

(A) extend for at least forty hours, and consist of classroom instruction and at least twenty hours (in the aggregate) of supervised clinical instruction directed toward preparing students to deliver home health services;

(B) be carried out under appropriate professional supervision and be designed to train students to maintain or enhance the personal care of an individual in his home in a manner which promotes the functional independence of the individual; and

(C) include training in—

(i) personal care services designed to assist an individual in the activities of daily living such as bathing, exercising, personal grooming, and getting in and out of bed; and

(ii) household care services such as maintaining a safe living environment, light housekeeping, and assisting in providing good nutrition (by the purchasing and preparation of food).

(3) In making grants and entering into contracts under this subsection, special consideration shall be given to entities which establish or will establish programs to provide training for persons fifty years of age and older who wish to become paraprofessionals (including home-maker home health aides) to provide home health services.

(4) Applications for grants and contracts under this subsection shall be in such form and contain such information as the Secretary shall prescribe.

(5) There are authorized to be appropriated for grants and contracts under this subsection \$2,000,000 for each of the fiscal years ending September 30, 1983, September 30, 1984, September 30, 1985, September 30, 1986, and September 30, 1987.

(c) Report to Congress with respect to grants and loans and training of personnel

The Secretary shall report to the Committee on Labor and Human Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives on or before January 1, 1984, with respect to—

(1) the impact of grants made and contracts entered into under subsections (a) and (b) of this section (as such subsections were in effect prior to October 1, 1981);

(2) the need to continue grants and loans under subsections (a) and (b) of this section (as such subsections are in effect on the day after January 4, 1983); and

(3) the extent to which standards have been applied to the training of personnel who provide home health services.

(d) "Home health services" defined

For purposes of this section, the term "home health services" has the meaning prescribed for the term by section 1395x(m) of this title.

(July 1, 1944, ch. 373, title III, § 339, as added Pub. L. 97-414, § 6(a), Jan. 4, 1983, 96 Stat. 2057; amended Pub. L. 98-555, § 6, Oct. 30, 1984, 98 Stat. 2856.)

REFERENCES IN TEXT

Subsections (a) and (b) of this section (as such subsections were in effect prior to October 1, 1981), referred to in subsec. (c)(1), mean subsections (a) and (b) of sec-

tion 255 of this title prior to repeal of section 255 by Pub. L. 97-35, title IX, § 902(b), Aug. 13, 1981, 95 Stat. 559, effective Oct. 1, 1981.

PRIOR PROVISIONS

A prior section 255, act July 1, 1944, ch. 373, title III, § 339, as added Nov. 10, 1978, Pub. L. 95-626, title II, § 207(a), 92 Stat. 3585, related to grant authority, etc., for home health services, prior to repeal by Pub. L. 97-35, title IX, § 902(b), (h), Aug. 13, 1981, 95 Stat. 559, 561, eff. Oct. 1, 1981.

Another prior section 339 of act July 1, 1944, ch. 373, title III, formerly § 331, 58 Stat. 698; June 25, 1948, ch. 654, § 4, 62 Stat. 1018; June 25, 1952, ch. 460, 66 Stat. 157; July 12, 1960, Pub. L. 86-624, § 29(b), 74 Stat. 419; renumbered § 339, Oct. 12, 1976, Pub. L. 94-484, title IV, § 407(b)(2), 90 Stat. 2268, which related to reception of persons suffering from leprosy in any hospital, was renumbered section 320 of act July 1, 1944, and transferred to section 247e of this title.

AMENDMENTS

1984—Subsecs. (a)(5), (b)(5). Pub. L. 98-555 inserted provisions authorizing appropriations for fiscal years ending Sept. 30, 1985, 1986, and 1987.

CHANGE OF NAME

Committee on Labor and Human Resources of Senate changed to Committee on Health, Education, Labor, and Pensions of Senate by Senate Resolution No. 20, One Hundred Sixth Congress, Jan. 19, 1999.

Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 104-14, set out as a note preceding section 21 of Title 2, The Congress. Committee on Commerce of House of Representatives changed to Committee on Energy and Commerce of House of Representatives, and jurisdiction over matters relating to securities and exchanges and insurance generally transferred to Committee on Financial Services of House of Representatives by House Resolution No. 5, One Hundred Seventh Congress, Jan. 3, 2001.

REPORT TO CONGRESS CONCERNING RESULTS OF STUDIES EVALUATING HOME AND COMMUNITY BASED HEALTH SERVICES; STUDIES OF REIMBURSEMENT METHODOLOGIES; INVESTIGATION OF FRAUD; DEMONSTRATION PROJECTS; HOME HEALTH SERVICES, DEFINED

Section 6(b)-(f) of Pub. L. 97-414 directed Secretary of Health and Human Services to report results of studies evaluating home and community based health services, and any recommendations for legislative action which might improve the provision of such services, to Congress prior to Jan. 1, 1985, to compile and analyze results of significant public or private studies relating to reimbursement methodologies for home health services and to report recommendations to Congress within 180 days after Jan. 4, 1983, to investigate methods available to stem medicare and medicaid fraud and abuse and extent to which such methods are applied and to report results to Congress within 18 months of Jan. 4, 1983, and to develop and carry out demonstration projects commencing no later than Jan. 1, 1984, to test methods for identifying patients at risk of institutionalization who could be treated more cost-effectively with home health services, and to test alternative reimbursement methodologies for home health agencies in order to determine most cost-effective way of providing home health services, and to report to Congress with regard to the demonstrations no later than Jan. 1, 1985; and defined "home health services" for purposes of this section.

SUBPART V—HEALTHY COMMUNITIES ACCESS PROGRAM

PRIOR PROVISIONS

A prior subpart VI, consisting of section 256a, related to health services for residents of public housing, prior

to repeal by Pub. L. 104-299, §4(a)(3), Oct. 11, 1996, 110 Stat. 3645.

§ 256. Grants to strengthen the effectiveness, efficiency, and coordination of services for the uninsured and underinsured

(a) In general

The Secretary may award grants to eligible entities to assist in the development of integrated health care delivery systems to serve communities of individuals who are uninsured and individuals who are underinsured—

- (1) to improve the efficiency of, and coordination among, the providers providing services through such systems;
- (2) to assist communities in developing programs targeted toward preventing and managing chronic diseases; and
- (3) to expand and enhance the services provided through such systems.

(b) Eligible entities

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

- (1) represents a consortium—
 - (A) whose principal purpose is to provide a broad range of coordinated health care services for a community defined in the entity's grant application as described in paragraph (2); and
 - (B) that includes at least one of each of the following providers that serve the community (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation)—
 - (i) a Federally qualified health center (as defined in section 1395x(aa) of this title);
 - (ii) a hospital with a low-income utilization rate (as defined in section 1396r-4(b)(3) of this title), that is greater than 25 percent;
 - (iii) a public health department; and
 - (iv) an interested public or private sector health care provider or an organization that has traditionally served the medically uninsured and underserved; and

(2) submits to the Secretary an application, in such form and manner as the Secretary shall prescribe, that—

- (A) defines a community or geographic area of uninsured and underinsured individuals;
- (B) identifies the providers who will participate in the consortium's program under the grant, and specifies each provider's contribution to the care of uninsured and underinsured individuals in the community, including the volume of care the provider provides to beneficiaries under the medicare, medicaid, and State child health insurance programs and to patients who pay privately for services;
- (C) describes the activities that the applicant and the consortium propose to perform under the grant to further the objectives of this section;
- (D) demonstrates the consortium's ability to build on the current system (as of the date of submission of the application) for

servicing a community or geographic area of uninsured and underinsured individuals by involving providers who have traditionally provided a significant volume of care for that community;

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

(F) provides evidence of community involvement in the development, implementation, and direction of the program that the entity proposes to operate;

(G) demonstrates the consortium's ability to ensure that individuals participating in the program are enrolled in public insurance programs for which the individuals are eligible or know of private insurance programs where available;

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

(I) describes a plan for evaluation of the activities carried out under the grant, including measurement of progress toward the goals and objectives of the program and the use of evaluation findings to improve program performance;

(J) demonstrates fiscal responsibility through the use of appropriate accounting procedures and appropriate management systems;

(K) demonstrates the consortium's commitment to serve the community without regard to the ability of an individual or family to pay by arranging for or providing free or reduced charge care for the poor; and

(L) includes such other information as the Secretary may prescribe.

(c) Limitations

(1) Number of awards

(A) In general

For each of fiscal years 2003, 2004, 2005, and 2006, the Secretary may not make more than 35 new awards under subsection (a) of this section (excluding renewals of such awards).

(B) Rule of construction

This paragraph shall not be construed to affect awards made before fiscal year 2003.

(2) In general

An eligible entity may not receive a grant under this section (including with respect to any such grant made before fiscal year 2003) for more than 3 consecutive fiscal years, except that such entity may receive such a grant award for not more than 1 additional fiscal year if—

- (A) the eligible entity submits to the Secretary a request for a grant for such an additional fiscal year;

(B) the Secretary determines that extraordinary circumstances (as defined in paragraph (3)) justify the granting of such request; and

(C) the Secretary determines that granting such request is necessary to further the objectives described in subsection (a) of this section.

(3) Extraordinary circumstances

(A) In general

In paragraph (2), the term “extraordinary circumstances” means an event (or events) that is outside of the control of the eligible entity that has prevented the eligible entity from fulfilling the objectives described by such entity in the application submitted under subsection (b)(2) of this section.

(B) Examples

Extraordinary circumstances include—

(i) natural disasters or other major disruptions to the security or health of the community or geographic area served by the eligible entity; or

(ii) a significant economic deterioration in the community or geographic area served by such eligible entity, that directly and adversely affects the entity receiving an award under subsection (a) of this section.

(d) Priorities

In awarding grants under this section, the Secretary—

(1) shall accord priority to applicants that demonstrate the extent of unmet need in the community involved for a more coordinated system of care; and

(2) may accord priority to applicants that best promote the objectives of this section, taking into consideration the extent to which the application involved—

(A) identifies a community whose geographical area has a high or increasing percentage of individuals who are uninsured;

(B) demonstrates that the applicant has included in its consortium providers, support systems, and programs that have a tradition of serving uninsured individuals and underinsured individuals in the community;

(C) shows evidence that the program would expand utilization of preventive and primary care services for uninsured and underinsured individuals and families in the community, including behavioral and mental health services, oral health services, or substance abuse services;

(D) proposes a program that would improve coordination between health care providers and appropriate social service providers;

(E) demonstrates collaboration with State and local governments;

(F) demonstrates that the applicant makes use of non-Federal contributions to the greatest extent possible; or

(G) demonstrates a likelihood that the proposed program will continue after support under this section ceases.

(e) Use of funds

(1) Use by grantees

(A) In general

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

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

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

(B) Specific uses

The following are examples of purposes for which a grantee may use grant funds under this section, when such use meets the conditions stated in subparagraph (A):

(i) Increases in outreach activities and closing gaps in health care service.

(ii) Improvements to case management.

(iii) Improvements to coordination of transportation to health care facilities.

(iv) Development of provider networks and other innovative models to engage physicians in voluntary efforts to serve the medically underserved within a community.

(v) Recruitment, training, and compensation of necessary personnel.

(vi) Acquisition of technology for the purpose of coordinating care.

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

(viii) Development of common processes for determining eligibility for the programs provided through the system, including creating common identification cards and single sliding scale discounts.

(ix) Development of specific prevention and disease management tools and processes.

(x) Translation services.

(xi) Carrying out other activities that may be appropriate to a community and that would increase access by the uninsured to health care, such as access initiatives for which private entities provide non-Federal contributions to supplement the Federal funds provided through the grants for the initiatives.

(2) Direct patient care limitation

Not more than 15 percent of the funds provided under a grant awarded under this section may be used for providing direct patient care and services.

(3) Reservation of funds for national program purposes

The Secretary may use not more than 3 percent of funds appropriated to carry out this section for providing technical assistance to

grantees, obtaining assistance of experts and consultants, holding meetings, developing of tools, disseminating of information, evaluation, and carrying out activities that will extend the benefits of programs funded under this section to communities other than the community served by the program funded.

(f) Grantee requirements

(1) Evaluation of effectiveness

A grantee under this section shall—

(A) report to the Secretary annually regarding—

(i) progress in meeting the goals and measurable objectives set forth in the grant application submitted by the grantee under subsection (b) of this section; and

(ii) the extent to which activities conducted by such grantee have—

(I) improved the effectiveness, efficiency, and coordination of services for uninsured and underinsured individuals in the communities or geographic areas served by such grantee;

(II) resulted in the provision of better quality health care for such individuals; and

(III) resulted in the provision of health care to such individuals at lower cost than would have been possible in the absence of the activities conducted by such grantee; and

(B) provide for an independent annual financial audit of all records that relate to the disposition of funds received through the grant.

(2) Progress

The Secretary may not renew an annual grant under this section for an entity for a fiscal year unless the Secretary is satisfied that the consortium represented by the entity has made reasonable and demonstrable progress in meeting the goals and measurable objectives set forth in the entity's grant application for the preceding fiscal year.

(g) Maintenance of effort

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

(h) Technical assistance

The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(i) Evaluation of program

Not later than September 30, 2005, the Secretary shall prepare and submit to the appropriate committees of Congress a report that describes the extent to which projects funded

under this section have been successful in improving the effectiveness, efficiency, and coordination of services for uninsured and underinsured individuals in the communities or geographic areas served by such projects, including whether the projects resulted in the provision of better quality health care for such individuals, and whether such care was provided at lower costs, than would have been provided in the absence of such projects.

(j) Demonstration authority

The Secretary may make demonstration awards under this section to historically black health professions schools for the purposes of—

(1) developing patient-based research infrastructure at historically black health professions schools, which have an affiliation, or affiliations, with any of the providers identified in subsection (b)(1)(B) of this section;

(2) establishment of joint and collaborative programs of medical research and data collection between historically black health professions schools and such providers, whose goal is to improve the health status of medically underserved populations; or

(3) supporting the research-related costs of patient care, data collection, and academic training resulting from such affiliations.

(k) Authorization of appropriations

There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2002 through 2006.

(l) Date certain for termination of program

Funds may not be appropriated to carry out this section after September 30, 2006.

(July 1, 1944, ch. 373, title III, §340, as added Pub. L. 107-251, title IV, §402, Oct. 26, 2002, 116 Stat. 1655.)

PRIOR PROVISIONS

A prior section 256, act July 1, 1944, ch. 373, title III, §340, as added July 22, 1987, Pub. L. 100-77, title VI, §601, 101 Stat. 511; amended Nov. 4, 1988, Pub. L. 100-607, title VIII, §§801(a), (c), 802(a), (b)(1), 803, 804, 102 Stat. 3168, 3169; Nov. 7, 1988, Pub. L. 100-628, title VI, §§601(a), (c), 602(a), (b)(1), 603, 604, 102 Stat. 3241, 3242; Aug. 16, 1989, Pub. L. 101-93, §5(t)(1), (3), 103 Stat. 615; Nov. 29, 1990, Pub. L. 101-645, title V, §§501-503, 104 Stat. 4724; Oct. 27, 1992, Pub. L. 102-531, title III, §309(c), 106 Stat. 3501, related to grant program for certain health services for the homeless, prior to repeal by Pub. L. 104-299, §4(a)(3), Oct. 11, 1996, 110 Stat. 3645, eff. Oct. 1, 1996.

Another prior section 256, act July 1, 1944, ch. 373, title III, §340, as added Nov. 10, 1978, Pub. L. 95-626, title I, §115(2), 92 Stat. 3567; amended Dec. 12, 1979, Pub. L. 96-142, title III, §301(a), 93 Stat. 1073; Aug. 13, 1981, Pub. L. 97-35, title IX, §903(b)(1), 95 Stat. 561; Jan. 4, 1983, Pub. L. 97-414, §8(h), 96 Stat. 2061, related to primary care research and demonstration projects to serve medically underserved population, prior to repeal by Pub. L. 97-35, title IX, §903(c), Aug. 13, 1981, 95 Stat. 561, eff. Oct. 1, 1982.

Another prior section 256, act July 1, 1944, ch. 373, title III, §340, formerly §332, 58 Stat. 698; renumbered §340, Oct. 12, 1976, Pub. L. 94-484, title IV, §407(b)(2), 90 Stat. 2268, related to apprehension, detention, treatment, and release of persons being treated for leprosy, prior to repeal by Pub. L. 95-626, title I, §105(b), Nov. 10, 1978, 92 Stat. 3560.

DEMONSTRATION PROJECT TO PROVIDE ACCESS TO AFFORDABLE CARE

Pub. L. 111-148, title X, §10504, Mar. 23, 2010, 124 Stat. 1004, provided that:

“(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act [Mar. 23, 2010], the Secretary of Health and Human Services (referred to in this section as the ‘Secretary’), acting through the Health Resources and Services Administration, shall establish a 3 year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees. The Secretary shall evaluate the feasibility of expanding the project to additional States.

“(b) ELIGIBILITY.—To be eligible to participate in the demonstration project, an entity shall be a State-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each State in which a participant selected by the Secretary is located shall receive not more than \$2,000,000 to establish and carry out the project for the 3-year demonstration period.

“(c) AUTHORIZATION.—There is authorized to be appropriated such sums as may be necessary to carry out this section.”

PURPOSE

Pub. L. 107-251, title IV, § 401, Oct. 26, 2002, 116 Stat. 1655, provided that: “The purpose of this title [enacting this subpart and subpart X (§256f et seq.) of this part and provisions set out as a note under section 1396a of this title] is to provide assistance to communities and consortia of health care providers and others, to develop or strengthen integrated community health care delivery systems that coordinate health care services for individuals who are uninsured or underinsured and to develop or strengthen activities related to providing coordinated care for individuals with chronic conditions who are uninsured or underinsured, through the—

“(1) coordination of services to allow individuals to receive efficient and higher quality care and to gain entry into and receive services from a comprehensive system of care;

“(2) development of the infrastructure for a health care delivery system characterized by effective collaboration, information sharing, and clinical and financial coordination among all providers of care in the community; and

“(3) provision of new Federal resources that do not supplant funding for existing Federal categorical programs that support entities providing services to low-income populations.”

§ 256a. Patient navigator grants

(a) Grants

The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to eligible entities for the development and operation of demonstration programs to provide patient navigator services to improve health care outcomes. The Secretary shall coordinate with, and ensure the participation of, the Indian Health Service, the National Cancer Institute, the Office of Rural Health Policy, and such other offices and agencies as deemed appropriate by the Secretary, regarding the design and evaluation of the demonstration programs.

(b) Use of funds

The Secretary shall require each recipient of a grant under this section to use the grant to recruit, assign, train, and employ patient navigators who have direct knowledge of the communities they serve to facilitate the care of individuals, including by performing each of the following duties:

(1) Acting as contacts, including by assisting in the coordination of health care services and provider referrals, for individuals who are

seeking prevention or early detection services for, or who following a screening or early detection service are found to have a symptom, abnormal finding, or diagnosis of, cancer or other chronic disease.

(2) Facilitating the involvement of community organizations in assisting individuals who are at risk for or who have cancer or other chronic diseases to receive better access to high-quality health care services (such as by creating partnerships with patient advocacy groups, charities, health care centers, community hospice centers, other health care providers, or other organizations in the targeted community).

(3) Notifying individuals of clinical trials and, on request, facilitating enrollment of eligible individuals in these trials.

(4) Anticipating, identifying, and helping patients to overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or other chronic disease.

(5) Coordinating with the relevant health insurance ombudsman programs to provide information to individuals who are at risk for or who have cancer or other chronic diseases about health coverage, including private insurance, health care savings accounts, and other publicly funded programs (such as Medicare, Medicaid, health programs operated by the Department of Veterans Affairs or the Department of Defense, the State children's health insurance program, and any private or governmental prescription assistance programs).

(6) Conducting ongoing outreach to health disparity populations, including the uninsured, rural populations, and other medically underserved populations, in addition to assisting other individuals who are at risk for or who have cancer or other chronic diseases to seek preventative care.

(c) Prohibitions

(1) Referral fees

The Secretary shall require each recipient of a grant under this section to prohibit any patient navigator providing services under the grant from accepting any referral fee, kickback, or other thing of value in return for referring an individual to a particular health care provider.

(2) Legal fees and costs

The Secretary shall prohibit the use of any grant funds received under this section to pay any fees or costs resulting from any litigation, arbitration, mediation, or other proceeding to resolve a legal dispute.

(d) Grant period

(1) In general

Subject to paragraphs (2) and (3), the Secretary may award grants under this section for periods of not more than 3 years.

(2) Extensions

Subject to paragraph (3), the Secretary may extend the period of a grant under this section. Each such extension shall be for a period of not more than 1 year.

(3) Limitations on grant period

In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.

(e) Application**(1) In general**

To seek a grant under this section, an eligible entity shall submit an application to the Secretary in such form, in such manner, and containing such information as the Secretary may require.

(2) Contents

At a minimum, the Secretary shall require each such application to outline how the eligible entity will establish baseline measures and benchmarks that meet the Secretary's requirements to evaluate program outcomes.

(3) Minimum core proficiencies

The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.

(f) Uniform baseline measures

The Secretary shall establish uniform baseline measures in order to properly evaluate the impact of the demonstration projects under this section.

(g) Preference

In making grants under this section, the Secretary shall give preference to eligible entities that demonstrate in their applications plans to utilize patient navigator services to overcome significant barriers in order to improve health care outcomes in their respective communities.

(h) Duplication of services

An eligible entity that is receiving Federal funds for activities described in subsection (b) of this section on the date on which the entity submits an application under subsection (e) of this section may not receive a grant under this section unless the entity can demonstrate that amounts received under the grant will be utilized to expand services or provide new services to individuals who would not otherwise be served.

(i) Coordination with other programs

The Secretary shall ensure coordination of the demonstration grant program under this section with existing authorized programs in order to facilitate access to high-quality health care services.

(j) Study; reports**(1) Final report by Secretary**

Not later than 6 months after the completion of the demonstration grant program under this section, the Secretary shall conduct a study of the results of the program and submit to the Congress a report on such results that includes the following:

(A) An evaluation of the program outcomes, including—

(i) quantitative analysis of baseline and benchmark measures; and

(ii) aggregate information about the patients served and program activities.

(B) Recommendations on whether patient navigator programs could be used to improve patient outcomes in other public health areas.

(2) Interim reports by Secretary

The Secretary may provide interim reports to the Congress on the demonstration grant program under this section at such intervals as the Secretary determines to be appropriate.

(3) Reports by grantees

The Secretary may require grant recipients under this section to submit interim and final reports on grant program outcomes.

(k) Rule of construction

This section shall not be construed to authorize funding for the delivery of health care services (other than the patient navigator duties listed in subsection (b) of this section).

(l) Definitions

In this section:

(1) The term "eligible entity" means a public or nonprofit private health center (including a Federally qualified health center (as that term is defined in section 1395x(aa)(4) of this title)), a health facility operated by or pursuant to a contract with the Indian Health Service, a hospital, a cancer center, a rural health clinic, an academic health center, or a nonprofit entity that enters into a partnership or coordinates referrals with such a center, clinic, facility, or hospital to provide patient navigator services.

(2) The term "health disparity population" means a population that, as determined by the Secretary, has a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates as compared to the health status of the general population.

(3) The term "patient navigator" means an individual who has completed a training program approved by the Secretary to perform the duties listed in subsection (b) of this section.

(m) Authorization of appropriations**(1) In general**

To carry out this section, there are authorized to be appropriated \$2,000,000 for fiscal year 2006, \$5,000,000 for fiscal year 2007, \$8,000,000 for fiscal year 2008, \$6,500,000 for fiscal year 2009, \$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

(2) Availability

The amounts appropriated pursuant to paragraph (1) shall remain available for obligation through the end of fiscal year 2015.

(July 1, 1944, ch. 373, title III, §340A, as added Pub. L. 109-18, §2, June 29, 2005, 119 Stat. 340; amended Pub. L. 111-148, title III, §3510, Mar. 23, 2010, 124 Stat. 537.)

PRIOR PROVISIONS

A prior section 256a, act July 1, 1944, ch. 373, title III, §340A, as added Nov. 6, 1990, Pub. L. 101-527, §3, 104 Stat.

2314; amended Oct. 27, 1992, Pub. L. 102-531, title III, §309(d), 106 Stat. 3502, related to health services for residents of public housing, prior to repeal by Pub. L. 104-299, §§4(a)(3), 5, Oct. 11, 1996, 110 Stat. 3645, effective Oct. 1, 1996.

Another prior section 256a, act July 1, 1944, ch. 373, title III, §340A, as added Nov. 10, 1978, Pub. L. 95-626, title I, §106(a), 92 Stat. 3560, related to technical assistance demonstration grants and contracts, prior to repeal by Pub. L. 100-77, title VI, §601, July 22, 1987, 101 Stat. 511.

AMENDMENTS

2010—Subsec. (d)(3). Pub. L. 111-148, §3510(1), added par. (3) and struck out former par. (3). Prior to amendment, text read as follows: “In carrying out this section, the Secretary—

“(A) shall ensure that the total period of a grant does not exceed 4 years; and

“(B) may not authorize any grant period ending after September 30, 2010.”

Subsec. (e)(3). Pub. L. 111-148, §3510(2), added par. (3). Subsec. (m)(1). Pub. L. 111-148, §3510(3)(A), substituted “\$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015” for “and \$3,500,000 for fiscal year 2010”.

Subsec. (m)(2). Pub. L. 111-148, §3510(3)(B), substituted “2015” for “2010”.

§ 256a-1. Establishing community health teams to support the patient-centered medical home

(a) In general

The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) Eligible entities

To be eligible to receive a grant or contract under subsection (a), an entity shall—

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

(B) be an Indian tribe or tribal organization, as defined in section 1603 of title 25;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions, as described in section 1396w-4 of this title (as added by section 2703), in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) Requirements for health teams

A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians or other primary care providers;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes

and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator,¹ assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals,² nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 300jj of this title) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 280j-2 of this title.

(d) Requirement for primary care providers

A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

¹ So in original. The comma probably should be “and”.

² So in original. Probably should be “hospital.”

(e) Reporting to Secretary

An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) Definition of primary care

In this section, the term “primary care” means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

(Pub. L. 111-148, title III, §3502, title X, §10321, Mar. 23, 2010, 124 Stat. 513, 952.)

REFERENCES IN TEXT

Section 2703, referred to in subsec. (b)(5), means section 2703 of Pub. L. 111-148.

CODIFICATION

Section was enacted as part of the Patient Protection and Affordable Care Act, and not as part of the Public Health Service Act which comprises this chapter.

AMENDMENTS

2010—Subsec. (c)(2)(A). Pub. L. 111-148, §10321, inserted “or other primary care providers” after “physicians”.

SUBPART VII—DRUG PRICING AGREEMENTS

§ 256b. Limitation on prices of drugs purchased by covered entities

(a) Requirements for agreement with Secretary

(1) In general

The Secretary shall enter into an agreement with each manufacturer of covered outpatient drugs under which the amount required to be paid (taking into account any rebate or discount, as provided by the Secretary) to the manufacturer for covered outpatient drugs (other than drugs described in paragraph (3)) purchased by a covered entity on or after the first day of the first month that begins after November 4, 1992, does not exceed an amount equal to the average manufacturer price for the drug under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] in the preceding calendar quarter, reduced by the rebate percentage described in paragraph (2). Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered outpatient drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the “ceiling price”), and shall require that the manufacturer offer each covered entity covered outpatient drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.

(2) “Rebate percentage” defined

(A) In general

For a covered outpatient drug purchased in a calendar quarter, the “rebate percent-