EXECUTIVE COMMITTEE MEETING TO CONSIDER THE MEDICARE, MEDICAID AND SCHIP INDIAN HEALTH CARE IMPROVEMENT ACT OF 2006; AND THE IMPROVING OUTCOMES FOR CHILDREN AFFECTED BY METH ACT OF 2006

THURSDAY, JUNE 8, 2006

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 11:33 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Present: Senators Hatch, Snowe, Thomas, Smith, Bunning, Crapo, Baucus, Jeffords, Bingaman, and Lincoln.

Also present: Kolan Davis, Republican Staff Director and Chief Counsel; Russ Sullivan, Democratic Staff Director; Dr. Alice Weiss, Health Counsel; Dr. Rodney Whitlock, Health Policy Advisor; Becky Shipp, Policy Advisor, Majority; Diedra Henry-Spires, Policy Advisor, Minority; David Schwartz, Oversight Counsel; Carla Martin, Chief Clerk; and Mark Blair, Deputy Clerk.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. For those who have been very patient in the audience, and staffs that have been waiting for us, staff is aware of the fact that we just had a vote in the Senate, others may not be aware of that. But we did have a vote, and that is why we are starting late.

Our first mark before us today is the Medicare, Medicaid and SCHIP Indian Health Care Improvement Act of 2006. This bill encompasses the provisions of the Indian Health Care Improvement Act reported by the Indian Affairs Committee on March 16, and we are dealing with just those provisions that are within the jurisdiction of the Finance Committee.

This legislation today helps us keep our commitment to provide quality health care to American natives. The legislation that we are considering today would allow the tribes to be able to use money for Medicare and Medicaid to maximize improvement of the care provided to the American Natives. This legislation provides for increased outreach to tribes to assist American Natives in applying for Medicaid and SCHIP.

This legislation also provides relief for American Natives for Medicaid cost sharing or premiums if that

person comes to Medicaid by contract or referral. This is a fair and balanced policy, as those American Natives would not be subject to cost sharing or premiums if their care was provided by an Indian Health provider.

This legislation creates incentives for Medicaid managed care plans that enroll Indians into the Indian Health providers in their networks. American Natives have relationships with their health care providers and many prefer to receive services from an Indian Health provider anyway.

Under current law, if an American Native sees a provider not in the plan's network, that provider will not likely get paid, except under certain circumstances.

So my mark, as Chairman, helps fix that by requiring managed care plans that serve a larger number of American Natives, to include Indian Health providers in their network, or to make alternative arrangements to make sure that these professionals are paid.

Finally, the legislation requires reporting of data on American Natives served, the status of their health care, and efforts being made to upgrade facilities that may not be in compliance with the Social Security Act requirements. This is valuable information that will aid us in ensuring that we are providing quality care to these people.

I really want to express appreciation to my Ranking Member, Senator Baucus, for helping us with this legislation, as well as the Chairman and Ranking Member of the Indian Affairs Committee, Senators McCain and Dorgan, respectively. The work that has gone into today's mark-up has been a bipartisan process, including both committees. Their assistance has been invaluable.

Today we will also consider a bipartisan Chairman's mark, the Improving Outcomes for Children Affected by Meth Act. This bill reauthorizes and improves the promotion of the Safe and Stable Families program, as well as Mentoring of Children of Prisoners program. There is a long history of Congress working productively on a bipartisan basis to improve child welfare.

I am glad to report that this spirit of bipartisanship is also demonstrated in the production of this legislation, as well as the one affecting American Natives.

The Senate Finance Committee has held two important hearings on child welfare. These are the first hearings that the Senate Finance Committee has held on child welfare issues in nearly 10 years.

One of those hearings dealt specifically with the effects that methamphetamine addiction has had on America's child welfare system. I am persuaded that meth

abuse and addiction have created unique and pressing problems, notably in rural States, including mine and Senator Baucus's, Iowa and Montana.

During these hearings, the committee also learned the terrible toll that methamphetamine addiction is taking on Native Americans. I am also convinced that the meth epidemic has created an unsustainable strain on an already over-burdened child welfare system in States and on reservations.

I am very pleased to have successfully worked this legislation with Senator Baucus, as well as the previous one I have already spoken about. I appreciate his thoughtful comments and questions during our hearings on meth abuse and child welfare.

By marking up this legislation today, our committee has the opportunity to help address the problems that the meth epidemic has created in the State's child welfare system.

We do this by directing $40 million a year towards grants for regional partnerships. These partnerships will increase the well-being of, and improve the permanency outcomes for, children affected by methamphetamine abuse and addiction. These grants will improve collaboration and coordination among providers of services for children and families.

The bill directs the Secretary to give consideration for receipt of these grants to rural areas that have a lack of capacity to serve the comprehensive family treatment services. By emphasizing comprehensive family treatment, we are promoting a promising strategy for families to recover from meth addiction altogether.

Additionally, the mark before us expands the Mentoring of Children of Prisoners program so that children in areas that have not been able to access these mentoring services may gain access to those programs.

The mark also increases and improves access for needed funding for Indian tribes, as well as increase States' accountability. These are all relatively modest improvements to a program that, while small, has worked very well.

I am pleased that we were able to adopt some of the administration's proposals, as well as suggestions from members of this committee. I think these changes will improve the permanency outcomes for our children.

So, I urge my colleagues to support both of these bipartisan pieces of legislation before the committee, and do it today.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator Baucus. Thank you, Mr. Chairman.

Just outside Crow Agency near Montana's southern border lies the Little Bighorn Battlefield National Monument. There in 1976, the U.S. Government launched a military campaign against the bands of Sioux and Cheyenne who refused to stay on the reservation. Those Sioux and Cheyenne sought to continue their traditional nomadic way of life.

General Armstrong Custer, with the U.S. Army, Crazy Horse, Sitting Bull, and Chief Gall led the Indian warriors. Teachers around Montana and throughout the Nation still tell the story of their battle.

The battlefield was once named for General Custer. In 1991, it was renamed Little Bighorn. The story of the battlefield's name alone is emblematic of the changing relationship that the U.S. Government has had with tribal governments throughout this great land.

In 2003, an Indian memorial was dedicated at the battlefield under the theme "Peace Through Unity." Today we carry on that theme of unity, unity among governments, peoples, and even committees of the Senate as we consider two important pieces of legislation.

Crazy Horse once said, "A very great vision is needed, and the man who has it must follow it as the eagle seeks the deepest blue of the sky." The two bills that we consider today were written with a great vision of the future, and it is our charge today to ensure that this great vision is fulfilled.

First, we will consider the Medicare, Medicaid and SCHIP Indian Health Care Improvement Act. This bill is a corollary to the Indian Health Care Improvement Act which was reported by the Indian Affairs Committee last October.

The provisions that we consider today deal directly with programs within the Finance Committee's jurisdiction. These provisions make needed changes to Medicare, Medicaid, and SCHIP to improve access to high-quality, culturally-appropriate health care throughout Indian country. This bill is crucial for the more than 66,000 Indians who live in Montana, and crucial for the millions of Indians living throughout America.

Indian people continue to experience significant health disparities: Indian life expectancy is two years less than for the general U.S. population; the death rate for tuberculosis is six times higher for Indians; the Indian suicide rate is 60 percent greater than the general population; about 12 percent of Indian homes lack

a safe indoor water supply; and Indian people have the highest prevalence of Type II diabetes of any population in the world.

Some of the financial and human costs of these disparities could be reduced with better access to preventive, accessible, and affordable health care.

The median population has grown by 65 percent over the last 16 years, but the Indian Health Service budget has grown by less than 2 percent a year. Today, funding for the Indian Health Service meets only 55 percent of what is needed to ensure that Indian people get good care.

Today, we begin to change that picture. This bill is years overdue--it is generations overdue for the tribes--and I am proud to stand behind it. I look forward to working with my colleagues on the Indian Affairs Committee to pass and complete the Indian Health Care Improvement Act.

The second bill we consider is the Improving Outcomes for Children Affected by Meth Act. I have made no secret of the struggle that Montana has experienced with methamphetamine. I hope that this legislation will help to ensure that families no longer struggle in secret with addiction.

I hope that this legislation would help to ensure

that families can get effective and comprehensive treatment, and I hope this legislation will help ensure that children whose parents are addicted to meth no longer have to shuttle from one temporary solution to another, never to resolution.

Today we offer children affected by meth the hope of treatment for their parents. With family treatment for meth-addicted parents, we offer those children the opportunity to heal with their parents. Today we offer States strategies and lessons learned to combat the epidemic.

I commend the thousands of caseworkers, foster families, neighbors, and friends across the country who have worked to provide safety, stability, and love for the more than half a million children in the Nation's foster care system.

I am committed to working on behalf of our child welfare system with the Chairman and Senator Rockefeller. Senator Rockefeller, of course, cannot be here today, but he has always been, and continues to be, dedicated to child welfare issues.

Reauthorization of the Promoting Safe and Stable Families program will help to support strong families, and I am pleased that this legislation also gives tribes across our country the ability to make much-needed

improvements to the tribal child welfare system.

The Nez Perce leader Chief Joseph said, "The Great Spirit Chief who rules above all will smile upon this land, and this time the Indian race is waiting and praying."

Indian tribes and American children have long waited and prayed. We have a long journey ahead of us before their patience and prayers will be answered, but I believe that today's mark-up sets us on the right course, and may the Great Spirit Chief who rules above all smile upon this enterprise today.

The Chairman. Thank you very much.

If there is no objection, I would go to consideration of the legislation.

The first consideration will be the Chairman's mark of the Medicare, Medicaid and SCHIP Indian Health Care Improvement Act, which is an original bill which I now place before the committee.

If you have any questions, we have staff members for the Majority, Rodney Whitlock and Becky Shipp, and we have Alice Weiss for the Minority staff.

Normally at this point we would proceed with a walk-through. If there is no objection, I would like to avoid the walk-through, then we would go to any questions that anybody has about the bill.

Is there any objection to avoiding the walk-through? [No response]. Are there any questions that any members would like to ask of the staff at this point?

Senator Bingaman. Mr. Chairman, could I just comment? I compliment you and Senator Baucus for putting this Chairman's mark together. It has some very important provisions that affect the Indian community, particularly in my State and throughout the country.

I think it is very good legislation and, as you have pointed out, overdue. So, I compliment you and strongly support the passage.

The Chairman. All right.

Now, we have one amendment filed to this bill. I was told, and if any member or staff says I am wrong, speak up, but --

Senator Baucus. Mr. Chairman, you are always right. [Laughter].

The Chairman. Thank you. Once in a while you need some bipartisanship around here as a Chairman, as you can see from this side of the aisle.

I was told that if that member was not here, they did not mind if we passed over their amendment. So since that person is not here, I would now ask that the committee favorably report the bill. That is the normal process, but we are still two members short.

So I would request, until two more members come, that we would then go on to Improving Outcomes for Children Affected by Meth Act. We again have Becky Shipp here, a Policy Advisor for the Majority staff, and we have Diedra Henry-Spires, Policy Advisor for the Minority staff, who would walk through this, normally.

But if we have agreement not to have a walk-through, then I would go to a point, if anybody has any questions that they want to ask of the Minority or the Majority staff on this bill.

Senator Lincoln. Mr. Chairman?

The Chairman. Proceed, Senator Lincoln.

Senator Lincoln. I would just like to make a few comments. Is this the appropriate place?

The Chairman. Yes, it would be.

Senator Lincoln. Well, Mr. Chairman, I want to thank you and Senator Baucus for bringing this issue up as well. I think Senator Baucus spoke very compassionately. I would like to add my voice.

In Arkansas, the top priority of our State's drug law enforcement agencies is the growing production and distribution of methamphetamines. This epidemic has had a profound effect on the children of Arkansas.

Our pediatricians, and our social workers, as Senator Baucus mentioned, across the State are seeing an alarming

number of exposed children. I have traveled with some of our law enforcement to see what they are up against and what these children are up against.

Not only have the children been neglected by parents who abuse meth, but many of them are so exposed to the toxic fumes while their parents are cooking, others are just victims of accidental poisoning or chemical burns. I have been to some of the methamphetamine cooking sites.

Some of the horror stories have just been phenomenal, mothers giving birth to sickly infants with meth in their system already, child abuse investigators that are discovering babies in cribs that are in the same room where their parents are cooking the methamphetamines.

I have actually been to one of the sites where they were cooking the methamphetamines and they were actually trying to sterilize the baby bottles on the same stove-top. It was just horrific.

These children that are being raised around the meth labs are now starting to exhibit the developmental and the mental problems for long-term exposure to the toxic fumes. I think, sadly, these stories go on and on.

But I am so encouraged that we are here today under the leadership of our Chairman and Senator Baucus to consider the Improving Outcomes for Children Affected by Meth Act. I am hopeful that the additional funds will go

where they are needed most, and that is to protect the thousands of children across our country who are being endangered by this terrible epidemic every single day, under circumstances they have absolutely no control over.

So I thank you, Mr. Chairman, and I thank Senator Baucus for really bringing this forward. It is a meaningful step for us to take.

The Chairman. I have been told that we are one short of a quorum, and that at least two or three other people are on their way.

Go ahead, Senator Bunning.

Senator Bunning. Well, I just would like to comment about methamphetamine and the problems.

The Chairman. Do that now.

Senator Bunning. Not only in your two States, not only in Arkansas. I just want to tell you one story that will emphasize just how bad the problem is in Kentucky.

I am driving south on I-75 between northern Kentucky and Lexington, Kentucky, and I get about half-way there and the traffic is dead stopped, nobody is going one way or the other.

So I brilliantly called the State Police and found out what was holding up the traffic. It was a moving methamphetamine lab that they had stopped for fear of exploding about 10 miles north of Lexington. Now, we

have about 48 counties in Kentucky, and this is the number-one problem.

I compliment you and Senator Baucus on this bill. It is much needed, and I urge its passage.

The Chairman. All right.

Senator Baucus. If I might, just very briefly, Mr. Chairman.

The Chairman. Please.

Senator Baucus. I mention, Senator Bunning--and you would be interested to hear this--you and Kentucky many times in Montana when I talk about methamphetamine. It was not too long ago and I was trying to get some money for HIDA, which is law enforcement money, as you well know, to combat methamphetamine.

You were about four or five seats away and said, hey, we have got to do something like that for Kentucky. We have a methamphetamine problem in Kentucky. So I keep pointing out that this is not just a Montana problem, that this is a national problem, and I mention Kentucky many times.

The Chairman. Thank you, Senator Baucus.

Senator Thomas? Then I think we are prepared to vote.

Senator Thomas?

Senator Thomas. Everyone is here. I just want to

say, I am on Indian Affairs and I appreciate very much you bringing this up. We talked about, it was a matter of jurisdiction, and it is over here now.

The methamphetamine thing, I think we just need to understand that it does a number of things, family preservation, family support, time-limited family reunification, adoption promotion and support. It does not cost additional money over what was already there. So, I urge passage, and thank you for bringing these two bills forward.

The Chairman. All right.

I ask, then, that the committee favorably report the Medicare, Medicaid and SCHIP Indian Health Improvement Act of 2006.

Senator Baucus. I so move we pass that, Mr. Chairman. I will help it along here.

The Chairman. All right. Those in favor, say aye.

[Chorus of ayes]

The Chairman. Those opposed, say no.

[No response]

The Chairman. It is quite obvious that the ayes have it. The bill is favorably reported.

I would ask Senator Baucus to move the next one.

Senator Baucus. Mr. Chairman, I move the passage of the next piece of legislation, that is, the Meth Act of

2006.

The Chairman. All right. Those in favor, say aye.

[Chorus of ayes]

The Chairman. Those opposed, say no.

[No response]

The Chairman. It is obvious the ayes have it. The bill is favorably reported.

Finally, then, I would ask unanimous consent that the staff have the authority to draft any necessary technical conforming changes to the Chairman's mark of both bills considered today. Without objection, that is ordered.

[No response]

The Chairman. I thank everybody for their kind cooperation.

[Whereupon, at 11:55 a.m. the meeting was concluded.]

I N D E X

UNITED STATES SENATE
COMMITTEE ON FINANCE

Charles E. Grassley, Chairman

Thursday, June 8, 2006

215 Dirksen Senate Office Building

Agenda for Business Meeting

1. An original bill entitled, "Medicare, Medicaid and SCHIP Indian Health Care Improvement Act of 2006.

2. An original bill entitled, "Improving Outcomes for Children Affected by Meth Act of 2006.

The Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006

Section 1. Short Title; Table of Contents

Current Law

No provision.

Chairman's Mark

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

Section 2. Expansion of payments under Medicare, Medicaid and SCHIP for All Covered Services Furnished by Indian Health Programs

(a) Medicaid

Current Law

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

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

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

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

Chairman's Mark

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

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

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

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

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

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

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

(b) Medicare

Current Law

The Social Security Act generally prohibits payment to any federal agency for services which would otherwise be covered under Medicare. However, Section 1880 of the Act provides an exception for IHS facilities. Section 1880(a) provides an exception for hospitals and skilled nursing facilities (SNF) whether operated by the Service or by an Indian tribe or tribal organization if and for so long as the entity meets the conditions and requirements for payments generally applicable to such facilities under Medicare. Section 1880(b) established a temporary provision for submission of an acceptable compliance plan for a hospital or SNF not meeting all of these conditions and requirements in 1976. Section 1880(c) specifies that payments to which any hospital or SNF of the IHS is otherwise entitled is to be placed in a special fund to be held by the Secretary. The Secretary is to use the payments (to the extent provided in appropriations Acts) exclusively for the purpose of making improvements in hospitals and SNFs which may be needed to achieve compliance with Medicare conditions and requirements. The provision would cease to apply when the Secretary determined and certified that substantially all the hospitals and SNFs of the IHS are in compliance. Section 1880(d) specifies that the annual report of the Secretary (required by the Indian Health Care Improvement Act) is to include a detailed statement of the status of hospitals and SNFs in terms of their compliance and of their progress toward achievement of such compliance.

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

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

Chairman's Mark

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

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

New Section 1880(c) would provide a cross reference to the special fund established under Section 401(c)(1) of the IHCIA for provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is entitled under Medicare in a special fund. It would provide a further cross reference to section 401(c)(1)(A and B) of the IHCIA, which require the Secretary to ensure that 100% of the payment for which facilities are eligible are paid out, and further requires facilities to use any amounts in excess of the amount necessary to achieve or maintain compliance for the purposes of improving IHS facilities.

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

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

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

(c) Application to SCHIP

Current Law

No provision.

Chairman's Mark

This provision would apply all but one subsection of these Medicaid provisions to the SCHIP program, including: (1) the provision regarding eligibility of Indian entities to receive reimbursement (as defined in the new Section 1911(a)); (2) the provision regarding compliance with conditions and requirements (as defined in the new Section 1911(b)); (3) the provision regarding the authority of the Secretary of HHS to enter into

agreements with states to provide Medicaid reimbursement to Indian entities (as defined in the new Section 1911(c)); (4) the provision regarding direct billing (as defined in the new Section 1911(e); and (5) the provision defining terms referring to Indian entities (as defined in the new Section 1911(f)). The provision regarding the special fund for improving IHS facilities (as defined in the new Section 1911(d)) would not apply to SCHIP.

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

Section 401, which revises Section 401 of the Indian Health Care Improvement Act Amendments of 2005, as reported (S. 1057), would amend parts of Sections 401, 402, and 405 of the Indian Health Care Improvement Act. Section 401(a), which is identical to Section 401(a) of S. 1057, would expand to SCHIP the prohibition in IHCIA on any Medicare and Medicaid payments received by a hospital or skilled nursing facility (SNF) of IHS (whether operated by the IHS, a tribe, or tribal organization under a Indian Self-Determination Act contract) for services provided to eligible Indians from being considered in determining appropriations for health care and services to Indians. Section 401(a) would also expand the prohibition to cover any such payments received by an Urban Indian Organization, and to cover payments for any services provided, not just services from hospitals or SNFs.

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

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

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

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

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

Section 3. Increased Outreach to Indians Under Medicaid and SCHIP and Improved Cooperation in the Provision of Items and Services to Indians Under Social Security Act Health Benefit Programs.

Current Law

No provision in Social Security Act.

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

Chairman's Mark

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

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

The new Section 1139(b) would require the Secretary, acting through CMS, to take such steps as necessary to facilitate cooperation with and agreements between states,

and the IHS, Indian Tribes, Tribal Organizations, or Urban Indian Organizations relating to the provision of benefits to Indians under Medicare, Medicaid, and SCHIP.

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

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

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

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

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

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

Section 4. Additional Provisions to Increase Outreach to, and Enrollment of, Indians in SCHIP and Medicaid

(a) Nonapplication of 10% Limit on Outreach and Certain Other Expenditures

Current Law

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

Chairman's Mark

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

(b) Assurance of Payments to Indian Health Care Providers for Child Health Assistance

Current Law

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

Chairman's Mark

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

(c) Inclusion of Other Indian Financed Health Care Programs in Exemption from Prohibition on Certain Payments

Current Law

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

Chairman's Mark

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

(d) Satisfaction of Medicaid Documentation Requirements

Current Law

Under the Deficit Reduction Act of 2005 (DRA), states are prohibited from receiving federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. Satisfactory evidence includes one document (from a list specified in the law) that provides reliable documentation of identity and proof of U.S. citizenship or nationality. Satisfactory evidence also includes one document (from a list specified in the law) that provides proof of U.S. citizenship or nationality and one document (also from a list specified in the law) that provides reliable documentation of identity.

Section 6036(a)(2) of DRA specifies that the requirements do not apply to an alien who is (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits,

(2) eligible for Medicaid on the basis of receiving Supplemental Security Income (SSI) benefits, or (3) eligible for Medicaid on such other basis as the Secretary of HHS may specify that satisfactory evidence had been previously presented.

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

Chairman's Mark

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

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

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

(e) Definitions.

Current Law

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

Chairman's Mark

For SCHIP purposes, the provision would specify that the terms "Indian," "Indian Health Program," "Indian Tribe," "Tribal Organization," and "Urban Indian Organization" have the same meanings given those terms in Section 4 of the IHCIA.

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

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

Section 5. Premiums and Cost Sharing Protections Under Medicaid, Eligibility Determinations Under Medicaid and SCHIP, and Protection of Certain Indian Property from Medicaid Estate Recovery.

(a) Premiums and Cost Sharing Protection Under Medicaid

Current Law

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

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

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

Chairman's Mark

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

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

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

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

(b) Treatment of Certain Property for Medicaid and SCHIP Eligibility

Current Law

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

There is no similar provision in current SCHIP law.

Chairman's Mark

Notwithstanding any other federal or state law, the provision would prohibit consideration of four different classes of property in determining Medicaid eligibility. These classes include: (1) property located on a reservation, including any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act (ANCSA), and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs; (2) for any federally recognized Tribe not described in the first class, property located within the most recent boundaries of a prior federal reservation; (3) ownership interests in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights; and (4) ownership interest in or usage rights to items not covered in the previous classes that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

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

(c) Continuation of Current Law Protections of Certain Indian Property From Medicaid Estate Recovery

Current Law

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

Chairman's Mark

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

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

Section 412, which replaces Section 412 of S.1057, as reported, would add a new Section 412 to the Indian Health Care Improvement Act, concerning Indian cost sharing and treatment of Indian property under Medicaid and SCHIP. Section 412(1) adds a cross-reference to Sections 1916(j) and 1916A(a)(1) of the Social Security Act, as

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

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

Section 6. Nondiscrimination in Qualifications for Payment for Services Under Federal Health Programs.

Current Law

No provision.

Chairman's Mark

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

the professional was licensed in another state. This would be in accordance with Section 221 of the IHCIA.

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

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

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

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

Section 7. Consultation on Medicaid, SCHIP and Other Health Care Programs Funded Under the Social Security Act Involving Indian Health Programs and Urban Indian Organizations.

Current Law

There are no provisions in current Medicaid or SCHIP statutes regarding a Tribal Technical Advisory Group (T-TAG) within the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare, Medicaid and SCHIP programs. Current federal guidance requires states submitting waivers under Section 1915 or 1115 of the Social Security Act to engage in the following activities related to consultation with Tribal Governments in their state: (1) notify in writing all federally-recognized Tribal Governments maintaining a primary office in the state at least 60 days before submitting the waiver or renewal of the state's intent to submit such waiver or renewal to CMS; (2) ensure the notice to the tribal Government describes the purpose of the waiver or renewal and anticipates the impact on tribal members; (3) ensure the notice also describes a method for appropriate Tribal representatives to provide official written comments and questions in a timeframe allowing state analysis and consideration and discussion between the states and the Tribes responding to the notice; (4) provide Tribal Governments with a reasonable period of at least 30 days in which to respond to the notice; and (5) provide an opportunity for an in-person meeting with Tribal representatives to discuss issues.

Chairman's Mark

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

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

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

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

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

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

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

Section 8. Sanctions Under the Social Security Act

Current Law

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

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

Chairman's Mark

The provision would add an additional subsection to New Section 1139, as added by Section 3, and amended by Sections 6 and 7, of this bill. New Section 1139(e) would

establish a process for requesting waivers of sanctions imposed against a health care provider under Title XI of the Social Security Act (General Administrative provisions). The process would apply insofar as the provider provided services through an Indian Health Program. The administrator of the affected Indian Health Program would petition the Secretary directly for a waiver.

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

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

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

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

Indian Tribes, Tribal Organizations, or Urban Indian Organizations and of the patients served by such entities.

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

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

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

Section 9. Rules Applicable Under Medicaid and SCHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities

(a) In General (for Medicaid)

Current Law

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

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

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

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

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

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

Chairman's Mark

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

The provision would stipulate that contracts with Medicaid MCEs must require those MCEs with a significant percentage of Indian enrollees (as determined by the Secretary), to meet other requirements as a condition of receiving Medicaid payments. These conditions include: (1) such MCEs must demonstrate that the number of participating Indian health care providers is sufficient to ensure timely access to covered Medicaid managed care services for those enrollees who are eligible to receive services from such providers; or (2) such MCEs must agree to pay non-participating Indian health

care providers (except for non-participating FQHCs and non-FQHC Indian Health providers that have a Memorandum of Agreement between CMS and the Indian Health Service) at a rate equal to the rate negotiated between such entity and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE would make for services rendered by a participating non-Indian health care provider. Special Medicaid payment rules would apply to an Indian health care provider that is an FQHC that does not participate with a Medicaid managed care entity. Payments to such non-participating FQHCs would be at rates otherwise applicable to FQHCs that are participating providers with the MCE. These provisions do not waive the existing requirement that states make supplemental payments due to a FQHC for services rendered under a contract with an MCE to bring the payment rate up to the rate owed under the prospective payment system. Indian health providers that are not federally qualified health care centers, and that elect to receive payment under Title XIX as an Indian Health provider under the Memorandum of Agreement between CMS and the Indian Health Service effective July 11, 1996 will also be eligible to receive a supplemental payment for that service in the same manner as a federally qualified health center under 1902(bb)(5).

In addition, such MCEs must agree to make prompt payment (in accordance with rules applicable to MCEs) to participating Indian health care providers or, in the case of a non-participating Indian health care provider (excluding non-participating FQHCs), the second condition listed above must apply. The provision also stipulates that the submission of a claim or other documentation for services by the IHP or UIO (consistent with Section 403(h) of the IHCIA) would be deemed to satisfy any requirement for an enrollee to submit a claim or other documentation. The provision would also require that as a condition of payment for covered services, the IHP or UIO comply with all generally applicable Medicaid requirements to the extent that these requirements do not conflict with other requirements or prohibitions imposed on the IHP or UIO through other statutes. The IHP or UIO shall only need to comply with those generally applicable requirements of a managed care entity as a condition of payment that are necessary for the entity's compliance with the State Plan such as those related to care management, quality assurance and utilization management.

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

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

The provision also contains a number of special rules that would be applicable to Indian MCEs. With respect to enrollment, Indian Medicaid MCEs could restrict

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

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

With respect to special rules for Indian Medicaid MCEs and advance directives, the provision would allow the Secretary to modify or waive requirements related to maintenance of written policies and procedures for such directives, if the Secretary finds that these requirements are not an appropriate or effective way to communicate such information to Indians.

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

In general, the provision specifies that under a Medicaid managed care program, if a health care provider is required to have medical malpractice insurance as a condition of contracting with a Medicaid MCE, an Indian health care provider that is either (1) a

FQHC that is covered under the Federal Tort Claims Act; (2) a provider that delivers services pursuant to a contract under the Indian Self-Determination and Education Assistance Act, would be deemed to satisfy such a requirement; or (3) the Indian Health Service, which is covered under the Federal Tort Claims Act.

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

(b) Application to SCHIP

Current Law

Under Title XIX, Section 1932(a)(2)(C) stipulates the rules regarding Indian enrollment in Medicaid managed care. A state may not require an Indian (as defined in Section 4(c) of the IHCIA) to enroll in a managed care entity unless the entity is one of the following (and only if such entity is participating under the plan): (1) the IHS, (2) an IHP operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or (3) an urban IHP operated by a UIO pursuant to a grant or contract with the IHS pursuant to Title V of the IHCIA.

Chairman's Mark

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

For Informational Purposes Only, Background on Provision Contained in Amendment of S. 1057

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

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

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

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

Section 413(d) of S. 1057, as reported, would deem requirements that Medicaid managed care programs' health care providers have medical malpractice insurance

coverage, as a condition for contracting with a managed care entity, to be satisfied if the Indian Health Program, or an Urban Indian Organization that is a federally-qualified health center, is covered by the Federal Tort Claims Act. Section 413(e) would define certain terms for the section.

Section 10. Annual Report on Indians Served by Social Security Act Health Benefit Programs .

Current Law

No provision.

Chairman's Mark

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

Section 11. Effective Date

Current Law

No provision.

Chairman's Mark

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

The Improving Outcomes for Children Affected by Meth Act of 2006

SECTION 1 – SHORT TITLE; TABLE OF CONTENTS

The short title of this bill is the Improving Outcomes for Children Affected by Meth Act of 2006.

SECTION 2 -- GRANTS FOR REGIONAL PARTNERSHIPS TO INCREASE THE WELL BEING OF, AND IMPROVE THE PERMANENCY OUTCOMES FOR, CHILDREN AFFECTED BY METHAMPHETAMINE ABUSE AND ADDICTION

Reservation of Funds

Current Law

There is no provision for grants to regional partnerships intended to improve the well-being and permanence outcomes of children affected by methamphetamine abuse and addiction. (For FY2006 the mandatory funding level authorized for the Promoting Safe and Stable Families program (Title IV-B, Subpart 2 of the Social Security Act) is $345 million and the discretionary funding level is authorized at up to $200 million.)

Chairman's Mark

The mark provides that in any year from FY2007-FY2011 that appropriations under this subpart are at least $345 million HHS must reserve $40 million for grants to improve outcomes for children affected by methamphetamine abuse and addiction. (The mark separately sets the mandatory funding authorization for the Promoting Safe and Stable Families (PSSF) program at $345 million for FY2007-FY2011 and continues the discretionary funding authorization of $200 million for each of those same years.)

Purpose

Current Law

No provision.

Chairman's Mark

The mark creates a new section in Title IV-B Subpart 2 of the Social Security Act that authorizes HHS to make competitive grants to regional partnerships that provide services and

activities designed to increase the well being of and improve the permanency outcomes for children who are in an out-of-home placement or who are at risk of such a placement as a result of parental or a caretaker's abuse of methamphetamines. These services and activities are to be provided via interagency collaboration and integration of programs and services.

Eligible Applicants

The mark defines an eligible applicant for the grants as a regional partnership (established on an intra-or interstate basis) and that includes any one or more of the following entities or individuals: child welfare service providers (non-profit and for-profit), community providers of health or mental health services, local law enforcement agencies, judges and court personnel, juvenile justice officials, school personnel, the state child welfare agency, the state agency responsible for administering the substance abuse prevention and treatment block grant (authorized under Title XIX–B, Subpart II of the Public Health Services Act), tribal child welfare agencies (or a consortium of tribal agencies) and any other providers, agencies, personnel, officials or entities related to provision of child and family services funded under Title IV-B, Subpart 2 of the Social Security Act.

Authorization of Grants and Minimum Period of Approval

From the amount reserved from PSSF funding ($40 million), HHS must award grants in each of FY2007–FY2011 to eligible regional partnerships that meet the requirements established in this new section of the Social Security Act. An eligible regional partnership must be approved to receive a grant for no less than two years and may receive approval for as many as five years. The amount of the grant must not be less than $500,000 and not more then $1 million for each fiscal year.

Application Requirements

To be eligible for a grant out of this funding, an eligible regional partnership must submit a written application to HHS containing recent evidence that methamphetamine abuse has increased out-of-home placements for children or the number of children at-risk of out-of-home placements in the partnership region. The application must also describe 1) the goals and outcomes the regional partnership intends to achieve and which will enhance the well-being of children receiving services or taking part in activities funded by the grants and will lead to safety and permanence for them; 2) the joint activities to be funded (entirely or in part) with funds provided by the grant and the sequence in which the proposed activities will be conducted while the grant funding is made available; 3) the strategies for integrating programs and services found to be appropriate for the child (and, if appropriate, the child's family); and 4) its strategies for collaborating with the state child welfare agency (unless the lead agency for the regional partnership is that agency), for consulting, as appropriate, with the state agency responsible for administering substance abuse treatment and prevention services, and for consulting with state law enforcement and judicial agencies. Finally, the application must include any other information HHS may require.

HHS may, to the extent it deems appropriate, exempt any regional partnership that includes a tribal child welfare agency or a consortium of such agencies from the requirement that the application describe what its strategies will be for collaborating with the state child welfare agency.

Use of Funds and Matching Requirement

The mark states that funds received by a regional partnership must only be used for services and activities intended to improve the well-being and permanence of children affected by methamphetamine abuse and addiction and where appropriate, the child's family. Specific uses may include providing family-based, comprehensive long-term drug treatment services, early intervention and preventative services, counseling for children and families, mental health services, and parenting skills training.

The mark provides that a regional partnership must provide non-federal resources to support the activities and services of the grant equal to 15% of the total cost in years one and two of the grant; 20% of such costs in the third and fourth years; and 25% for the fifth year of the grant. The non-federal resources may be in cash or in-kind (and HHS is permitted to attribute the fair market value of such in-kind goods, services and facilities).

Consideration in Making Awards and Determining their Amounts

The mark provides that in considering whether to award a grant and the amount of that grant, HHS must consider the demonstrated need of the eligible regional partnership applying for assistance. Further it must ensure diversity among the lead agencies applying on behalf of an eligible regional partnership to which it awards these grants. Finally in awarding these grants and determining their amounts, HHS must give priority to eligible regional partnerships in rural areas that have been significantly affected by methamphetamine abuse and addiction by parents or caretakers of children; have limited resources to address the needs of children affected by this abuse and addiction; and lack capacity for access to comprehensive family treatment services.

Performance Indicators

The mark requires HHS to establish indicators that will be used to periodically assess the performance of the regional partnerships awarded grants under this section and, specifically, their success in achieving increased well being and improved permanence outcomes for children affected by parental or a caretaker's methamphetamine abuse and addiction. The indicators must be established no later than 18 months after this legislation is enacted and only after HHS consults with both its Administration for Children and Families (ACF) and its Substance Abuse and Mental Health Administration (SAMHSA). In addition -- with respect to the states, territories, or tribes in which awards to regional partnerships have been made – HHS must consult with the following individuals: state and territorial governors, state legislators, state and local public officials responsible for administering child welfare and alcohol and drug abuse

prevention and treatment programs, court staff, consumers of service or activities funded by the grants, advocates for children and parents who come to the attention of the child welfare system, and tribal officials.

Grantee Reports and Reports to Congress

The mark requires each regional partnership that receives a grant under this section to report annually to HHS. The report must describe the activities carried out during the fiscal year with funds received under this grant, and any information HHS determines necessary to provide an accurate description of the activities conducted with the funds and of any planned changes in the use of the funds for the succeeding fiscal year. A regional partnership must submit its first annual report no later than September 30 of the first fiscal year that it receives this grant funding and, by that same date for each year in which it continues to receive the grant funds. In addition, no later than 12 months after HHS establishes the performance indicators (described above), information regarding these indicators must be incorporated into each regional partnership's annual report.

On the basis of these reports from the regional partnership grantees, the mark requires HHS to annually prepare a report on the services provided and activities conducted by the grants to increase the well being of and improve permanence outcomes for children affected by parental or a caretaker's methamphetamine abuse and addiction. The report must also discuss the performance indicators established and the progress made to address the needs of families with methamphetamine abuse problems (who come to the attention of the child welfare system) and in achieving the goals of child safety, permanence and family stability. HHS must annually submit this report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

SECTION 3 – REAUTHORIZATION OF THE PROMOTING SAFE AND STABLE FAMILIES PROGRAM

Extension of Funding Authorized for the Promoting Safe and Stable Families program

Current Law

For FY2006, authorizes mandatory funding of $345 million for the Promoting Safe and Stable Families program (Title IV-B, Subpart 2 of the Social Security Act) and discretionary funding of $200 million for each of FY2002-FY2006.

Chairman's Mark

The mark extends the mandatory PSSF funding authorization of $345 million for five years (FY2007-2011) and extends the discretionary funding authorization of $200 million for each of those same five years.

Extension of Court Entitlement to Allotment of Set-aside Funds and Required Match

Current Law

For each of FY2002 - FY2006, each eligible state highest court is entitled to an allotment of funds to assess and make improvements to its handling of child welfare proceedings. This allotment is provided out of funds set-aside from the total funding provided for the Promoting Safe and Stable Families program. (The minimum which must be provided via this set-aside is $10 million per year and the maximum amount which may be available is $16.6 million per year.) In order to receive their full allotment of funds in each of these years, the state highest court must provide a 25% match of the federal funds it is allotted.

Chairman's Mark

The mark extends the entitlement of eligible state's highest courts to this same allotment amount from funds set-aside out of the Promoting Safe and Stable Families program appropriations for each of FY2007-FY2011 and it continues to condition a state highest court's full receipt of its allotment in each of those same five years on provision of a 25% funding match by the court.

Technical Correction of Funding of Promoting Safe and Stable Families for FY2006

Current Law

In December 2005 the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006 (P.L. 109-149) appropriated $305 million in mandatory funds for the Promoting Safe and Stable Families program for FY2006. (At the time this was the full mandatory funding level authorized for the program.) The Deficit Reduction Act of 2005, which was enacted in February 2006, raised the mandatory funding authorization for the program to $345 million for FY2006.

Chairman's Mark

The mark amends P.L. 109-149 to increase the FY2006 mandatory appropriation provided for the Promoting Safe and Stable Families program to $345 million effective as of February 8, 2006.

SECTION 4 – REAUTHORIZATION AND EXPANSION OF THE MENTORING CHILDREN OF PRISONERS PROGRAM

Purposes Amended

Current Law

Provides that the purpose of the Mentoring Children of Prisoners program (Section 439 of the Social Security Act) is to authorize the U.S. Department of Health and Human Services (HHS) to make competitive grants to support the establishment or expansion and operation of programs that provide mentoring services to children of prisoners (via a network of public and private community entities) and which are in areas with substantial numbers of children who have incarcerated parents.

Chairman's Mark

The mark adds a new purpose of this program. That purpose is to authorize HHS to enter into a cooperative agreement with a national mentoring support organization to provide greater flexibility nationwide to increase the number of children of prisoners receiving mentoring services.

Extension of the Mentoring Children of Prisoners Program

Current Law

Out of the funding provided for this program, requires HHS to make grants in each of FY2002-FY2006 for provision of mentoring services to children of prisoners. The grants may be made to eligible State or local governments, tribal governments or consortia, faith-based organizations, and community-based organizations.

Chairman's Mark

The mark extends the requirement that HHS make grants (to State or local governments, tribal governments or consortia, faith-based organizations, and community-based organizations) for the provision of mentoring services to prisoners for each of FY2007-FY2011.

Increased Access to Mentoring Services

Current Law

No provision.

Chairman's Mark

The mark establishes requirements for a cooperative agreement between HHS and a national mentoring support organization. HHS must award the cooperative agreement on a competitive basis to a national mentoring support organization that has substantial experience in mentoring and mentoring services for children, and in developing quality program standards for planning and assessing mentoring programs for children. The purpose of the cooperative agreement is for this national mentoring organization to 1) identify and approve mentoring programs in all 50 states and the District of Columbia that meet certain quality program standards; 2) organize outreach activities to increase awareness among families of children of prisoners of the availability of vouchers for mentoring services (including making publicly available a list of approved programs to public and private entities); and 3) distribute vouchers directly to approved programs that have been selected by families of children of prisoners to provide mentoring services for their children.

Application Requirements

The mark requires an organization seeking to enter this cooperative agreement with HHS to submit an application to HHS that demonstrates its experience with mentoring and mentoring services for children and with the development of quality program standards for planning and assessing mentoring programs for children. The application must also include a plan that details the proposed voucher distribution program and must include the quality program standards for mentoring developed by the entity and describe how the entity will organize and implement these quality program standards. The entity must further describe in its application how it will organize and implement the distribution of vouchers, including how it will ensure that children in urban and rural communities and children with other geographic, linguistic, or cultural barriers to receipt of mentoring services will have access to such services; and that, if the entity usually provides gender-specific programs or services, both girls and boys will be appropriately served by the program. Finally, in its application the entity must also identify those organizations it knows that comply with quality program standards for mentoring; describe the strategic plan of the entity to work with families of prisoners to develop the list of mentoring programs that accept vouchers distributed under this program; and describe the methods that it will use to evaluate the voucher program, the extent to which the program is achieving the purposes of the cooperative agreement and supports the establishment or expansion and operation of programs that provide mentoring services to children of prisoners in areas where there are substantial numbers of children with incarcerated parents.

In addition, the mark specifies that as a part of the application the entity must agree to 1) include criminal background checks of mentors in any quality program standards for approved mentoring programs; 2) maintain records, make reports, and cooperate with reviews and audits that HHS finds necessary as part of overseeing the cooperative agreement and expenditures; 3) cooperate fully with the ongoing and final evaluation of the voucher program, including allowing HHS access to the voucher distribution program, program-related records and documents, and staff, as well as, to the mentoring programs to which vouchers were distributed; and 4) to provide

any other information HHS finds necessary to show the entity's capacity to carry out the cooperative agreement.

The mark states that the value of a voucher under this subsection can be disregarded for purposes of determining the eligibility for – or the amount of – any other federal, or federally supported assistance for the recipient family.

Evaluations and Reports

Current Law

Requires HHS to conduct an evaluation of the mentoring programs conducted under the Mentoring Children of Prisoners provisions and to submit to Congress a report on the findings no later than April 15, 2005.

Chairman's Mark

The mark requires HHS to conduct evaluations of the programs authorized under the Mentoring Children of Prisoners provisions, including the program for increased access to mentoring services (via vouchers) that is created in this legislation.

The mark provides that no later than 12 months after the enactment of this legislation, HHS must submit a report to Congress that includes: 1) the characteristics of the mentoring programs funded under this section; 2) the plans for implementation of the cooperative agreement to increase access to mentoring services (including through distribution of vouchers); and 3) a description of the outcome-based evaluation of the programs authorized under this section (which HHS is conducting as of the date of the bill's enactment), including how the evaluation has been expanded to evaluate the program to increase access to mentoring services through distribution of vouchers; and 4) the date by which HHS will submit to Congress a final report on this evaluation.

Authorization of Discretionary Appropriations for Mentoring Children of Prisoners

Current Law

For each of FY2002 and FY2003, authorizes discretionary appropriations of $67 million for the Mentoring Children of Prisoners program; authorizes appropriations for this program in every succeeding year (indefinite or no-year limit) at "such sums as may be necessary".

Chairman's Mark

The mark authorizes appropriations up to $67 million for each of FY2007-FY2011.

Reservation of Program Funds for Mentoring Voucher Program

Current Law

Annually provides that 2.5% of the funds appropriated for Mentoring Children of Prisoners must be reserved for HHS to spend on research, technical assistance and evaluation related to the programs funded.

Chairman's Mark

The mark retains the current set-aside for research, technical assistance and evaluation. It further requires HHS to reserve not more than 50% of the total amount appropriated for each fiscal year to carry out the new program for increasing access to mentoring services (via vouchers). However, HHS must use at least $25 million of the appropriated funds to continue providing competitive grants to programs that provide mentoring services to children of prisoners. And if the total appropriation for the Mentoring Children of Prisoners program is less than $25 million, no funds would be available for the purpose of increasing access to mentoring services (via vouchers).

GAO Evaluation and Report

Current Law

No provision

Chairman's Mark

No more than 3 years after the enactment of this legislation, the Government Accountability Office (GAO) must submit to Congress a report evaluating the implementation and effectiveness of the program first authorized by this legislation for increasing access to mentoring services **(via vouchers)**.

SECTION 5 – ALLOTMENT AND GRANTS TO INDIAN TRIBES

Increase Set-aside for Tribal Promoting Safe and Stable Families Programs

Current Law

Requires that 1% of all mandatory Promoting Safe and Stable Families funds, and 2% of any discretionary appropriations for the program, be set aside for tribal programs. (The minimum tribal funding provided is $3.45 million and the maximum annual tribal funding possible is $7.45 million.)

Chairman's Mark

The mark requires that 3% of all mandatory Promoting Safe and Stable Families funds, and 3% of any discretionary appropriations for the program, be set aside for tribal programs. (The minimum tribal funding provided would be $10.35 million and the maximum annual tribal funding possible would be $16.35 million.)

Access to Allotment for Tribal Consortia

Current Law

Out of the tribal funds reserved, Indian tribes or tribal organizations with an approved plan must be allotted Promoting Safe and Stable Families funds (based on the relative share of tribal persons under age 21 but only among tribes or tribal organizations with approved plans). HHS may exempt a tribe from any plan requirement that it determines would be inappropriate for that tribe (taking into account the resources, needs, and other circumstances of that tribe). However, no tribe or tribal organization may have an approved plan (or receive funds) unless its allotment is equal to at least $10,000. Funds allotted are paid directly to the tribal organization of the Indian tribe to which the money is allotted.

Chairman's Mark

The mark permits tribal consortia to have access to an allotment of Promoting Safe and Stable Families program funds (and related technical assistance) on the same basis as is currently available to Indian tribes. A tribal consortia's allotment is to be determined based on the number of tribal persons under age 21 in each tribe that is a part of the tribal consortia. A tribal consortium could select which Indian tribal organization (among the tribes in the consortium) would receive the direct payment of its allotment.

SECTION 6 – STATE PLAN AMENDEMENTS

Monitoring and Evaluation of Families Adopting or Supporting Significant Numbers of Children

Current Law

In order to receive Promoting Safe and Stable Families funds states must provide certain assurances to HHS.

Chairman's Mark

The mark adds a new condition of funding under the program, which would require states to establish procedures to provide additional evaluation of any family that seeks to provide foster care to, or to adopt, a large number of children or more than one sibling group. This additional evaluation, which must be done before the placement is made, is to fully assess whether the family has the ability to care for this number of children. The statute provides that states must establish this additional evaluation procedure for a family seeking to care for, or adopt, more than 4 children or more than one group of siblings, or -- provided the state can demonstrate good cause for this and receives approval from HHS – any other certain number of children or sibling groups the state chooses.

In the case of a foster family, the procedures must also provide for ongoing monitoring to assess the family's continued ability to provide for this number of children or sibling groups. In the case of a family seeking to adopt the procedures must include monitoring before the adoption is permitted to enable the agency to assess whether the family has the ability to care for this number of children or siblings.

Within 18 months of the legislation's enactment, and as a condition for continued approval of its PSSF plan, the state must submit to HHS a plan for implementing these procedures. Within 60 days of its receipt of such a plan from a state, HHS must notify the state of its approval of the plan or of any necessary additions or modifications that must be made before it can be approved.

State Submission of Annual Expenditure Reports to HHS and Provision of Report to Congress

Current Law

States must spend "significant portions" of the funds they receive under the Promoting Safe and Stable Families program on four categories of services: family support, family preservation, time-limited family reunification, and adoption promotion and support; and they may spend no more than 10 percent of the funds to administer the program. Every five years states must develop a plan, including goals, for the use of the program funds and the plan must be made available to HHS and to the public. Further states must annually review their progress in meeting those goals and they must separately submit to HHS (and make available to the public) descriptions of the service programs they intend to provide in the upcoming fiscal year (within each of the four service categories), the geographic areas where these services will be available, and the populations that will be served. Finally states are required to furnish such reports to HHS, in whatever format and containing whatever information it may require.

As implemented by HHS states are required to spend at least 20% of their Promoting Safe and Stable funds on each of the four service categories (unless they can provide an "especially strong rationale" for not doing this). Every five years states must prepare a five-year Child and Family Services Plan (CFSP) that establishes goals and describes the state's plan for provision of child and family services under the Promoting Safe and Stable Families program, as

well as, across a range of federal child welfare programs (including Child Welfare Services under Title IV-B, Subpart 1 of the Social Security Act; State Grants, under the Child Abuse Prevention and Treatment Act; and the Chafee Foster Care Independence Program and related Education and Training Vouchers, both under Section 477 of the Social Security Act). In addition, states must each year submit an Annual Progress and Services Report, the CFS-101 Part I -Annual Budget Request, and the CFS-101 Part II - Annual Summary of Child and Family Services. The reports must be submitted to the regional offices of the HHS Administration for Children and Families (ACF).

On form CFS-101 Part I states report how they intend to allocate their Promoting Safe and Stable Families funds (between the four service categories) for the upcoming fiscal year and also request their funding allotments for Child Welfare Services, CAPTA state grants, the Chafee Foster Care Independence Program and Education and Training Vouchers. On form CFS-101, Part II states report how they expect to spend all child welfare dollars (federal and state) in thirteen separate categories (and by specific federal funding stream). States must also report on the number of families or individuals expected to be served and the geographic areas that will be served. This information is due to the HHS regional office three months before the start of the fiscal year for which funds are being requested (e.g. by June 30, 2005 for request of FY2006 funds).

Chairman's Mark

No later than June 30 of each year, the mark requires states to submit to HHS one copy of the forms CFS- 101, Part I and CFS-101 Part II (or any successor forms) with information concerning *planned expenditures* for child and family services in the immediately succeeding fiscal year as well as a second set of the same forms showing the *actual expenditures* for child and family services in the immediately preceding fiscal year. However, with regard to the form (CFS-101 Part II) used to show *actual* expenditures by 13 separate categories and multiple funding streams, states would only be required to submit information regarding their actual expenditures for the preceding fiscal year under two federal funding streams: the Child Welfare Services and Promoting Safe and Stable Families programs (Title IV-B, Subpart 1 and 2 of the Social Security Act.)

The mark further provides that HHS must compile these reports (showing planned and actual expenditures for the specified fiscal years) and no later than September 30 of each year must submit this compilation to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate

The mark provides that the first state submission of such forms to HHS under this requirement must be made by June 30, 2007 and that HHS must submit the first compilation of such forms to Congress by September 30, 2007.

SECTION 7 – EFFECTIVE DATE

Current Law

Mandatory and discretionary funding for the Promoting Safe and Stable Families Program is authorized through FY2006, including set-asides for allotments to tribes, grants to state highest courts, and expenditures by HHS (for evaluation, training, technical assistance, and research related to the program). HHS is authorized to make grants under the Mentoring Services for Children Program through FY2006 and funding for this program is authorized indefinitely.

Chairman's Mark

The mark provides that effective with October 1, 2006, the annual funding authority (mandatory and discretionary) for the Promoting Safe and State Families program is extended through FY2011 (with current set-aside amounts continued for HHS and increased for tribes). HHS is authorized to make grants under the Mentoring Services for Children Program for each of FY2007-FY2011 (with funds authorized for that purpose for those same years).

Unless otherwise specified in the legislation, other changes made by the mark are also effective on October 1, 2006. However, if HHS determines that state legislation is required in order for a state to meet any new requirement under this legislation, the state must have until the completion of the first state legislative session after enactment of this act to comply with such new requirements.

Statement for the Finance Committee Markup
of the "Medicare, Medicaid, and SCHIP
Indian Health Care Improvement Act of 2006"
Senator Olympia J. Snowe
June 8, 2006

I would like to thank the Chairman and the Ranking Member for holding this mark-up this morning. The reauthorization of the Indian Health Care Improvement Act has a serious "past due" notice on it and I know Maine's Native American tribes are anxious for this process to move forward.

Despite the tireless efforts of our Indian health care providers, the health status of Native Americans is not in the condition it should be. Native Americans are 391 percent more likely to die from diabetes than Caucasians. Although improvements have been made in the past few decades, Native Americans and Alaska Natives have an infant death rate almost double the rate for Caucasians. In a country with the cutting edge technology and medical breakthroughs such as ours, we must do better.

Yet when tribes in Maine are asked about the biggest problem facing tribal health, funding is at the top of that list. Is that any wonder when, according to a 2004 Washington Post editorial, the Indian Health Service **spends only $1,914 per patient per year**, about half of what the government spends on prisoners ($3,803) and **far below what is spent on the average American** ($5,065)! When you couple low financial resources with severe workforce shortages, you have huge problems with health care access. This is especially true in rural areas. For example-- members of the

Micmac tribe live in just about every pocket of Aroostook County where we are experiencing severe provider shortages.

As we consider the legislation before us today, I'm particularly encouraged by steps this bill takes to help increase Medicaid and SCHIP enrollment. American Indians and Alaska Natives have the highest rate of un-insurance among any other demographic. The bill we are considering takes steps to improve access of Indians residing on or near reservations to Medicaid and SCHIP programs by providing for enrollment at or near the reservation. These outreach efforts can also include the out-stationing of eligibility workers. This is critical in rural areas. The bill also exempts Indians from Medicaid enrollment fees, premiums, deductions, co-payments, cost sharing, or similar charges for services provided by the Indian Health Service or through contract or referral. I hope that through greater outreach and education about Medicaid and SCHIP eligibility, we can make improvements in the health and well-being among all tribal members.

Throughout my years in Congress, I have enjoyed my relationship with Maine's Native American tribes – including both the Passamaquoddy and Penobscot Tribes, and Aroostook Band of Micmacs, and the Houlton Band of Maliseets. I believe that the combination of this bill, as well as the increased funding for tribal set-asides in the Promoting Safe and Stable Families Program, which we will consider next, will represent some real momentum on tribal issues.

At the end of the day, it is critical for Congress to continue to work with Native Americans to help build on these achievements, preserve the unique Native American way of life, and address the priorities of our communities.

Thank you.

The committee voted to approve both bills during this morning's mark-up.

Opening Statement of Sen. Chuck Grassley, Finance Committee Chairman,
on the *Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006*
and the *Improving Outcomes for Children Affected by Meth Act of 2006*
Thursday, June 8, 2006

Our first mark before us today is the *Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006*. This bill encompasses the provisions of the *Indian Health Care Improvement Act*, S.1057, reported by the Indian Affairs Committee on March 16, that are in the jurisdiction of the Finance Committee. This legislation today helps us keep our commitment to provide quality health care to Indians. The legislation we are considering today would allow the tribes to be able to use money from Medicare and Medicaid to maximize improvement of the care provided to Indians. This legislation provides for increased outreach for Indian tribes to assist Indians in applying for Medicaid or SCHIP. This legislation also provides relief for Indians from Medicaid cost-sharing or premiums if that Indian comes to Medicaid by contract or referral. This is a fair and balanced policy as those Indians would not be subject to cost-sharing or premiums if their care was provided by an Indian Health provider.

This legislation creates incentives for Medicaid managed care plans that enroll Indians to include Indian Health providers in their networks. Indians have relationships with their health care providers and many prefer to receive services from an Indian Health provider. Under current law, if an Indian sees a provider not in the plan's network, that provider won't likely get paid except under certain circumstances. The Chairman's Mark helps fix that by requiring managed care plans that serve a large number of Indians to include Indian Health providers in their networks or to make alternative arrangements to make sure they're paid.

Finally, this legislation requires reporting of data on Indians served, the status of their health care, and efforts being made to upgrade facilities that may not be in compliance with Social Security Act requirements. This is valuable information that will aid us in ensuring that we are providing quality care to Indians. I appreciate the efforts of Senator Baucus in helping us with this legislation as well as Senator McCain and Senator Dorgan. The work that has gone into today's markup has been a bipartisan process involving both committees. Their assistance has been invaluable.

Today we will also consider a bipartisan Chairman's Mark, the *Improving Outcomes for Children Affected by Meth Act of 2006*. This bill reauthorizes and improves the Promoting Safe and Stable Families program as well as the Mentoring of Children of Prisoners program. There is a long history of the Congress working productively on a bipartisan basis to improve child welfare. I am glad to report that this spirit of bipartisanship is alive and well on the Senate Finance Committee.

The Senate Finance Committee has held two important hearings on child welfare. These are the first hearings the Senate Finance Committee has held on child welfare issues in nearly ten years. One of those hearings dealt specifically with the effects that methamphetamine addiction has had on America's child welfare system. I am persuaded that meth abuse and addiction have created a unique and pressing problem, notably in rural states like Iowa and Montana.

During these hearings, the committee also learned the terrible toll that methamphetamine addiction is taking on Native American Indians. I am also convinced that the meth epidemic has created an unsustainable strain on an already overburdened child welfare system in states and on Indian reservations. I am very pleased to have successfully worked on this legislation with Senator Baucus. I appreciated his thoughtful comments and questions during our hearings on meth abuse and child welfare. By marking up this legislation today, members of the Senate Finance Committee have the opportunity to help address the problems that the meth epidemic has created for state child welfare systems. We do this by directing $40 million a year toward grants for regional partnerships. These partnerships will increase the well-being of, and improve the permanency outcomes for, children affected by methamphetamine abuse and addiction.

These grants will improve collaboration and coordination among providers of services for children and families. The Secretary is directed to give consideration for receipt of these grants to rural areas that have a lack of capacity for access to comprehensive family treatment services. By emphasizing comprehensive family treatment, we are promoting a promising strategy for families to recover from meth addiction together.

Additionally, the mark before us expands the Mentoring of Children of Prisoners program, so that children in areas that have not been able to access these mentoring services may gain access to these important programs. The mark also increases and improves access for needed funding for Indian Tribes as well as increases states' accountability.

These are all relatively modest improvements to a program that, while small, has worked very well. I am pleased that we were able to adopt some of the Administration's proposals as well as suggestions from members of the Senate Finance Committee. I think that these changes will improve permanency outcomes for children. I urge my colleagues to support both of the bipartisan pieces of legislation before the Committee today.

Senator John D. Rockefeller IV
Written Statement –Senate Finance Committee
The Improving Outcomes for Children Affected by Meth Act of 2006
June 8, 2006

Mr. Chairman, I would like to commend you for this legislation, the Improving Outcomes for Children Affected by Meth Act of 2006. It is a good signal that our Committee has taken a bipartisan approach for child welfare policy. This legislation will reauthorize the Promoting Safe and Stable Families Program, which I have been proud to work on with you and others for more than a decade. I also truly appreciate your leadership and Senator Baucus's leadership on developing the initiative to help regional partnerships cope with the tragedy of meth and children. The expert witnesses at the Finance hearings brought to light the dire needs of many children and families that have been struck down by the scourge of methamphetamine addiction.

The methamphetamine pilot project is an important addition to promoting Safe and Stable Families Program because the methamphetamine epidemic has become a serious burden to the child welfare system. Last year in West Virginia, the state had protective custody of 158 children who were removed from homes where people were suspected of selling or manufacturing methamphetamine.

We are also aware that this epidemic is no longer a rural state problem. This addiction has reared its dangerous head in our suburbs and urban centers. In the July 2005 survey by the National Association of Counties (NACo), 58% of the counties said methamphetamine was the number one drug problem.

I am extremely concerned because methamphetamine use has been identified as one of the most devastating addictions and because so many young mothers with infants and toddlers succumb to this addiction. It is also very worrisome that this addiction often leads to child abuse and neglect.

Breaking this addiction requires a long-term commitment to recovery and the assistance of many service agencies.

I wholeheartedly back the methamphetamine pilot project because it directly promotes child safety, permanence and family stability. I like that the guidelines for prevention and early intervention services make child safety a

paramount concern. I also can support this legislation because it stresses the importance of comprehensive and innovative treatment programs. During our recent child welfare hearings many experts reported treatment and aftercare programs that were demonstrating promising results.

I hope that the methamphetamine pilot project, Improving Outcomes for Children Affected by Meth, will stimulate innovative partnership and new approaches to help children and their family deal with the devastation of meth addiction. The goal to encourage coordination of services among the many agencies that get involved in helping children and families will fundamentally improve outcomes for children.

This is important legislation, and I want to work closely with you to promote the reauthorization of the Promoting Safe and Stable Families Program and new Senate investment to deal the methamphetamine.