that demonstrate in their applications plans to utilize patient navigator services to overcome significant barriers in order to improve health care outcomes in their respective communities.

(h) Duplication of services

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

(i) Coordination with other programs

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

(j) Study; reports

(1) Final report by Secretary

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

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

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

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

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

(2) Interim reports by Secretary

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

(3) Reports by grantees

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

(k) Rule of construction

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

***(l)* Definitions**

In this section:

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

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

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

(m) Authorization of appropriations

(1) In general

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

(2) Availability

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

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

PRIOR PROVISIONS

A prior section 256a, act July 1, 1944, ch. 373, title III, § 340A, as added Nov. 6, 1990, Pub. L. 101–527, § 3, 104 Stat. 2314; amended Oct. 27, 1992, Pub. L. 102–531, title III, § 309(d), 106 Stat. 3502, related to health services for residents of public housing, prior to repeal by Pub. L. 104–299, §§ 4(a)(3), 5, Oct. 11, 1996, 110 Stat. 3645, effective Oct. 1, 1996.

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

AMENDMENTS

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

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

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

Subsec. (e)(3). Pub. L. 111–148, § 3510(2), added par. (3).

Subsec. (m)(1). Pub. L. 111–148, § 3510(3)(A), substituted ''$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015'' for ''and $3,500,000 for fiscal year 2010''.

Subsec. (m)(2). Pub. L. 111–148, § 3510(3)(B), substituted ''2015'' for ''2010''.

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

(a) In general

The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this sec-

tion as ''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

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

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

(b) Eligible entities

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

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

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

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

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

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

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

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

(c) Requirements for health teams

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

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

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

(A) personal physicians or other primary care providers;

(B) whole person orientation;

(C) coordinated and integrated care;

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

(E) expanded access to care; and

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

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

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

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

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

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

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

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

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

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

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

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

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

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

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

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

(A) a transitional care program that provides onsite visits from the care coordinator,[1] assists with the development of discharge plans and medication reconciliation

[1] So in original. The comma probably should be ''and''.

upon admission to and discharge from the hospitals,[2] nursing home, or other institution setting;

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

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

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

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

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

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

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

(d) Requirement for primary care providers

A provider who contracts with a care team shall—

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

(2) provide access to participant health records; and

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

(e) Reporting to Secretary

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

(f) Definition of primary care

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

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

REFERENCES IN TEXT

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

CODIFICATION

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

AMENDMENTS

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

[2] So in original. Probably should be ''hospital,''.

SUBPART VII—DRUG PRICING AGREEMENTS

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

(a) Requirements for agreement with Secretary

(1) In general

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

(2) "Rebate percentage" defined

(A) In general

For a covered outpatient drug purchased in a calendar quarter, the ''rebate percentage'' is the amount (expressed as a percentage) equal to—

(i) the average total rebate required under section 1927(c) of the Social Security Act [42 U.S.C. 1396r–8(c)] with respect to the drug (for a unit of the dosage form and strength involved) during the preceding calendar quarter; divided by

(ii) the average manufacturer price for such a unit of the drug during such quarter.

(B) Over the counter drugs

(i) In general

For purposes of subparagraph (A), in the case of over the counter drugs, the ''rebate percentage'' shall be determined as if the rebate required under section 1927(c) of the Social Security Act [42 U.S.C. 1396r–8(c)] is based on the applicable percentage provided under section 1927(c)(3) of such Act.

(ii) "Over the counter drug" defined

The term ''over the counter drug'' means a drug that may be sold without a prescription and which is prescribed by a physician (or other persons authorized to prescribe such drug under State law).

(3) Drugs provided under State medicaid plans

Drugs described in this paragraph are drugs purchased by the entity for which payment is