS AND LIMITATION ON RECOVERY.—If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under title XVIII of the Social Security Act, title XIX of such Act, or another third-party payer, the following shall apply:

(A) The I/T/U shall be the payer of last resort under section 2901(b) of the Patient Protection and Affordable Care Act (25 U.S.C. 1623(b)).

(B) If there are any third-party payers, the I/T/U shall pay the amount for which the patient is being held responsible after the provider or supplier of services has coordinated benefits and all other alternate resources have been considered and paid, including applicable copayments, deductibles, and coinsurance that are owed by the patient.

(C) The maximum payment by the I/T/U shall be only the portion of the payment

amount determined under this section not covered by any other payer.

(D) The I/T/U payment may not exceed the rate calculated in accordance with paragraph (1) of this section (plus applicable cost sharing).

(E) In the case payment is made under such title XIX for an item or service such payment shall be considered payment in full and there shall be no additional payment made by the I/T/U for such item or service.

(3) AUTHORIZED SERVICES.—Payment shall be made only for those items and services authorized by an I/T/U consistent with this section or section 503(a) of the Indian Health Care Improvement Act (25 U.S.C. 1653(a)).

(4) NO ADDITIONAL CHARGES.—

(A) If an amount has not been negotiated under paragraph (1)(A) for an item or service, the provider or supplier shall be deemed to have accepted the applicable payment amount under paragraph (1)(B) for such item or service as payment in full if—

(i) the item or service was provided based on a referral;

(ii) the provider or supplier submits a notification of a claim for payment to the I/T/U; or

(iii) the provider or supplier accepts payment for the provision of such item or service from the I/T/U.

(B) A payment made and accepted in accordance with this section shall constitute payment in full and the provider or its agent, or supplier or its agent, may not impose any additional charge—

(i) on the individual for I/T/U authorized items and services; or

(ii) for information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

(5) NOTIFICATION OF CLAIM.—The Indian Health Service shall not adjudicate a notification of a claim that does not contain the information described in subsection (b)(1) with an approval or denial, except that the Service may request further information from the individual, or as applicable, the provider or supplier, necessary to make a decision.

A notification of a claim meeting the requirements specified herein does not guarantee payment.

(6) RATE AUTHORIZED.—No service shall be authorized and no payment shall be issued under this section in excess of the rate authorized by this section.

(d) AUTHORIZATION BY AN URBAN INDIAN ORGANIZATION.—An urban Indian organization may authorize for purchase items and services for an eligible urban Indian as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) according to section 503 of such Act (25 U.S.C. 1653) and applicable regulations. Services and items furnished by physicians and other health care professionals and non-hospital-based entities shall be subject to the payment methodology set forth in this section.

(e) EXCEPTION.—In the case of a payment described in subsection (c) that is with respect to a rare specialty service, as specified by the Secretary of Health and Human Services, or a service furnished in highly rural and medically underserved areas, as specified by the Secretary, the Indian Health Service or tribe or tribal organization involved may negotiate an amount for such payment for such service that is greater than the payment amount that

would be recognized under title XVIII of the Social Security for such service.

(f) REPORT.—Not later than two years after the date of the enactment of this Act, the Secretary of Health and Human Services, acting through the Director of the Indian Health Service, shall submit to Congress a report on the impact of this section on access to care under the Purchased/Referred Care program, including recommendations for such legislative actions as the Secretary determines appropriate.

SEC. 302. ALLOCATION OF PURCHASED/REFERRED CARE PROGRAM FUNDS.

(a) IN GENERAL.—Title II of the Indian Health Care Improvement Act is amended by inserting after section 226 (25 U.S.C. 1621y) the following new section:

"SEC. 227. PURCHASED/REFERRED CARE PROGRAM DISBURSEMENT FORMULA.

''(a) IN GENERAL.—The Secretary shall, with respect to the Purchased/Referred Care program (formerly referred to as the 'contract health services program') funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization, review the distribution of funds pursuant to the program and initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate or promul-

gate regulations to develop and implement a revised distribution formula in accordance with the subsequent subsections of this section.

''(b) CONSIDERATIONS.—In developing the revised distribution formula under subsection (a), the Secretary shall consider—

''(1) the extent to which services are available at a Service hospital or facility of the Service rather than the mere existence of such a hospital or facility;

''(2) population growth and the potential for population growth;

''(3) the socioeconomic makeup of the population of each contract health service delivery area;

''(4) the geographic makeup of each contract health service delivery area;

''(5) the size of the hospital or facility;

''(6) the relative regional cost of purchasing services;

''(7) actual counts of Purchased/Referred Care users; and

''(8) accreditation problems at the Service hospital or facility of the Service.

''(c) IMPLEMENTATION DEADLINE.—The revised distribution formula under subsection (a) shall be implemented not later than the date that is 3 years after the

first October 1 following the date of the enactment of this Act.

''(d) TRANSITION.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, for the period beginning on the first October 1 following the date of the enactment of this section and ending the day before the implementation date of the revised distribution formula under subsection (a), the Secretary shall provide for the distribution of funds, with respect to direct health care services provided by a Service facility, pursuant to the Purchased/Referred Care program (and with respect to services provided by any other facility under such program, at the option of such facility) be consistent with the following:

''(A) During any portion of such period for which a Service area has been designated as a high IHS level area under paragraph (2)(B), such area shall not receive any funds pursuant to such program in addition to the base allotment determined under the distribution formula under the program for 2016 with respect to such area.

''(B) In the case that during such period the amount of funds made available to the

Service for such distribution under such program is in excess of the total amounts of base allotments for distribution under such program for 2016, the Secretary shall distribute such excess amount, in accordance with a methodology specified by the Secretary, to Service areas which for an applicable portion of such period of excess funding have been designated as a low IHS level area under paragraph (2)(A).

''(2) AREA DESIGNATIONS.—For purposes of paragraph (1), the Secretary shall, with respect to each contract health service delivery area—

''(A) review the services provided in the area to determine the IHS medical priority level pursuant to section 136.23(e) of title 42, Code of Federal Regulations, of such services; and

''(B) in the case majority, as specified by the Secretary, of the services so provided in the area were determined to have—

''(i) such a priority level of a I or II, designate such area as a low IHS level area; and

''(ii) any other priority level, designate such area as a high IHS level area.

''(e) APPLICATION OF REDUCTION CLAUSE.—In the case of a facility that, as of the date of the enactment of this section, is under contract with the Secretary with respect to the Purchased/Referred Care program and such contract applies to a period to which subsection (d) or the revised distribution formula under subsection (a) applies, if application of subsection (d) or the revised distribution formula results in the distribution of an amount of funds to such facility during such period that is less than the amount of funds that would be provided during such period to such facility under such contract with respect to the Purchased/Referred Care program before application of such subsection (d) or such revised distribution formula, respectively, the Secretary may under section 106(b) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450j–1(b)) reduce such amount accordingly to be consistent with such subsection (d) or revised distribution formula, respectively.

''(f) CLARIFICATION.—Nothing in this section shall be construed to supersede a Tribe's self-governance contract under the Indian Self-Determination and Education Assistance Act.

''(g) UPDATE.—The Secretary shall periodically, but not more frequently than once every 3 years and not less frequently than once every five years, review and, as nec-

essary, update the formula implemented under subsection (a).

''(h) CONSULTATION.—In developing the formula under subsection (a) and reviewing and making updates to such formula under subsection (f), the Secretary shall consult with Indian tribes, including such tribes consulted for purposes of carrying out section 226.

''(i) REPORTS.—Not later than one year after the date of the enactment of this section, and annually thereafter, the Secretary shall submit to Congress a report on the implementation of this section. Each such report shall include information, with respect to the period for such report, on—

''(1) the distribution of funds for such period pursuant to the Purchased/Referred Care program among the contract health service delivery area, tribes, tribal organizations, and urban Indian organizations;

''(2) whether during such period any contract health service delivery area, tribe, tribal organization, or urban Indian organization had a shortfall in such funding and, if so, the amount of such shortfall; and

''(3) recommendations for such legislative action as the Secretary deems appropriate.''.

(b) CONFORMING AMENDMENTS.—Section 226 of the Indian Health Care Improvement Act (25 U.S.C. 1621y) is amended—

(1) in subsection (a)—

(A) by striking ''As soon as practicable after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009'' and inserting ''Not later than 2 years after the date of the enactment of section 227'';

(B) by striking ''the study'' and inserting ''a study''; and

(C) by striking ''as requested by Congress in March 2009, or pursuant to section 830'' and inserting '', including as amended pursuant to section 227'';

(2) in subsection (b)—

(A) in the matter preceding paragraph (1), by inserting '', and submit, not later than one year after the date of the enactment of section 227 and annually thereafter, to Congress a report on'' after ''pursuant to the program'';

(B) in paragraph (3), by striking at the end ''and'';

(C) by redesignating paragraph (4) as paragraph (5);

(D) by inserting after paragraph (3) the following new paragraph:

''(4) to determine whether during the period of the report any contract health service delivery area, tribe, tribal organization, or urban Indian organization had a shortfall in such funding and, if so, the amount of such shortfall; and

''(5) recommendations for such legislative action as the Secretary deems appropriate.''; and

(E) in paragraph (5), as redesignated by subparagraph (C), by inserting '', including recommendations for such legislative actions as the Secretary determines appropriate'' before the period at the end; and

(3) by striking subsection (c).

SEC. 303. PURCHASED/REFERRED CARE PROGRAM BACKLOG.

Title II of the Indian Health Care Improvement Act (25 U.S.C. 1621), as amended by section 302, is further amended by adding at the end the following new section:

"SEC. 228. PURCHASED/REFERRED CARE PROGRAM BACKLOG.

''Not later than one year after the date of the enactment of this section, the Secretary shall develop and implement a system to prioritize any backlog of unpaid balances under the Purchased/Referred Care program for each Service area. In developing such system, the Secretary shall consider—

''(1) the monetary amount of each such unpaid balance; and

''(2) how long such balance has remained unpaid.''.

SEC. 304. REPORT ON FINANCIAL STABILITY OF SERVICE HOSPITALS AND FACILITIES.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on issues related to the financial stability of hospitals and facilities of the Indian Health Service that have experienced sanction or threat of sanction by the Centers for Medicare & Medicaid Services. Such report shall focus on the effects of any revenues lost as a result of the sanction or threat of sanction and shall include recommendations for legislative action.

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