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INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007

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Mr. DORGAN, from the Committee on Indian Affairs, submitted the following

R E P O R T

[To accompany S. 1200]

The Committee on Indian Affairs, to which was referred the bill (S. 1200) to amend the Indian Health Care Improvement Act to revise and extend that Act, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

PURPOSE

The purpose of the Indian Health Care Improvement Act Amendments of 2007 (S. 1200) is to reauthorize the Act to maintain and improve the Indian health care delivery system. This legislation is intended to raise the health status of American Indians and Alaska Natives [1] to the highest possible level in accordance with Healthy People 2010.[2]

S. 1200 builds upon current law to set forth policies, programs and procedures designed to address health care deficiencies in Indian and urban Indian communities, and to streamline service delivery to those communities. In addition, S. 1200 addresses the health problems and associated socio-economic conditions in Native American communities by authorizing the Indian Health Service (IHS) and tribes to adopt current health industry "best practices."

[1] The original Act defines the term "Indian" to include Indians and Alaska Natives.

[2] Healthy People 2010 is the major health agenda for the Nation. "It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats." U.S. Department of Health and Human Services, www.healthypeople.gov.

69–010

BACKGROUND

Enacted in 1976, the Act established the first comprehensive framework for the delivery of health care services for Native people, including various health programs, projects, and facilities. The Act was last reauthorized in 1992, and authorized funding for various programs through Fiscal Year 2000. Public Law 106–568 included a simple extension of the Act's authority through FY 2001. Congress has continued to fund programs under the Act through the general permanent authority under the Snyder Act (25 U.S.C. 13).

THE REAUTHORIZATION PROCESS

The work on the latest reauthorization of the Indian Health Care Improvement Act began in 1999. Bills have been introduced since the 106th Congress[3] to provide numerous improvements and updates to current law, many of which are contained in S. 1200.

In June, 1999, the Director of the IHS convened a National Tribal Steering Committee on the Reauthorization of the Indian Health Care Improvement Act (NSC), which was comprised of tribal leaders and representatives from Indian health organizations to facilitate the Act's reauthorization. The NSC held a series of meetings in 1999, during which extensive discussions were held between the NSC and Department of Health and Human Services (DHHS) officials. The NSC also received technical assistance from DHHS officials during these meetings.

The NSC set out to craft a comprehensive legislative proposal that would reflect a consensus of the Indian tribes. With over 560 federally-recognized Indian tribes, each with unique histories, cultures, locations and needs, the NSC faced serious challenges. Despite the many differences, they coalesced around a draft document which formed the basis of the bills introduced, S. 2526 (106th Congress) and S. 212 (107th Congress). Neither bill was enacted.

During the 108th Congress, the Committee, the NSC and the Administration engaged in extensive negotiations over reauthorization issues, but action on a final version of that Congress' bill, S. 556, did not occur before the conclusion of the 108th Congress. Several recommendations developed during these negotiations were incorporated into S. 1057, which was introduced in the 109th Congress.

In the first session of the 109th Congress, the Indian Affairs Committee favorably reported an amendment in the nature of a substitute to S. 1057. In the ensuing months, the Committee engaged in discussions with the Administration—not only DHHS, but also the Department of Justice. Changes based on these discussions were made in an amendment in the nature of a substitute to S. 1057. In addition, the Committee worked extensively with the Senate Finance Committee on provisions in the jurisdiction of that committee, which were separately reported out by the Finance Committee on June 8, 2006, as S. 3524, and incorporated in to the amendment in the nature of a substitute to S. 1057. Comments were also received from the Senate Health, Education, Labor and Pensions Committee, on provisions over which that Committee maintains an interest, and many were incorporated. A new bill,

[3] S. 2526 (106th Congress), S. 212 (107th Congress), S. 556 (108th Congress), S. 1200 and S. 4122 (109th Congress).

based on the amendment in the nature of a substitute, was introduced as S. 4122 on December 8, 2006, the last day of the second session of the 109th Congress. No further consideration of that measure occurred.

OVERVIEW OF INDIAN HEALTH CARE HISTORY

The history of the Federal responsibility for Indian health care is quite extensive and well-documented in numerous sources, including past Senate reports accompanying prior legislation, (see, e.g., Senate Report Nos. 94–133, 102–392, 108–411 and 109–222).

Based on the U.S. Constitution, treaties, statutes and the historical, political and legal relationship with the Indian tribes, the United States has assumed a trust responsibility for the provision of health care to Indian people. Those laws and relationships serve as the backdrop for the government-to-government relationship.

Extensive research indicates that the health of Indians deteriorated after contact with the European colonists, as the aboriginal inhabitants had no natural immunities to the diseases carried by the new arrivals. Decades later, when Federal policy forced the Indians to relocate from their homelands and settle on reservations and, in many cases, prohibited the conduct of traditional practices—including traditional healing—the health of Indians continued to plummet. Thus, health care became a particularly significant element of the treaties and other agreements between the Indian tribes and the United States.

During the early 1800s, the health care provided was little more than vaccinations for the Indians around federal military posts in order to protect the soldiers and non-Indians from the possibility that Indians might spread diseases. During the late 1800s, physicians and hospitals were added to the reservations and other outposts. Mention of the provision of health care was included in treaties. For example, the Treaty with the Chippewa, Red Lake and Pembina Bands, of 1864, stated in Article 4,

> The United States also agree[s] to furnish said bands of Indians, for the period of fifteen years, one blacksmith, *one physician*, one miller, and one farmer; and will also furnish them annually, during the same period, with fifteen hundred dollars' worth of iron, steel, and other articles for blacksmithing purposes, and one thousand dollars for carpentering, and other purposes (emphasis added).[4]

With respect to federal agencies overseeing the responsibility for Indian health, the task was first assigned to the War Department in 1803, then to the Interior Department in 1849, before finally being transferred to the Department of Health, Education and Welfare (DHEW), the predecessor of the DHHS, in 1955. The Division of Indian Health within DHEW had initial responsibility for Indian health before eventually being renamed the Indian Health Service.[5]

In 1921, Congress enacted the Snyder Act (25 U.S.C. 13), to provide for permanent appropriations authority for Indian health programs and services. However, the Snyder Act did not provide

[4] Charles J. Kappler, Indian Affairs: Laws & Treaties, Vol. II, at 861.

[5] Report on Indian Health by Task Force Six: Indian Health in the Final Report to the American Indian Policy Review Commission (Final Report) at 32.

meaningful standards by which to measure progress in Indian health status or other improvements in services.

The lack of standards in the Snyder Act and other organized efforts led the American Indian Policy Review Commission to conclude in 1976 that

> there [was] no clear overall direction or policy for implementation of the various programs. As a result, the Indian Health Services operates primarily an emergency and crisis oriented service. . . . This has resulted in increased prevalence of certain health deficiencies which are virtually unknown in the general population.[6]

Shortly after the responsibility for Indian health was transferred to DHEW, Congress passed the Indian Sanitation Facilities and Services Act, 42 U.S.C. 2004, which authorized the IHS to provide sanitation facilities to Indian communities. These sanitation facilities were critical to eliminating many health maladies associated with the lack of proper sanitation, such as dysentery and infectious hepatitis.

The administration of Indian health had initially been managed in a piecemeal approach, then ultimately was placed within the IHS, an agency of the DHHS. Based on that history and in fulfillment of the special trust obligation to Indian people, Congress passed the Indian Health Care Improvement Act to provide coordinated programs and meaningful direction in Indian health care administration. The underlying responsibility to provide health care did not originate with the Act; rather, the Act was passed after Congress recognized that a sea-change in administration and management was needed to ensure improvements were achieved in Indian health status and services.

THE PRE-IHCIA INDIAN HEALTH SYSTEM

At the time of passage of the Act in 1976, the information on Indian health painted a stark portrait of existence in Indian communities. Senate Report No. 94–133 accompanying S. 522, the Indian Health Care Improvement Act of 1976, which was signed into law as Public Law 94–437, indicated that the "vast majority of Indians still live in an environment characterized by inadequate and understaffed health facilities, improper or nonexistent waste disposal and water supply systems, and continuing dangers of deadly or disabling diseases."[7]

Health Status. These conclusions were based upon the statistics at the time. For example, the "incidence of tuberculosis for Indians and Alaska Natives [was] 7.3 times higher than the rate for all citizens of the United States. . . . [T]he suicide rate . . . [was] approximately twice as high as in the total U.S. population."[8] Also troubling was the infant mortality rate for Indian babies, which was significantly higher than the national average.[9]

Health Professionals. Compounding the low health status were the difficulties in recruiting and retaining qualified health professionals—Indian health professionals, in particular—to work in the

[6] Id. at 12.
[7] S. Rep. No. 94–133, at 36 (1976).
[8] Id.
[9] Id.

Indian communities. The available information indicated that out of 500 doctors in the Indian Health Service, only 3 were Indian.[10] Overall, "in 1975, there were only 72 American Indian physicians to serve the needs of 1,000,000 American Indians, most of whom lived on Reservations."[11] Likewise, only half of the number of pharmacists needed was employed in these Indian communities.[12]

Health Facilities. The conditions and availability of health facilities did not fare any better. A significant number of the existing facilities were over twenty years old. Many others were "old one-story, wooden buildings with inadequate electricity, ventilation, insulation and fire protection systems, and of such insufficient size as to jeopardize the health and safety of their occupants."[13] The Joint Committee on Accreditation of Hospitals (JCAHO) found that "only 24 of the 51 existing IHS hospitals" met accreditation standards and "two-thirds [were] obsolete and that 22 need[ed] complete replacement."[14]

Funding. The funding available for the provision of health services to Indians also revealed significant disparities. For example, "[p]er capita expenditures for Indian health purposes [were] 25 percent below per capita expenditures for health care in the average American community."[15]

Accordingly, the goals of the Act held great promise for the advancement of Indian health by improving the direction in programs and access to other programs, such as Medicare and Medicaid.

CURRENT INDIAN HEALTH SYSTEM

Since 1976, significant improvements have been made in the programs and funding levels authorized for Indian health through the Act and the amendments thereto. Yet, a comparison of historic statistics with current status indicators shows that, while real progress has been made, significant disparities still persist.

Indian Health Status. The Indian Health Service report 2000–2001 Trends in Indian Health indicates the age-adjusted death rates for American Indians and Alaska Natives for 1996–1998 was five times the rate for U.S. all-races in 1997.[16] Despite a decrease of 64% over a period spanning 1972 to 1999, Indian infant mortality rates still remained 24% higher than other U.S. populations.[17] Other Indian mortality rates far exceeded the mortality rates of other U.S. populations for causes including alcoholism (638%), diabetes mellitus (291%), unintentional injuries (215%), pneumonia and influenza (67%), gastrointestinal disease (38–40%) and heart disease (20%).

Even during the short period of 1997 to 2004, the "prevalence of diagnosed diabetes increased by 47 percent in all major regions (all ages) served by the Indian Health Service." The most alarming increase, however, has occurred among younger American Indians

[10] Id., at 55.
[11] Headlands Indian Health Careers, Program History, available at http://www.headlands.ouhsc.edu/history.asp.
[12] S. Rep. No. 94–133, at 42 (1976).
[13] Id. at 36–37.
[14] Id., at 37.
[15] Id.
[16] U.S. Department of Health and Human Services, Indian Health Service, 2000–2001 Trends in Indian Health, at 68.
[17] U.S. Department of Health and Human Services, Indian Health Service, 2000–2001 Trends in Indian Health, at 162.

and Alaska Natives, with a 160 percent increase from 1990–2004 for young adults aged 25–34 years, and a 128 percent increase for adolescents aged 15–19 years from 1990–2004.[18]

Recent information also indicates that suicide rates among youth in Indian Country are predominately higher than for non-Indian youth. In 2005, the Committee held two hearings on the issue of Indian youth suicide. A field hearing was held in Bismarck, N.D. on May 2, 2005, and an oversight hearing was held in Washington, D.C. on June 15, 2005. During the second session of the 109th Congress, on May 17, 2006, the Committee held an oversight hearing on suicide prevention programs and their application in Indian Country.

According to national data for 2002, suicide was the second leading cause of death for Indians of both sexes in the 15–34 year age range, and the fourth leading cause of death for both sexes in the 10–14 year age range. On the reservations of the Northern Great Plains (States of North and South Dakota, Iowa, Minnesota and Nebraska), the rate of Indian youth suicide is up to 10 times higher than it is elsewhere in the country. At several Indian health facilities, the demand for mental health care outstripped capacity.[19] In at least one facility, the mental health services were to be cut by 20% in FY 2005 because funding had been depleted.[20]

Another alarming and growing problem arising in Indian communities is the use of methamphetamines. The Committee held an oversight hearing on the problem of methamphetamine in Indian Country on April 5, 2006. According to the National Survey on Drug Use and Health, the past-year use rate during a 2002–2004 survey period among American Indians and Alaska Natives aged 12 and older is higher than every other population except Native Hawaiians or other Pacific Islanders and youth reporting two or more races.[21]

Health Facilities. According to the Indian Health Service's FY 2008 budget request, the IHS health care facilities system is made up of 163 Service Units (63 IHS, 100 tribal); 48 Hospitals (33 IHS, 15 tribal); and 603 Ambulatory Care Centers (92 IHS and 511 tribal) (consisting of Health Centers, School Health Centers, Health Stations and Alaska Village Clinics).[22]

According to the IHS Health Facilities Construction Priority System, the estimated unfunded total cost to meet the need was nearly $3.5 billion as of FY 2008.[23] In addition, the backlog for the maintenance and improvement needs of current facilities was estimated at $408,956,000.[24]

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[18] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2008, Justification of Estimates for Appropriations Committees, at CJ–147.

[19] United States Government Accountability Office, Report to the Committee on Indian Affairs, U.S. Senate, Indian Health Service: Health Care Services Are Not Always Available to Native Americans, GAO Report No. GAO–05–789, (August, 2005) at 18.

[20] GAO Report No. GAO–05–789 at 18.

[21] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health, The NSDUH Report, September 16, 2005, http://oas.samhsa.gov/2k5/meth/meth.htm.

[22] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2008, Justification of Estimates for Appropriations Committees, at CJ–251.

[23] U.S. Department of Health and Human Services, Indian Health Service, chart of Health Care Facilities FY 2009 Planned Construction Budget (March 30, 2007).

[24] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2008, Justification of Estimates for Appropriations Committees, at CJ–164.

However, on the positive side, "All IHS and Tribally-operated hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified by the Centers for Medicare and Medicaid Services (CMS)." [25]

In addition, since the Indian Sanitation Facilities and Services Act, Public Law 86–121, codified at 42 U.S.C. 2004, was passed in 1959, "over 270,000 Indian homes have been provided sanitation facilities" which served to reduce "[t]he gastroenteric and post-neonatal death rates among the Indian people . . . primarily because of the increased prevalence of safe drinking water supplies and sanitary waste disposal systems." [26] The IHS noted that "[i]n 1955, more than 80 percent of American Indians and Alaska Natives were living in homes without essential sanitation facilities." [27] The age-adjusted gastrointestinal death rate was "15.4 per 100,000 population. . . . 4.3 times higher than that for all other races in the United States." [28] But by 1995, that death rate was reduced to 1.7 per 100,000, although that 1995 rate is still 40% higher than the rate for all races in the United States.[29]

In FY 2005, approximately $132 million was appropriated for sanitation facilities construction, of which $91.7 million was appropriated to the Indian Health Service and more than $40.4 million came from other Federal agencies and non-Federal sources such as tribes and state agencies.[30] IHS estimated that in FY 2005, the Sanitation Construction Program provided sanitation facilities to a total of 24,072 homes.[31] However, the total estimated costs needed to address the sanitation deficiencies in existing homes as of the end of FY 2006 totaled over $2.2 billion, with projects considered economically feasible totaling $1 billion. There were more than 155,000 Indian and Alaska Native homes in need of sanitation facilities, including more than 38,000 which are without potable water. [32]

Health Professionals. The number of Indian health professionals has increased since the Act was first signed into law. According to the latest Census information, there were over 1,300 Indian physicians and surgeons and over 10,000 Indian registered nurses.[33] These numbers suggest that the incentives in the Act have assisted in increasing these numbers. However, vacancy rates for key health professionals indicate that a substantial need still exists for qualified health professionals in the Indian health system. The December, 2006, vacancy rates for health professions with the greatest

[25] Id., at CJ–167.

[26] U.S. Department of Health and Human Services, Indian Health Service. The Sanitation Facilities Construction Program of the Indian Health Service, Public Law 86–121, Annual Report for 2005, at 1.

[27] Id., at 21.

[28] Id.

[29] Id.

[30] U.S. Department of Health and Human Services, Indian Health Service. The Sanitation Facilities Construction Program of the Indian Health Service, Public Law 86–121, Annual Report for 2005, at 5.

[31] Id.

[32] U.S. Department of Health and Human Services, Indian Health Service, Justification of Estimates for Appropriations Committees for Fiscal Year 2008, at CJ–170.

[33] U.S. Census Bureau, American FactFinder, Census 2000 Summary File 4, Table PCT86. The numbers are for individuals reporting only the American Indian and Alaska Native race.

shortfalls consist of Dentists (32%), Optometrists (12%), Nurses (17%), and Pharmacists and Physicians (both 12%).[34]

Types and Level of Services. The IHS, tribal and urban Indian health programs provide an array of basic medical, dental and vision services, including inpatient care, and routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc.,[35] as well as other preventive, clinical and environmental health services. When these services are not available at their facilities, IHS, tribal and urban programs purchase medical care and urgent care services through the Contract Health Services program.

Even though basic services may be available at an Indian health facility, access to these services is not assured. In its study on the availability of health services to Indians in August, 2005, the Government Accountability Office (GAO) found that Indian patients often had to wait more than 30 days—in some cases two to six months—between setting the appointment for services and receiving the services, a time frame "in excess of standards and goals identified in other federally operated health service delivery systems."[36] Moreover, "[t]he most frequent gaps were for services aimed at the diagnosis and treatment of medical conditions that caused discomfort, pain, or some degree of disability but that were not emergent or acutely urgent."[37] For example, in some cases, adult Indian patients "could wait as long as 120 days to get approval for eyeglasses."[38] According to one tribal official interviewed by the GAO, these situations create an environment in which Indian patients become demoralized and may wait until their condition becomes "an emergency that required a higher level of treatment."[39]

The Committee is deeply concerned with the GAO's findings and its conclusions that the disturbing result of these gaps are "diagnosis or treatment delays that exacerbate[] the severity of a patient's condition and create[] a need for more intensive treatment."[40] The Committee is further concerned that these gaps increase the costs of health care and diminish the potential for prevention efforts.

The Committee appreciates the Administration's efforts in promoting prevention as a key to reducing health care costs, but believes a much greater effort is needed to reduce gaps in health services to Indians. Improvements are needed in all areas of the Indian health care system to ameliorate problems and delays in service delivery. The improvements outlined in S. 1200 for programs and policies, provisions in S. 1200 which would be new to the Act, including services for home- and community-based care, youth suicide prevention and convenient care services, and the National Bipartisan Commission on Indian Health Care study on the delivery

[34] U.S. Department of Health and Human Services, Indian Health Service, Justification of Estimates for Appropriations Committees for Fiscal Year 2008, at CJ–125.
[35] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2008, Justification of Estimates for Appropriations Committees, at CJ–71.
[36] GAO Report No. GAO–05–789, at 15.
[37] Id., at 19.
[38] Id.
[39] GAO Report No. GAO–05–789, at 16.
[40] Id., at 21.

of federal health care services to Indians are all designed to help address these problems.

THE INDIAN HEALTH CARE IMPROVEMENT ACT

In passing the Indian Health Care Improvement Act of 1976, Congress set forth ambitious goals for improving the health of Indians, including encouraging Indian participation in "the planning and management" of health services (25 U.S.C. 1601(b)). The Act "would provide the direction and financial resources to overcome the inadequacies in the existing Federal Indian health care program."[41] These goals built upon the foundation laid in President Nixon's 1970 "Special Message to the Congress on Indian Affairs."[42] In his "Special Message," President Nixon declared that "[t]he time ha[d] come to break decisively with the past and to create the conditions for a new era in which the Indian future is determined by Indians acts and Indian decisions."[43]

Breaking decisively with the past meant a radical change in health care delivery, beginning with the administration of the programs and policy-making. Placing administrative and decision-making authority in the hands of Indian tribal governments, rather than solely in the agency's hands, was both a fundamental and logical change in the approach in health care delivery. Reconfirming the tribes' authority to administer health programs, however, took several years to achieve.[44]

Today, nearly half of the IHS budget is administered through tribal contracts or compacts under the Indian Self-Determination and Education Assistance Act of 1976 (ISDEAA), 25 U.S.C. 450 et seq. Title I contracts and Title V compacts total more than $1.6 billion. The IHS currently administers contracts and Annual Funding Agreements with 245 tribes or tribal organizations, and 72 compacts and 93 funding agreements with 322 tribes.[45] These numbers not only reflect congressional policy of promoting tribal self-determination, but generate a higher level of cooperation among Indian health providers.

GENERAL PRINCIPLES IN THE REAUTHORIZATION

During the reauthorization process, a critical assessment of the Act was undertaken by the Committee and the Indian health community and several basic principles emerged. The history of Indian health and the interplay between the ISDEAA and the Act are key considerations in the development of sound Indian health policy.

Self-Determination. Since self-determination was declared to be the new direction in Federal Indian policy, tribal participation has significantly contributed to improving both health and other serv-

[41] Senate Report No. 94–133, at 13.

[42] President's Special Message to Congress on Indian Affairs, 213 Pub. Papers 564 (July 8, 1970).

[43] President's Special Message to Congress on Indian Affairs, 213 Pub. Papers 565 (July 8, 1970).

[44] See, e.g., U.S. General Accounting Office, now, U.S. Government Accountability Office, Report to the Chairman, Select Committee on Indian Affairs, U.S. Senate, Indian Health Service, Contracting under the Indian Self-Determination Act, GAO Report No. GAO/HRD–86–99, September, 1986.

[45] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2008, Justification of Estimates for Appropriations Committees, at CJ–258.

ices for Indian people.[46] Meaningful participation by tribes in administering programs through contracting or compacting has been a principal means of implementing the self-determination policy.

However, simply administering a program designed and handed down by the agency does not accomplish the vision embodied in self-determination. Indian and Alaska Native participation is critical in the development of the framework of these programs and services. Tribal self-determination involves tribes designing or modifying programs, as well as formulating new ideas, concepts and methodologies of how those programs or services should be delivered to their own communities.

Negotiated Rulemaking and Consultation. Such participation means appreciable engagement between the agency and Indian tribes, and numerous tools have successfully increased that involvement. For example, negotiated rulemaking under the Administrative Procedures Act has been found to be useful in several initiatives such as education, housing and Self-Governance.[47]

The Committee has received testimony from tribal participants in negotiated rulemaking that "true understanding among tribes and with IHS is achieved"[48] through that process. That "true understanding" is consistent with the Committee's desire to foster consensus-building and reduce obstacles that negatively impact health care service delivery, as well as to carry out the government-to-government relationship between Indian tribes and the federal government.

The Administration has expressed concerns about the time and resource constraints involved in negotiated rulemaking. The Committee strongly supports fiscal accountability and decreased bureaucracy, but believes that the long-term benefits of negotiated rulemaking more than justify the costs which may be required in the short-term.

The Committee believes that the Indian tribal and urban health providers—as first responders in the health system—should be directly involved in developing health programs and the regulations that affect their service populations. Tribal involvement in rulemaking not only leads to a more informed rule, but it fosters tribal support. In addition, negotiated rulemaking can save costs to all parties in the long run. By building a higher level of consensus in the regulations, the IHS lowers the potential for legal challenges to the rules and associated litigation costs. The Committee favors consensus-building over litigation and encourages this long-term view. The concerns are further abated by the limited number of program criteria or requirements under the Act which are subject to negotiated rulemaking. Section 802 outlines the scope for negotiated rulemaking which is limited to Titles II (except for section 202) and VII, a few sections in Title III, and section 807.

Besides negotiated rulemaking, the Committee has favored consultation with tribes as another tool to increase tribal participation,

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[46] See e.g., National Indian Health Board, Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management, 1998.

[47] See, e.g., No Child Left Behind Act, Pub. L. 107–110, 25 U.S.C. 2001, et seq.; Native American Housing Assistance and Self-Determination Act, Pub. L. 104–330, 25 U.S.C. 4116; Indian Self-Determination and Education Assistance Act, Pub. L. 106–477, 25 U.S.C. 458aa–16.

[48] Indian Health Care Improvement Act Amendments of 2005: Joint Hearing on S. 1057 Before the Senate Committee on Indian Affairs and Senate Committee on Health, Education, Labor and Pensions, 109th Cong., 1st Session, S. Hrg. 109–162 at 725 (July 14, 2005) (statement of Don Kashaveroff, President, Seldovia Village Tribe).

but has generally left the manner or method of consultation to the discretion of the Secretary.

For example, the ISDEAA simply requires an annual consultation on the budget. However, the Secretary has in the past implemented a rigorous regional and national schedule for budget consultation, holding the 9th Annual HHS Tribal Budget Formulation and Policy Consultation Session in Washington, DC, March 28 and 29, 2007.[49]

The Committee recognizes that the Administration has made efforts to involve Indian tribes in decision-making through the consultation policy issued by the DHHS.[50] The Committee also recognizes that the Department's policy has attempted to address a wide variety of matters affecting Indian communities. However, the Committee is concerned that the scope of the Department policy may not fully encompass all critical matters for which the Committee believes consultation should be used, or that comments received are fully considered.

Such matters involve the development of program eligibility or criteria, or relate to specific tribes, Indian population groups (e.g., women) or to special tribal history, customs, or practices. Consequently, remaining committed to promoting tribal input by institutionalizing consultation, the Committee has provided for robust consultation requirements in several key areas, while leaving the manner of consultation to Secretarial discretion.

Flexibility. In addition, the Committee believes that less bureaucracy and more flexibility are needed to tailor programs or services to address local community health needs.[51] The Committee is pleased that the Administration has joined in supporting flexibility and new approaches to health care, and expanding the range of options of health services.[52]

However, in the course of negotiating this legislation, the Administration has repeatedly indicated its preference to change mandatory programs to discretionary ones to meet budgetary constraints and to give the Secretary maximum flexibility.[53] The Committee has accommodated these principles based on the understanding that Indian tribes would also be accorded the same flexibility under the Act and the ISDEAA.

The Committee has been informed that, in the past, the Indian tribes had been foreclosed from implementing programs that the agency did not actually implement either under the Act or the Snyder Act, 25 U.S.C. 13. Simple program authorizations under the Act and the Snyder Act were deemed insufficient to allow the Indian tribes to administer the programs even under the redesign provisions of the ISDEAA.

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[49] See www.hhs.gov/iga/tribal.

[50] U.S. Department of Health and Human Services, Department Tribal Consultation Policy, January, 2005, available at www.hhs.gov/ofta/docs/FnlCnsltPlcywl.pdf.

[51] Flexibility also eliminates the need to identify each and every program that may be administered by IHS, the tribal or urban programs (e.g., the definition of "health professions" does not identify every profession that may be authorized). Many of the decisions or priorities are left to the Indian health providers to determine to implement as needed. The Committee is aware that the IHS, Indian tribes and urban programs engage in extensive budget consultations, sometimes two years in advance of implementation, where programs and professions to emphasize for scholarships is discussed.

[52] S. Hrg. 109–162 at 589 (statement of Dr. Grim, Director, U.S. Department of Health and Human Services, Indian Health Service).

[53] Id., at 596, and S. Hrg. 110–53 at 38 (March 8, 2007) (statement of Admiral John Agwunobi).

It is the Committee's intent, however, that simple authorizations are sufficient to enable tribes to implement programs, even if the Federal agency chooses not to, provided all other applicable provisions of the Act, the Snyder Act and the ISDEAA are met. The Committee believes that this interpretation is necessary to enable Indian tribes to meet the needs of their communities and required, if the Secretary is to experience the flexibility desired.

Oversight and Reporting. In the past, the Committee has been reluctant to eliminate certain mandates, such as those requiring studies. For example, many studies and reports mandated by the 1976 Act have never been completed. These studies were intended to provide insight into the accomplishments and challenges in Indian health and to assist the Congress in seeking new approaches to service delivery. The Committee is troubled that the health status of Indians reflects many of the same problems it did in 1976, and that several mandated studies, reports and programs in current law have been disregarded.

Consequently, the Committee has included in S. 1200 provisions which will establish a National Bipartisan Commission on Indian Health Care to thoroughly review opportunities for improvement of the Indian health care system. During the 108th Congress, the bill to reauthorize the Act, S. 556, contained provisions requiring the Bipartisan Commission to study the potential of funding Indian health as an entitlement. Based on the Administration's recommendations offered during the 108th Congress, the Committee modified the Commission's objectives to what is now included in S. 1200.

In addition, the Committee has included authorization of the Native American Health and Wellness Foundation, provisions to promote the mission of IHS in improving Indian health. This Foundation is not a substitute for the federal obligation to provide health services to Indians, but is intended to complement the federal obligation in ways in which the United States has fallen short.

While much discretion and flexibility is provided to the IHS throughout S. 1200, the Committee must preserve the necessary mechanisms to fulfill its oversight function. The primary means is through active reporting requirements by the Secretary. Congress simply cannot leave unfettered the operations of these important programs without appropriate assurances that Indian people are being served consistent with Congressional intent and priorities. Moreover, Congress should be informed of how and when these programs meet—or fall short of meeting—the basic health needs of Indian people.

KEY PROVISIONS

Several key improvements to the Act contained in S. 1200 are particularly noteworthy:

Health Professions. Difficulties in recruiting and retaining qualified health professionals have long been recognized as a significant factor impairing Indians' access to health care services.[54] Noting that many Indian communities are often in remote locations and lack adequate housing and educational and recreational opportuni-

[54] See also GAO Report No. GAO–05–789, at 4.

ties for employees and their families,[55] the GAO reported that some critical positions such as for pharmacists and dentists remained vacant for several years in some locations.[56]

The provisions in Title I address the health professional shortage in Indian communities. Congress specifically included these provisions in 1976 because the existing programs to improve manpower capabilities were woefully inadequate or completely unsuitable for Indian health providers and communities.[57]

The programs existing in 1976 did "not link the recipients [of scholarships] directly to the Indian Health Service," were "not designed to recruit and support Indians," and were too limited in the "category of health professionals" supported by these programs.[58]

Consequently, Congress developed a new approach and the IHS scholarship program was born. Fears of duplication were quickly disproven by the obvious need for and success of these programs in filling vacancies and returning Indian health professionals to the Indian communities. Today, the program has expanded to include a wide variety of health professions as determined by the priorities set by the IHS and the Indian tribes. Besides the scholarships, the program also now includes loan repayments, a tribal scholarship program, and bonus incentive payments.

These programs specifically target the needs of the Indian health system. For example, the scholarship priorities are developed through a year-long consultation process wherein the IHS sends the program information and request for priority to each Indian tribe and the tribal education and health programs. The comprehensive list is developed based on the IHS and tribal health professional projected needs, vacancies and available positions. By focusing on the specific needs of Indian communities, the Committee believes that this approach has significantly improved Indian health.

Targeting the specific needs of the Indian health system has become the hallmark of the Indian health professional policy. Likewise, a continuous and seamless transitional approach also is a key policy component in increasing the number of Indian health professionals. The Committee strongly encourages the Secretary to evaluate all opportunities to improve the chances of success for Indian health professionals, including obtaining the licenses or certifications necessary for providing health care services. The Committee has been made aware of the need to increase the number of licensed health professionals in the Indian health system and included provisions in S. 1200 to address that need. S. 1200 provides for portability of current licenses for tribal health professionals consistent with other Federal health licensing provisions. In addition, S. 1200 authorizes programs to enhance and facilitate enrollment in and completion of courses of study in health professions.

The Committee believes that the Title I programs should fully equip the Indian student trainees with the tools needed to transition into the health profession, including successfully completing all courses of study and passing the required licensing or board examinations. In addition, the Committee expects that the IHS would

[55] GAO Report No. GAO–05–789, at 4.
[56] Id.
[57] Senate Report No. 94–133, at 55–57.
[58] Id., at 55–56.

also ensure that scholarship recipients are provided every opportunity to fulfill their service obligations, including technical assistance in understanding their obligations.

The remedial programs, scholarships, grants, externships, service obligations and advanced training established in Title I are all designed to provide seamless opportunities for successfully recruiting and training Indians for health professions. As part of the long-term view of Indian health professions, the Committee believes continuity is necessary in administering the Title I programs.

The incentives fostered by scholarships, loan repayments, and bonuses are multiplied when combined with professional development programs for health professionals which the Committee believes to be essential components of recruitment and retention programs in the Indian health system. S. 1200 establishes several professional development programs in Title I such as opportunities for advanced training and research, tribal cultural orientation, training in the administration and planning of tribal health programs and tribal demonstration projects for innovative recruitment, placement and retention programs, which may include professional development programs.

Such additional training for health professionals is particularly important in developing leadership and collaboration skills and ensuring that a culturally-competent workforce exists within the Indian health system. The Committee strongly encourages the Secretary and tribal and urban Indian health providers to develop innovative programs or take advantage of existing models for such professional development to increase and maintain the number of Indian health professionals in the Indian health system.

In addition, the Committee takes a long-term view of health professions in S. 1200. The most urgent placement needs are in the direct care positions, such as dentists, doctors, nurses, and pharmacists. In the long-term, Indian health professionals are also needed in educational positions to bolster recruitment levels and improve the new Indian health professionals' chances of success.

The Committee has been informed that significant need exists at the tribal colleges and universities to increase the number of Indian instructors in the nursing programs.[59] The Committee recognizes that Indian instructors often have personal knowledge of the health disparities in Indian communities and a deep commitment to serve these communities for the long-term. Indian educators increase the likelihood of success for Indian students and bring to the classroom the unique cultural competence required in the Indian health field.

With that in mind, the Committee included provisions in Title I of S. 1200 allowing a scholarship recipient to fulfill his or her service obligation (required in exchange for the scholarship) by teaching in a tribal college or university nursing or other health related program, provided the Secretary determines that health services to Indians will not be decreased. In addition, the Secretary may, prior to waiving any service obligation or repayment of a scholarship, consider placement of a scholarship recipient in a teaching capacity in a tribal college or university nursing or related health program.

[59] Joseph F. McDonald, Ed.D., President, Salish-Kootenai College, Letter to Chairman John McCain, U.S. Senate Committee on Indian Affairs, September 22, 2005.

Other provisions for nursing grants were added to extend a preference in grant awards to tribal college and university nursing programs.

Prior to including these provisions, the Committee considered the likelihood that inexperienced, new graduates might be placed in teaching positions. One tribal college president indicated that "these [instructors] are clinically seasoned, mature [Bachelor of Science—Nursing] prepared nurses returning to school for educational and career mobility."[60] Teaching positions available for these individuals would include lab coordinators and clinical instructors. This tribal college President also indicated that "new [registered nurse] graduates of associate or generic baccalaureate programs would not be qualified to teach."[61]

The Committee believes these positions should be filled by experienced faculty and expects that the Secretary and the tribal colleges or universities would coordinate these opportunities and be selective in placing these individuals to avoid compromising the quality of education and accreditation.

The Committee strongly encourages the Secretary to examine the Title I programs with targeted, holistic, long-term approaches in mind and to develop more opportunities to increase the number of Indians in the health professions. The Committee believes that in the long-run, improving health educational opportunities at every level will also contribute to improving the health of Indian communities.

Home Health Care. Current law authorizes a feasibility study to be conducted on hospice care services. However, the IHS has never conducted that study and, now, 14 years later, to conduct such a study would greatly delay what have already been demonstrated to be much needed services.

The Committee has been informed that some Indian tribes and tribal organizations, through pilot projects, have provided this type of service or other services such as home health care with great success. The Committee is concerned that not authorizing these and other long-term or home health care services through the Indian health care system—services that have been an accepted part of the national health care system and Medicare since 1983—will prevent IHS and tribes from utilizing a proven, effective health delivery vehicle.

Currently, home health care, long-term care and hospice care are not readily available to most Native communities. Many Indians must travel long distances, only to be placed in facilities that are far from home, culturally unfamiliar, and not conducive to their overall well-being. Home health care is crucial for these individuals. Having culturally-appropriate facilities close to Indian communities not only promotes the patient's well-being, but enables family members to more easily visit the patient.

Section 213 of S. 1200 authorizes services such as home health care, long-term care and hospice care, which are a standard part of the health care industry. If the Indian health system is to advance into the 21st Century, then Indian health programs must be

[60] Joseph F. McDonald, Ed.D., President, Salish-Kootenai College, Letter to Honorable Don Young, U.S. House of Representatives, November 1, 2005.

[61] Joseph F. McDonald, Ed.D., President, Salish-Kootenai College, Letter to Honorable Don Young, U.S. House of Representatives, November 1, 2005.

authorized to make these services available for their Indian patients, if circumstances warrant.

However, the Department of Justice has indicated that it has concerns regarding the provision of services for which no standards exist.[62] To address those concerns, S. 4122 in the 109th Congress included language that required standards to be in place from either the Secretary or the state in which the Indian health program was located. This type of requirement has been a part of the Indian health system as required in the Indian Self-Determination and Education Assistance Act.[63]

Indian tribes want to ensure that the services authorized in Section 213 are consistent with those services reimbursable by Medicaid and, in particular, those services already authorized in compacts or contracts entered into by the tribes or tribal organizations and the IHS pursuant to the ISDEAA.

To that end, S. 1200 authorizes the Secretary to promulgate standards to govern any service in the absence of state standards. It is the intent of the Committee that those services already authorized in compacts or contracts will remain so authorized and that the Secretary is authorized to issue interim standards in the absence of either state standards or final Secretarial standards. The Committee expects the Secretary to act promptly to promulgate these standards, so that services to Indian patients are not disrupted or denied.

Convenient Care Services. Section 213 also authorizes the Secretary to provide funding to meet the health status objectives of the Act for convenient care services programs pursuant to section 306(c)(2)(A). Section 213 further authorizes health care delivery demonstration projects that include a "convenient care services" program as an alternative means of delivering health care services to Indians.

In including this new provision, the Committee seeks to address the lack of access to health care services that exists in so many tribal communities, which may be due to limited hours of operation at existing health care facilities, lack of staff, or other factors. It is the Committee's hope that these convenient care services projects may expand the availability of health care, as well as decrease the need for more-costly emergency room visits, thereby reducing the over-stressed Contract Health Services budget.

Traditional Health Care Practices. For much of America's history, the federal government's policy of assimilation and termination sought to destroy Indian cultures and religions, as well as tribal legal, political and economic institutions. Indian people were denied the exercise of traditional practices or punished, should those ceremonies be practiced, as well as were punished for speaking their own languages and observing other traditional ways.

However, federal policy toward Native people has run the gamut, with the policy of one period often contradicting that of another. An example of such a policy shift occurred following the 1928 Merriam Report, which generated several initiatives to improve health con-

[62] S. Hrg. 110–53 at 41 (March 8, 2007) (statement of C. Frederick Beckner III, Deputy Assistant Attorney General, Civil Division, Department of Justice).

[63] See 25 U.S.C. 450f(a)(2). "The contractor shall include in the proposal of the contractor the standards under which the tribal organization will operate the contracted program, service, function, or activity. . . ."

ditions for Native Americans.[64] One reform was the active solicitation of traditional Indian healers to participate in federal health services to Indians.

The Indian Health Care Improvement Act currently contains provisions to promote long-practiced traditional health care practices of the Indian tribes served by IHS, tribal and urban Indian health programs, consistent with the standards for the provision of health care, health promotion, and disease prevention. Authority also exists for culturally appropriate health care with respect to specific programs (the Community Health Representative Program), specific elements of the Indian population (Indian youth and Indian women), and specific services and training (mental health). These practices encourage respect for and affirmation of concepts of Indian and Alaska Native cultural values, beliefs and traditions that Indian people define for themselves as a complement to western medical practices in promoting good health and curing illness.

Former IHS Director Dr. Emery A. Johnson, in "Policy and Procedures in reference to P.L. 95–341," the American Indian Religious Freedom Act of 1978, stated the Service's views as follows:

> The Indian Health Service has continued to recognize the value and efficacy to [sic] traditional beliefs, ceremonies, and practices of the healing of body, mind and spirit. . . . It is, therefore, the policy of the Indian Health Service to encourage a climate of respect and acceptance in which an individual's private traditional beliefs become a part of the healing and harmonizing force within his/her life.

More recently, in 1994, IHS Director Michael H. Trujillo issued a "Traditional Cultural Advocacy Program Policy Statement" which states:

> The Indian Health Service (IHS) recognizes the value of traditional beliefs, ceremonies, and practices in the healing of body, mind, and spirit. The IHS encourages a climate of respect and acceptance in which traditional beliefs are honored as a healing and harmonizing force with individual lives, a vital support for purposeful living, and an integral component of the healing process. It is the policy of the IHS to facilitate [sic] right of American Indian and Alaska Native people to their beliefs and health practices as defined by the tribe's or village's traditional culture. This policy is meant to complement and support previously stated IHS policy for implementing the American Indian Religious Freedom Act of 1978 (Public Law 95–341, as amended).

The Department of Veterans Affairs' National Center for Post-Traumatic Stress Disorder is adding traditional healing methods, such as talking circles and healing herbs, to modern medical treatments for American Indian and Alaska Native veterans and service personnel returning from active duty in the Middle East and suf-

[64] Merriam, Lewis (ed.), Institute for Government Research, The Problem of Indian Administration (1928) (commonly referred to as the "Merriam Report").

fering from post-traumatic stress disorder problems.[65] The American Cancer Society (Society) includes Native American healing in a section on its website concerning treatment decisions.[66] The Society, in connection with work at Montana State University, is providing funding to a group of Indian women health care workers on the Crow Reservation in Montana to help IHS providers understand traditional Crow healing practices and customs.

The Committee believes that health care treatment should be relevant to and effective for the population to be served, and thus regards traditional health care practices as an important part of culturally appropriate care for Indian people. These practices have been a part of the IHS, tribal and urban Indian health care system for years, are provided only at the request of the patient or family members, and are within the traditional culture of that individual. It is the Committee's understanding, based on Department of Justice testimony to the Committee on March 8, 2007, that no medical malpractice suit has ever been filed arising from a traditional health care practice.[67] Thus, the risk for the United States in terms of liability appears to be insignificant, compared to the benefits of allowing Indian patients to obtain this care. DOJ's concerns are unfounded in light of the fact that traditional health care practices are based in Native healing sciences. The bill has the legislative purpose of providing for the highest possible health status for Indians without intruding on Indian self-determination.

Behavioral Health. S. 1200 has a strong focus on behavioral health. Title VII takes a comprehensive and integrative approach to behavioral health, providing both prevention and treatment programs for Indian children, youth, women and elders. The bill also emphasizes the interconnectedness of services related to alcohol and substance abuse, child welfare, suicide prevention and social services. Particular programs are authorized for Indian youth, Indian women, those affected by fetal alcohol disorder in Indian communities, and both the victims and perpetrators of child sexual abuse in Indian households.

In addition to a comprehensive approach to addressing behavioral health services, the Committee recognizes and affirms the importance of providing care within the context of an individual's family, community and particular tribal culture, such as is used by the systems of care model.

Indian Youth Suicide Prevention. The alarming suicide rates among Indian youth indicate a great need for improved, comprehensive behavioral health care services.

The nation was shocked in March, 2005, when a troubled 16-year-old member of the Red Lake Band of Chippewa Indians in Minnesota shot and killed his grandfather, his grandfather's partner, five fellow high school students, a high school teacher and a security guard and seriously wounded several others at Red Lake High School on the reservation before killing himself. Several other

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[65] See Department of Veterans Affairs' National Center for Posttraumatic Stress Disorder website, www.ncptsd.va.gov/ncmain/index.jsp, and, e.g., www.adn.com/front/v-printer/story/9137819p-9054019c.html.

[66] www.cancer.org/docroot/ETO/content/ETO_5_3X_Native_American_Healing.asp?sitearea=ETO.

[67] S. Hrg. 110–53 at 14 (March 8, 2007) (statement of C. Frederick Beckner III, Deputy Assistant Attorney General, Civil Division, Department of Justice). See also S. Hrg. 110–53 at 104, testimony of Duke McCloud.

young people from that reservation subsequently took their own lives.

The publicity around the Red Lake incident, which was then the nation's second-most deadly school shooting, brought attention to the fact that, in Indian Country, suicide impacts a younger population than in the rest of the country. The suicide rate for Indian and Alaska Native youth, aged 15–24, is two and one-half times higher than the national average. Youth suicide "clusters" have also occurred on reservations in North and South Dakota, New Mexico and Arizona and in Native communities in Alaska.

During the 109th Congress, the Committee held three hearings specifically on the issue of Indian youth suicide: one in Bismarck, North Dakota on May 2, 2005, and two oversight hearings in Washington, DC (on June 15, 2005, and on May 17, 2006), to discuss the kinds of resources and services being provided to Indian youth who have expressed suicidal thoughts or attempted suicide.

Based on the information developed through hearings, the Committee has included provisions in S. 1200 which address youth suicide as part of the behavioral health program provisions and in a culturally-appropriate manner. Section 708 authorizes the Secretary to award grants for telemental health demonstration projects to provide counseling to Indian youth and health providers, training for Indian community leaders, and the development of culturally-relevant materials. The Committee recognizes that suicide prevention for Indian youth is a long-term effort that must address many multi-factorial causes. Questions such as whether the loss of cultural identity contributes to the youth suicide problem remain unanswered. Therefore, S. 1200 also makes suicide a priority for the IHS research agenda, particularly the identification of various factors that either protect the tribal community or make that community at risk for suicides, and the role the loss of tribal identity plays in suicidal behavior. Finally, provisions included in Title I encourage more Indian people to enter into the psychology profession by increasing the number of grants for the program commonly referred to as In-Psych (Indians into the Psychology) from three to nine and by authorizing a specific level of funding.

Urban Indians. Providing health care services to urban Indians has been a part of Federal policy for nearly 40 years. Congress began funding urban Indian clinics in 1967 when $321,000 was provided for an Indian clinic in Rapid City, South Dakota.[68]

Congress specifically included urban Indian health programs as part of the Indian health care system in the Act in 1976, recognizing that the Federal obligation for health care extended to these individuals. These provisions sought to correct disparities in health levels for Indians living in urban areas, first as pilot programs and later permanently in the Indian health care system.[69]

The policies and status of Indians and Indian tribes under Federal laws, treaties and judicial decisions provide ample support for continuing and improving programs for urban Indians. Under this varied history, the Federal Government had dealt with Indian tribes in a variety of ways: some by treaty, others not by treaty.

[68] Senate Report No. 94–133, at 136. In 1972, Congress added funding to the IHS appropriations for a pilot program in Minneapolis. Others followed in 1973 in Oklahoma City, Seattle and California (which covered nine urban Indian organizations).

[69] See Senate Report Nos. 94–133, 100–508 and 108–411.

The Federal Government had ignored some Indian tribes completely. Other Indian tribes were legislatively excluded from receiving services under some administrative programs, yet were allowed to exercise treaty rights. Some Indian tribes were "terminated," yet later "restored" to a government-to-government relationship with the United States.

Courts have long held that Congress has the broad power to legislate for the benefit of Indians, even if located off of the reservation, and to define who is an Indian and for what purposes they may be provided services, even if they may not be an enrolled member of a federally-recognized Indian tribe.[70]

For example, Congress has enacted laws which define Indians in different ways for different purposes.[71] Even the criminal statutes under Title 18 of the U.S. Code regarding crimes on Indian reservations do not define who is an Indian. In other cases, Congress did not define Indians, or place geographical limitations on the service areas in which they may be served. The Snyder Act, 25 U.S.C. 13, authorizes permanent funding for health care for "the Indians throughout the United States." This statute does not confine the services to Indians who are members of current federally-recognized tribes or to those living only on reservations. The Snyder Act has never been repealed nor otherwise limited in this respect. Under this Act, Congress has provided a more inclusive definition of urban Indian than mere membership in a federally-recognized Indian tribe, including members of "terminated" tribes, that is, groups that once had a political government relationship with the United States which was ended under the "termination" policy of Federal-Indian relations.

Termination was another failed Federal Indian policy designed to end the government-to-government relationship with Indian tribes and assimilate their members into the larger society. When that policy gave way to self-determination, however, and Congress sought to try to remedy the devastating effects of termination, Congress saw fit to continue the health services in the Act to those individuals. See *Menominee Tribe* v. *U.S.*, 391 U.S. 404 (1968). Likewise, by including members of state-recognized tribes, Congress recognized that several Indian tribes had treaty relations with individual states before the Federal Government was established.

Congress did not in this Act recognize either the "terminated tribes" or the state-recognized tribes on the same basis or for the same purposes as the federally-recognized tribes under this Act. However, the U.S. Supreme Court has found that extending Federal protection for limited purposes, such as for services provided in this Act, is within Congress' power.

Further, in adopting S. 1200, the Committee is of the opinion that the Congress was on firm constitutional footing based on long-

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[70] U.S. Const., Art. I, Sec. 8, cl. 3. See also Cohen, Felix. Handbook of Federal Indian Law, at 23. 1982 ed.; *U.S.* v. *Holliday,* 70 U.S. 407, 417 (1865) (the broad power also includes Congress' dealings with individual Indians). As the courts suggest, Federal policy for Indians cannot be confined to reservation boundaries. ("The overriding duty of our Federal Government to deal fairly with Indians wherever located has been recognized by this Court on many occasions." *Morton* v. *Ruiz,* 415 U.S. 199 (1974) (citing *Seminole Nation* v. *U.S.*, 316 U.S. 286, 296 (1942); ("Patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." *U.S.* v. *Raszkiewicz*, 169 F.3d 459, 465 (7th Cir. 1999).)

[71] See, e.g., Indian Arts and Crafts Act, Pub.L. 101–644, 25 U.S.C. 305; No Child Left Behind Act, Pub. L. 107–110, 25 U.S.C. 7491; and the American Indian Probate Reform Act of 2004, Pub. L. 108–374, 25 U.S.C. 2201.

standing precedent. Indeed, the U.S. Supreme Court has held that "it is not meant . . . that Congress may bring a community or body of people within the range of this power by arbitrarily calling them an Indian tribe, but only that in respect of distinctly Indian communities the questions, whether, *to what extent* and for what time they shall be recognized and dealt with as dependent tribes requiring the guardianship and protection of the United States are to be determined by Congress, and not by the courts." *U.S.* v. *Sandoval*, 231 U.S. 28, 46 (1913) (emphasis added). Accordingly, the Act extends health benefits to members of these groups (terminated tribes and state-recognized tribes) without extending Federal recognition to them for all purposes.

In enacting this Act, the Committee has found ample justification for extending health services to the Indians who ended up in these urban areas because of several major developments:

> First, Indians were provided an opportunity to work and share in the Nation's prosperity in industries prior to and during World War II; second, thousands of Indian men and women served in the Armed Forces away from their reservation, traditional communities or Alaska Native villages; third, formal government relocation programs moved many Indian families from low employment, rural areas to urban areas where "employment opportunities" were considered more readily available; and fourth, countless numbers of Indians attempting to escape depressed conditions on their reservations voluntarily relocated.[72]

The comprehensive approach of this Act is needed to more fully implement the Federal responsibility for Indian health care, and, even more so today, to address health disparities facing the Indians who had moved from the reservations as a result of the relocation policies. Relocating Indians from reservations to urban areas was the Federal policy and program first begun in 1931.[73] "Relocation complemented other termination programs designed to promote rapid assimilation. Once relocated, Indians were cut off from the special federal services that had been available to them as reservation residents." [74]

Congress has previously recognized that the establishment of urban Indian health programs was necessary to rectify the errors of failed Federal Indian policies such as relocation.[75] The Committee further found that Title V of the original Act "represent[ed] a Federal policy commitment to provide the essential authorities and financial resources to permit urban Indian organizations to develop needed health services and to strengthen relationships with existing community health and medical care programs." [76]

The justifications for this policy are still valid today. Recent statistics indicate that urban Indians suffer health disparities, as do Indians living on reservations. For example, the mortality rates are higher due to accidents (38% higher than other populations), chronic liver disease and cirrhosis (126% higher), diabetes (54% higher),

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[72] Senate Report 94–133, at 131.
[73] Felix Cohen, Handbook of Federal Indian Law (1982 ed.), at 169.
[74] Id.
[75] Senate Report No. 94–133, at 138.
[76] Id., at 140.

alcoholism (178% higher), and sudden infant death syndrome (157% higher).[77]

The Committee believes that continuation of services to urban Indians, recognized in the original Act and affirmed by S. 1200, makes sense from both policy and fiscal perspectives. The Committee has received testimony that these urban Indian health programs improve health services for Indians located in the urban centers in a highly cost-effective manner.

In addition, the Committee has received testimony that without the urban Indian health programs, urban Indians would not seek care or could delay seeking proper medical attention until their health problems erupt into emergency situations or reach advanced stages when treatment is costlier and the rate of survival is much lower.

By being located closer to the urban Indians than the tribal health programs on the reservations, urban Indian health programs reduce the number of emergency room visits by providing early disease prevention services.

For example, the South Dakota Urban Indian Health Center operates three clinics with more than 17,500 patient encounters per year under the Title V program. This center provides such services as a foot care home visit program whereby Community Health Representatives conduct home visits to assess diabetic patients (or those at risk for diabetes). These home visits are a critical part of chronic disease management, particularly in avoiding amputations due to diabetes.

The First Nations Community Health Source in Albuquerque, New Mexico provides dental, primary, and behavioral health care for approximately 45,000 urban Indians and handles approximately 12,700 patient encounters per year under the Title V program.

The Native Americans for Community Action in Flagstaff, Arizona provides immunizations, mental health and youth substance abuse prevention services among several other primary care services for urban Indians. The Committee has received testimony suggesting that the patients at this urban Indian health center would either have to travel 100 or more miles to visit an IHS clinic on the reservation or wait two or three weeks for an appointment at the local Community Health Center. Either alternative would impose significantly more burdens on the patient, and the testimony further suggests that most patients would simply avoid the care altogether.

The Tucson Indian Center in Tucson, Arizona also provides important disease prevention services such as substance abuse prevention, wellness programs and immunizations. This Center provides services for over 2,500 patient encounters under the Title V programs.

The health program operated by the Nevada Urban Indians, Inc. in Reno, Nevada provides, among other things, immunization and diabetes education programs and experienced over 9,000 patient encounters in 2005. The Native American Rehabilitation Associa-

[77] The Health Status of Urban American Indians and Alaska Natives, Urban Indian Health Institute, March 16, 2004, at v. Available at *www.uihi.org.* See also American Journal of Public Health, August 2006, Vol. 96, No. 8, "A Nationwide Population-Based Study Identifying Health Disparities Between American Indians/Alaska Natives and the General Populations Living in Select Urban Counties."

tion of the Northwest, Inc. in Portland, Oregon experiences nearly 9,300 patient encounters per year, including 1,040 for mental health care and 3,400 for alcohol and drug treatment. The N.A.T.I.V.E. Project in Spokane, Washington provides a community wellness program and community outreach services for diabetes screening and health education for a community of approximately 12,000 urban Indians.

These programs, particularly the wellness, diabetes, and behavioral health programs are critical to preventing the development of diseases which may require long-term disease management such as for diabetes and alcohol or drug addictions. In addition, the outreach, screening and home-based care programs are vital in ensuring the patients receive early intervention and care rather than waiting until they need emergency services which cost far more than intervention services.

Urban Indian health programs provide culturally-appropriate health care for Indians. The Committee has received testimony that Indians may avoid non-Indian (or "mainstream") health providers who are unfamiliar with or insensitive to Indian culture. The urban Indians have confidence in the urban Indian health programs and are more likely to seek care when the provider recognizes and respects culturally-appropriate care.

Urban Indian health programs also address continuity of care for Indians migrating between the urban areas and reservations. Even though the disavowed policy of relocation no longer forces such migration, moving from the reservation to urban areas is not uncommon for these individuals, and neither is their return to the reservation. For example, the urban Indians may travel to the reservation for traditional ceremonies, tribal political (elections) or cultural events (such as pow-wows), clan or family events, and so on. On the other hand, Indians may move to the urban areas for job or educational opportunities—and carry with them the need for continuity of care. The Committee has received testimony that these programs recognize the migration and account for it in their patient care, particularly for quality follow-up care.

The urban Indian health programs provide services for the uninsured Indians who might not be able to obtain care elsewhere. With poverty rates of urban Indians hovering at 25% (compared to 14% for the general population), and nearly half living below 200% of the Federal poverty level (compared to 30% for the general population),[78] it is no surprise that many urban Indians are uninsured. The Committee has received testimony that in Boston, MA, 87% of the Boston Indian Center's clients have no health insurance. In Arizona, nearly two out of three urban Indians have no insurance.

The Committee believes that the urban Indian health programs are a crucial component in the overall Federal effort to reduce the health disparities for the urban Indians. Without such services by the Title V health programs, it is quite likely that the health disparities among the urban Indians will increase. This result would contradict the Congressional policy set forth in this Act and in other statutes of increasing access to health care and of remedying

[78] The Health Status of Urban American Indians and Alaska Natives, Urban Indian Health Institute, at v.

health disparities that result from the past failed Federal Indian policies.

Dental Health Aide Therapists. Decades of inadequate access to dental care, along with other factors that contribute to the generally worse health condition of Indians as compared to the general population, have led to a true epidemic of dental disease in Indian communities, and in Alaska Native communities, in particular.

During the 108th and 109th Congresses, there was considerable discussion surrounding the Dental Health Aide Therapists (DHAT) Program in Alaska Native communities. The Committee received testimony regarding the crisis in oral health care in Alaska Native communities and how the DHAT program was a result of Alaska Native leaders and health providers searching for a means of addressing it. The Committee believes that the use of Alaska Natives trained through the DHAT program to serve as dental health aide therapists in Alaska is a necessary response to this access to care crisis.

The DHAT program in Alaska has been part of the Community Health Aide Program since 2002, and DHATs provide a wide range of oral health care promotion and disease prevention services. For the most part, the DHAT program is supported and applauded for its efforts in reducing the extraordinary dental crisis in Alaska Native communities. However, some activities have generated controversy because they require the performance of certain irreversible procedures, specifically, the treatment of dental caries, pulpotomies and extractions of teeth.

In January, 2006, the American Dental Association (ADA), the Alaska Dental Society (ADS) and several individual dentists filed a lawsuit in Alaska Superior Court, seeking to stop the practice of dentistry and dental surgery by non-dentists by asking the court to declare the Alaska Native Tribal Health Consortium and its Dental Health Aide Therapists program in violation of state dental licensing laws. On June 27, 2007, the Alaska Superior Court dismissed the case, noting in its decision that DHAT is part of the Community Health Aide Practitioner Program and Congress clearly intended the utilization of paraprofessionals in providing care through both CHAP and DHAT.

When the House Resources Committee marked up its version of the Indian health reauthorization in the second session of the 109th Congress, the Committee agreed to an amendment offered by Representative Young (R–AK) regarding the Dental Health Aide Therapist program in Alaska. The language, which the Committee has been informed was agreed to by the American Dental Association and the Alaska Native Health Board, prohibits dental health aide therapists from performing all oral and jaw surgeries except pulpal therapy or extraction of adult teeth after consultation with a licensed dentist in a dental emergency. That agreed-upon bill language is carried forward and included in S. 1200.

National Bipartisan Commission on Indian Health Care. The Committee intends that S. 1200 will provide many much-needed improvements to the Indian health system. However, adequate funding levels remain a significant factor in achieving those improvements.

For several years, the Committee has received testimony regarding the substantial funding needs for Indian health.[79] Federal appropriations have increased over time, but, as evident in the IHS Level of Need Funded Study, have not reached optimal levels.[80] While the reimbursements from Medicaid and Medicare have been beneficial in adding additional resources, they are not a complete solution to the funding deficiencies.

The Committee has concluded that an overarching assessment of need and financing mechanisms is warranted to address the health disparities and financing for Indian health care. Accordingly, section 814 establishes the National Bipartisan Commission on Indian Health Care to study the optimal manner in which to provide and finance health care services to Indians.

This Commission will have broad authority to conduct hearings and other activities needed to provide Congress with comprehensive and thoughtful recommendations regarding the optimal means of delivering health care services to Indians. The Committee intends that this Commission will also serve as an appropriate forum for addressing outstanding questions relative to financing, including, among others, balancing concerns about overutilization and deficiencies.

Indian Health Care Facilities Construction. During the 109th Congress, much discussion between the National Steering Committee and the Committee centered around section 301, which directs the Secretary to maintain a health care facility priority system for construction.

Background: Development of the Priority System. In the early 1980's, the IHS developed a health care facilities priority system (Priority System) for construction of various types of health care facilities in Indian communities. In 1988, pursuant to Public Law 100–713 (as amended by Public Law 102–573), Congress required the IHS to provide an annual report which set forth (1) the current priority system; (2) the planning, design, construction and renovation needs of the top-10 priority inpatient and outpatient facilities (including staff quarters); (3) the justification and projected costs of these projects; and (4) the methodology for establishing the priorities.

In this Priority System, construction projects for hospitals, health centers, staff quarters and youth regional treatment centers go through three key phases, wherein the IHS solicits proposals for

[79] See Hearing on the President's Fiscal Year 2008 Budget Request for Indian Programs Before the Senate Comm. on Indian Affairs, 110th Cong., 1st Sess., February 15, 2007, S. Hrg. 110–48; Hearings on the President's Fiscal Year 2007 Budget Request for Indian Programs Before the Senate Comm. on Indian Affairs, 109th Cong., 2nd Sess., February 14, 2006, S. Hrg. 109–396, Pt. 1 and February 23, 2006, S. Hrg. 109–396, Pt. 2; Hearing on the President's Fiscal Year 2006 Budget Request for Indian Programs Before the Senate Comm. on Indian Affairs, 109th Cong., 1st Sess., February 16, 2005, S. Hrg. 109–9; Hearings on the President's Fiscal Year 2005 Budget Request for Indian Programs Before the Senate Comm. on Indian Affairs, 108th Cong., 2nd Sess., February 11 and 25, 2004, S. Hrg. 108–420; Hearing on the President's Fiscal Year 2004 Budget Request for Indian Programs Before the Senate Comm. on Indian Affairs, 108th Cong., 1st Sess., February 26, 2003, S. Hrg. 108–60; Hearings on the President's Fiscal Year 2003 Budget Request for Indian Programs Before the Senate Comm. on Indian Affairs, 107th Cong., 2nd Sess., March 5, 7, and 14, 2002, S. Hrg. 107–360.

[80] See, e.g., "LNF Primer," U.S. Department of Health and Human Services, Indian Health Service, located at http://www.ihs.gov/NonMedicalPrograms/Lnf/docs2003/Primer.pdf.

health facility construction and ranks the proposals according to their relative need for construction.[81]

The projects are selected for inclusion on a "Priority List" after completion of Phases I and II, then move up the Priority List as Phase III is completed and appropriations for the projects are provided.

Congressional Directive To Revise the Priority List. In 1999, in the conference report accompanying the FY 2000 Interior Appropriations Act (House Report 106–406), Congress directed the IHS, working closely with Indian tribes, to review and revise the Priority System. In recognizing the "extreme need for new and replacement hospitals and clinics," Congress noted that "there should be a base funding amount, which serves as a minimum annual amount in the budget request." Congress further noted that several issues needed to be considered in revising the Priority System and that "a more flexible and responsive program can be developed that will more readily accommodate the wide variances in tribal needs and capabilities."[82]

In response to this directive, the IHS Director convened a Facilities Appropriations Advisory Board (FAAB) and a Facilities Needs Assessment Workgroup to review the Priority System and make recommendations for revision. According to the IHS, the FAAB was comprised of 12 members representing Indian tribes and two members representing the IHS, and the Workgroup was established by the IHS Director to make recommendations to the FAAB. The Committee has been informed that, earlier this year, the FAAB submitted final recommendations to the IHS Director, but no final decision has been made on these recommendations.

Meanwhile, in 1999, the National Steering Committee developed language regarding the Priority System contained in section 301 of the various iterations of bills introduced for the reauthorization of the Act. The language in section 301 remained primarily the same until 2006, when the Committee refined certain provisions and included an additional protected category in section 301(c)(1)(D), referred to as the "grandfather" provision, in S. 4122, introduced at the end of the 109th Congress.

Grandfather Provision. The "grandfather" provision of section 301(c)(1)(D) protects the priority status of health care facilities (in certain categories) on the Priority List from being affected by changes to the Priority System being contemplated by the IHS, pursuant to the 1999 Interior Appropriations Conference Report instruction. These projects have been on the Priority List since at least 1991.

Under the "grandfather" provision, the protected categories include:

(1) *Top 10 Projects*. Projects in the FY 2008 IHS budget justification for the 10 top-priority inpatient, outpatient, staff quarters and Youth Regional Treatment Centers (YRTC) projects. Currently, those projects include:

Inpatient: Phoenix and Whiteriver, AZ; Barrow and Nome, AK.

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[81] For a detailed discussion on the Priority System and the three phases, see U.S. Department of Health and Human Services, Indian Health Service, "Healthcare Facilities Construction Priority System Methodology," June 3, 2004, located at http://www.ihs.gov/TribalLeaders/triballetters/2004_Letters/06-28-2004_Enclosure.pdf; and "Health Care and Related Facilities," located at http://www.ihs.gov/NonMedicalPrograms/DFEE/InfoSheets/infosheet.PDF.

[82] House Report 106–406, at 138–139.

Outpatient: Ft. Yuma, Red Mesa, Kayenta, San Carlos and Winslow-Dilkon, AZ; St. Paul, AK; Sisseton, Eagle Butte and Rapid City, SD.

YRTC: Wadsworth, NV; Central-Southern and Northern California.

(2) *Phase I and II*. Projects that have completed Phases I and II of the Priority System in effect *on the date of enactment* of the Indian Health Care Improvement Act Amendments. Currently, these projects include: Ft. Belknap, MT; Wagner, SD; Sells and Bodaway-Coppermine, AZ; Gallup, Alamo, Albuquerque, Pueblo Pintado, Crownpoint and Shiprock, NM.

During the 109th Congress, a third category was added:

(3) *Secretarial Discretion*. Projects not in the other two protected categories and selected on the initiative of the Secretary or at the request of an Indian tribe or tribal organization.

During the 109th Congress, the IHS, FAAB and Workgroup began finalizing their recommendations and draft revisions to the Priority System. The Committee had been informed that these drafts purported to revise what would constitute Phases I and II of the Priority System. These proposed changes could then have affected what projects would be "grandfathered" under section 301(c)(1)(D) and thus change the priority of several projects which have been waiting on the Priority List for many years.

Due to the uncertainty of when the IHS will approve the final changes (before or after the Act is reauthorized) and what those changes will consist of, the third category was added to ensure that the Secretary still has authority to prioritize projects which might no longer qualify under the other two protected categories.

Innovative Approaches. Currently, construction funding generally has been applied to the projects on the Priority List. The Committee has been informed that the total cost of the current Priority List is in excess of $200 million as of FY 2008, with other unmet needs in the billions of dollars. At the time of the congressional directive in 1999, the construction appropriations was over $41 million and even reached over $94 million in FY 2004. The amount of appropriations increased slightly until FY 2006, after which it has decreased quite significantly.

Ideally, with a continuation of the level of funding appropriated following the conference report directive in FY 2000, the current Priority List should have been nearing completion by the time revisions to the Priority System were finalized. Unfortunately, significant unforeseen national events occurred since the Appropriations Committee's directive, which affected the amount of available appropriations for closing out the current Priority List and allowing other projects to be added to the List and built. Thus, the current Priority List has not been completed, whereas the revisions to the Prriority System are nearing completion.

The Committee has been informed that while projects have been on the Priority List for a number of years, many other needed projects have never been on the Priority List. The Committee had been requested to include an alternative approach in S. 1200 to address the remaining unmet needs through the concept of an Area Distribution Fund. Under an Area Distribution Fund, a portion of construction funding could be devoted to IHS Area priorities. This localized approach would allow other smaller projects to be com-

pleted, instead of waiting until the entire current Priority List is completed.

In light of the facilities backlog, section 301(f) of S. 1200 encourages the Secretary to seek innovative approaches to address unmet needs for health care facility construction, and requires the Secretary to consult and cooperate with Indian tribes in developing these innovative approaches. The Committee recognizes that the Secretary has engaged in considerable work revising the Priority System thus far. These proposed revisions may also be useful in developing innovative approaches.

However, the Committee encourages the Secretary, prior to finalizing the revisions, to take into consideration the fiscal circumstances under which the 1999 congressional directive occurred, relative to those experienced today, and how innovative approaches to financing construction may be implemented in such a manner which is fair and equitable to those Indian tribes to be served by the projects on the current Priority List and those Indian tribes which have not had the opportunity to have their projects placed on the list.

The Committee expects the IHS to work with Indian tribes in developing the types of innovative approaches to pursue, as well the contours of those approaches. The Secretary has used broad authority to develop and maintain the Priority System since the 1980s, and section 301(f) also provides broad authority to implement innovative approaches, such as an Area Distribution Fund, if, after consultation with the Indian tribes, it is determined that this is an appropriate system to address the health facility needs of Indian communities. The Committee also expects the IHS to work with Indian tribes and to submit a minimum budget request consistent with the congressional directive which will accommodate both the current Priority List and any innovative approaches.

Elevation of the IHS Director. Section 601 of S. 1200 elevates the Director of the IHS to the position of Assistant Secretary for Indian Health within the Department of Health and Human Services. The purpose of this elevation is to foster the government-to-government relationship between Indian tribes and the United States, facilitate advocacy for Indian health policy, and promote consultation on Indian health matters. Presently, the Director of the Indian Health Service is appointed by the President and confirmed by the Senate pursuant to 25 U.S.C. 1661(a). The Director reports to the DHHS Secretary through the Assistant Secretary for Health.

During the 109th Congress, the provisions elevating the Director to the Assistant Secretary were included in the introduced bill, S. 1057, but not in the final iteration, S. 4122, due to objections by the Administration. The Committee has continued to receive testimony in strong support of elevation from the Indian tribes.[83] The testimony received by the Committee and consultation with Indian tribes during the 110th Congress have counseled in favor of including the provisions in S. 1200 as part of the IHCIA reauthorization.

Previous bills establishing this position in the Department have either been favorably approved by the Committee or passed the Senate: S. 558 (108th Congress, passed by the Senate), S. 214

[83] Indian Health Care Improvement Act: Hearing of the Senate Indian Affairs Committee, 110th Cong., 1st Session, S. Hrg. 110–53 at 74 (March 8, 2007) (statement of Rachel Joseph).

(107th Congress, ordered reported by the Committee), S. 299 (106th Congress, passed by the Senate), S. 1770 (105th Congress, passed by the Senate), S. 311 (104th Congress, ordered reported by the Committee), and S. 2067 (103rd Congress, passed by the Senate).

Like these legislative predecessors, S. 1200 facilitates the government-to-government relationship between the United States and Indian tribes by providing the necessary leadership within the Administration on Indian health issues to bring focus, priority and national attention to the health care status and needs of Indians. Section 601 is intended to enhance the Federal capacity to respond to the ongoing health crisis in Indian Country and the continuing frustration of Indian tribes and patients that their needs and concerns are not adequately addressed under the current administrative policy and budgetary processes.

Previous Senate reports further elaborate upon the evolution of the IHS and the need and purposes for establishing this position. (See Senate Report Nos. 108–76, 107–170, 106–148, 105–319, and 103–327.) Nevertheless, an abbreviated discourse is necessary to inform the continuing need for elevating the Director to the Assistant Secretary for Indian Health.

Budgetary Improvement. The IHS operates a comprehensive health care delivery system nationwide through a variety of health care facilities and services and through contracts and compacts with Indian tribes under the Indian Self-Determination and Education Assistance Act, with Urban Indian Organizations, or with private health care providers through the contract health services program.

Efforts to address Indian health care needs have been tempered by the steady decline in purchasing power of the IHS budget. Indeed, the IHS 2004 study on Level of Need Funding indicated that the funding fell short of meeting the health care needs of Indian people and was operating at approximately a 40% deficiency.

The Committee has not seen appreciable decreases to this deficiency to convince it that elevation is not necessary. One of the principal justifications for the elevation has been past Administrations' failure to incorporate tribal recommendations in the final budget request, despite tribal participation throughout the budget process.

For example, the Committee received testimony estimating health care needs in excess of $19.7 billion to achieve parity for Indian people.[84] Past budgets have reflected marginal increases, even in the era of tight budgets, but these increases have not closed the gap on the "level of need" funding deficiency.

In addition, the Committee has also received testimony that Indian tribes requested continued funding for the Urban Indian Organizations during the annual budget formulation sessions.[85] However, the FY 2007 and FY 2008 President's Budget Requests zeroed out funding for the Urban Indian Organizations.[86] These decreases

[84] S. Hrg. 110–48 at 184 (testimony of H. Sally Smith).

[85] Id.

[86] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2007, Justification of Estimates for Appropriations Committees, at IHS–49, and U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2008, Justification of Estimates for Appropriations Committees, at CJ–121.

are disturbing in light of the alarming disparities that exist between the health status of the Indian population and other populations in the United States. These disparities have been well-documented in past Committee reports, legislation and testimony before the Committee.[87]

Although the Committee has received testimony that the Director has access and policy input within the DHHS, the health care status of Indians remains at such levels which necessitate a modified level of leadership and advocacy. The establishment of the Assistant Secretary for Indian Health will facilitate advocacy within DHHS and the Office of Management and Budget for the funding resources and policies that are necessary to effectively and efficiently address the health care needs and concerns of the Indian people.

Regulatory and Administrative Improvement. The Indian health care system presents cross-cutting issues which involve DHHS agencies other than the IHS. The Committee recognizes the current attention given to Indian health issues as well as the revitalization of the Intra-departmental Council on Native American Affairs within the DHHS which would address matters in DHHS agencies affecting Indian health.

Despite this revitalization, concerns have been raised with the Committee that broad administrative and regulatory matters within DHHS affecting Indian health have not been addressed either properly or timely. The Committee intends that this position would create an opportunity for the Assistant Secretary for Indian Health to be involved in the formulation of policy and regulatory authority on these larger issues which affect Indian health rather than simply addressing matters which are solely Indian in nature.

As stated in previous Committee reports, the Committee continues to believe that the institutionalization of a senior policy official responsible for Indian health within the DHHS is necessary to bring parity and reduce deficiencies in the delivery of Indian health care services. This institutionalization is also important to ensure that the advocacy and the knowledge of the United States legal and moral obligations for Indian health and the mission of the IHS is carried forward in future Administrations.

Third Party Reimbursements. Funding from sources other than IHS appropriations has been identified as a factor affecting the availability of health care services for Indians.[88] Those funding sources include third-party reimbursements from Medicaid and Medicare. In some cases, these reimbursements constitute up to 50% of the medical care budget for a particular Indian health program.[89]

With more resources, the Indian health care system could provide more services, and the Committee strongly encourages IHS and the Indian tribes to seek additional resources to supplement the appropriated sums provided annually.[90] The GAO noted that "[f]acilities with higher reimbursements had additional funds with

[87] See, for example, footnotes 46 and 76, above.
[88] GAO Report No. GAO–05–789, at 4.
[89] Id., at 5.
[90] S. 1200 includes amendments to the ISDEAA which authorize the Native American Health and Wellness Foundation to promote the mission of IHS through such means as receiving donations which supplement, not offset, appropriations. Offsetting in Indian health care programs is generally prohibited by law. See 25 U.S.C. Sec. 1641(a).

which they could hire staff, purchase equipment and supplies, and renovate their buildings."[91] In one case, 31 percent of a facility's clinical providers and other staff was funded by third party reimbursements.[92]

S. 1200 provides for an increase in access to Medicaid by removing barriers through waivers of premiums and cost-sharing at Indian health facilities and by codifying agency regulations or practices which recognize the unique nature of and special circumstances applying to Indian property, particularly trust and restricted property.[93] Likewise, S. 1200 provides other means of removing barriers to obtaining third-party reimbursements, such as the process for seeking waivers of sanctions, which promotes favorable state-tribal relations.

Waiver of Medicaid Co-Pays. One fundamental purpose of the Indian Health Care Improvement Act is to improve access to health care for Indian people. Removing barriers to such access is a critical aspect in accomplishing that purpose. To that end, section 204 of Title II of S. 1200 prohibits cost-sharing under Medicaid.[94]

Indian tribes have strongly advocated that this policy waiving Medicaid co-pays reflects the federal trust obligation for Indian health wherein the health care has been "pre-paid"—for example, by the treaty agreements exchanging tribal lands for health care. As additional justification, the Indian tribes contend that this policy is not unusual to the Medicaid system, since other Medicaid policies reflect that federal obligation. An example of this is the 100% FMAP or Federal Matching Assistance Percentage, wherein the federal government provides 100% of the reimbursement to states of Medicaid reimbursements for services provided by the IHS or tribal health programs.

Moreover, Indian tribes contend that the waiver of the co-pay is necessary to create incentives to enroll in Medicaid. Recognizing the federal obligation for Indian health care, the IHS, tribal and urban health programs do not charge the Indian patients cost-sharing for participating in the Indian health system to which Medicaid provides reimbursements. Charging the Indian patient a Medicaid co-pay will create a disincentive to enroll, essentially barring that Indian patient's access to Medicaid; as a result, the overall Indian health budget, along with the ability to provide additional services, may suffer. On the other hand, waiver of the co-pay will continue to encourage Indian patients to enroll in Medicaid programs, thus "stretching" IHS appropriated dollars.

The Committee is aware of concerns that cost sharing discourages overutilization of health care services, which should be of particular concern to a system which is overburdened already. However, this concern may be addressed in several ways.

Cost-sharing would not achieve the intended purpose of modifying behavior to avoid overutilization within the Indian health system. Overutilization assumes that there are otherwise adequate levels of services available to a population of non-overutilizers. Pu-

[91] GAO Report No. GAO–05–789, at 26.

[92] Id.

[93] As a general rule, these special types of property are not included in eligibility calculations for income taxes or federal benefits.

[94] This provision is modeled after the current Centers for Medicare and Medicaid Services State Children's Health Insurance Program regulation prohibiting cost-sharing for Indian children (42 C.F.R. Section 457.535).

nitive or disincentive measures will not work if the service is not available or delayed. Services being unavailable or delayed have been documented by the GAO study,[95] and the IHS Level of Need Funded (LNF) Study. The data in the GAO study reported that many Indian people are not seeking health care services until it is too late. There was no evidence in this GAO report that overutilization of the health care services occurred at the Indian health programs.

The data in the LNF Study also suggests that many Indian patients may have to delay seeking health care because services are rationed, rather than available for every health care need. In other words, Indian patients are not running to the clinic for every sniffle, but may wait until their health care needs become emergent problems. Thus, it is unlikely that overutilization occurs, so there is no problem that the cost-sharing would obviate. Imposing cost-sharing, on the other hand, may serve to further exacerbate the problem of delaying health care by requiring a co-pay by Indian patients who can ill afford it.

Removing barriers to enrollment will enable Indian patients to enroll in Medicaid, and the ensuing Medicaid reimbursements will assist the Indian health program in providing more services, thereby diminishing the potential of overburdening the system. Cost-sharing is, in reality, cost-shifting. If Indian patients are eligible and qualify for Medicaid, then the patient should take advantage of the available program. By not enrolling, the cost that should be borne by Medicaid continues to strain the IHS budget, which has been documented to be insufficient to meet the needs of Indian communities.

Consequently, S. 1200 continues the policy and provisions regarding Medicaid co-pays that were reported favorably by the Senate Finance Committee in S. 3524 during the 109th Congress.

Non-Eligibles. Congress has recognized that "without a proper health status, the Indian people will be unable to fully avail themselves of the many economic, educational, and social programs already directed to them."[96] Providing services to Indian people improves the health of Indians in a direct manner.

However, protecting the health of Indians requires attention to issues other than direct services to Indians. In the 1800s, services such as vaccinations were provided to Indians located near forts to protect the health of soldiers.[97] Now the tables are turned. Under certain circumstances, individuals not otherwise eligible for Indian health care may receive a limited scope of health services under the Act to protect the health of Indians.

Serving "non-eligibles" for these purposes comports with the Administration's goals of promoting "healthy Indian . . . communities"[98] and "including new approaches to delivering care."[99] Serving non-eligibles has been a policy of the Act for many years

[95] GAO Report No. GAO–05–789, (August, 2005).
[96] Senate Report 94–133, at 23.
[97] See American Indian Policy Review Commission, Task Force Six, Final Report to the Commission, Vol. 6, at 28.
[98] S. Hrg. 109–162, at 585 (statement of Dr. Grim, Director, U.S. Department of Health and Human Services, Indian Health Service).
[99] Id. at 589.

and it reflects a logical and reasonable approach to protect Indian health.

For example, the Act provides that services may be provided to a non-eligible pregnant woman carrying an Indian's child. 25 U.S.C. 1680c(c)(3) (Section 807(d)(3) of S. 1200). In addition, services may be provided to prevent the outbreak of communicable diseases such as tuberculosis. 25 U.S.C. 1680c(c)(2) (Section 807(d)(2) of S. 1200).

In including these "non-eligible individuals" in the service delivery system, Congress has set forth considerations for the IHS and Indian tribes to address prior to providing the services—the "two-part determination" contained at 25 U.S.C. 1680c(b)(1)(A):

> (i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and
>
> (ii) there is no reasonable alternative health facility or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

However, the Committee is aware that questions have arisen regarding how the two-part determination applies to Indian tribes with contracts or compacts under ISDEAA.

Where services are directly provided by the IHS, the Indian tribe(s) served by the Service Unit and the IHS jointly make the two-part determination (25 U.S.C. 1680c(b)(1)(A)). Section 807 of S. 1200 provides that, for programs administered by an Indian tribe pursuant to a contract or compact under the ISDEAA, the Indian tribe is authorized to provide services to non-eligibles, but "shall take into account" the two-part determination.

Congress has made it clear that the determination shall be made in both instances: in the case of direct services it is made by both IHS and the Indian tribes and, in the case of ISDEAA contracts or compacts, by Indian tribes. Congress did not provide in the Act express substantive or procedural provisions governing how the determinations should be made, given the innumerable variations in circumstances for the Indian communities.

However, Section 807 does provide some guidance on how the parties may determine whether there will be no diminution of services. For example, the non-eligibles receiving services "shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary" (25 U.S.C. 1680c(b)(2)(A)). In other words, no diminution may be experienced if the funded used to serve these people is replaced by other funding.

In addition, health services may be provided to indigent non- eligibles if there is a reimbursement agreement with the State or local governments. These provisions, however, do not limit the ability of either the IHS or Indian tribes to include additional considerations in determining whether services would be decreased. Other budgetary factors, delays in services, and appointment waiting times,[100] are all other considerations that may be appropriate, depending on the particular circumstances.

Likewise, when assessing reasonable alternatives, the IHS and Indian tribes may be confronted by factors such as remote locations, distances to other health facilities and other unique difficulties, which render other health care alternatives unavailable. Ques-

[100] See GAO Report No. GAO–05–789.

tions surrounding what is available should be placed in the context of the following policy considerations. First, services under this Act are for the ultimate protection of Indian health. Second, the IHS and tribal health programs are the payors of last resort which means, in this situation, that all other avenues of obtaining health services should be exhausted by the non- eligible individual prior to seeking assistance from either IHS or the tribal health programs.

The Committee has been informed that some health providers may refuse to serve Medicaid beneficiaries, thus making any other health service alternatives unavailable. In those situations, if good faith efforts have been made to obtain services and all avenues have been exhausted, it appears that there may be an arguable case of unavailability.

When making these determinations, Indian tribal leaders are placed in a difficult situation. On the one hand, the federal obligation for Indian health—which the Indian tribe is administering—is secured for the benefit of Indians. Authorizing services for non-eligibles is a determination not made lightly by Indian tribal leaders. On the other hand, withholding services from these non-eligibles under the limited circumstances enumerated in this Act may serve to do harm to Indian people by not eliminating general health hazards.

Evaluations were left in S. 1200 to the IHS and Indian tribes based on their particular circumstances and, if appropriate, could be developed more fully through negotiated rulemaking or consultation.

SECTION-BY-SECTION ANALYSIS

A significant portion of current law has been carried forward by S. 1200 and reorganized in the various titles according to subject matter. S. 1200 also adds several new provisions to current law which may (1) amend current law, such as turning a demonstration project into a permanent program, (2) clarify or make small additions, such as including Tribal Organizations in various sections, or (3) introduce brand new programs to the Indian health care system, such as Indian youth suicide prevention, intervention and treatment through the use of telemedicine, and convenient care services.

The following section-by-section analysis will, where relevant, identify whether current law has been changed followed by an explanation of the current law to be reauthorized by S. 1200. In addition, the codified section in current law is also noted to provide ease of reference.

Section 1. Short title; table of contents

Section 1 provides that this Act may be cited as the "Indian Health Care Improvement Act Amendments of 2007," and contains the table of contents.

TITLE I—AMENDMENTS TO INDIAN LAWS

The provisions of Title I are within the jurisdiction of the Senate Indian Affairs Committee.

Section 101. Indian Health Care Improvement Act amended

This section sets forth a host of provisions which incorporate provisions of current law and make amendments to the Act.

Section 1. Short title; table of contents

This Act may be cited as the "Indian Health Care Improvement Act." Section 1 also sets for the table of contents for Title I.

Section 2. Findings

Section 2 sets out Congressional findings for the Act, which indicate that the health levels of Indians are below that of the rest of the U.S. population and that the provision of health care is consonant with the Federal relationship and responsibility to Indian people.

Amendments: This section maintains current law.

Current Law: This section is Section 1601 of current law.

Section 3. Declaration of national Indian health policy

This section declares national policy, in fulfillment of the special trust responsibilities and legal obligations to Indians, to assure the highest possible health status for and raise the health status of Indians and Urban Indians through the provision of health services.

Amendments: This section amends current law by (1) replacing the enumerated list of health level objectives with the goals contained in the Healthy People 2010 national health agenda; and (2) adding new language to (a) add trust to the responsibilities being fulfilled by the national policy, (b) allow Indians to set their priorities according to their needs, (c) increase the health profession degrees awarded to Indians so the levels of Indian health professionals in each Service Area is at least the level of the general population, (d) require consultation with Indian Tribes, Tribal Organizations and Urban Indian Organizations, consistent with the policy of Indian self-determination, and (e) provide funding to Indian tribal programs and facilities consistent with levels of IHS programs and facilities.

Current Law: This section is Section 1602 of current law.

Section 4. Definitions

Section 4 provides definitions for terms used throughout the Act.

Amendments: This section maintains current law and adds several new definitions. Assistant Secretary, behavioral health, tribal college or university, telehealth, contract health service, and telemedicine are examples of new definitions not now in current law.

Current Law: Section 1603 of current law provides definitions for terms used throughout the Act.

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

Section 101. Purpose

This section states the purpose of this title, which is to increase the number of Indians entering health professions and providing health services, and to assure an optimum supply of health professionals to provide health services to Indians.

Amendments: This section maintains current law and adds language indicating congressional intent to maximize the number, and assure an optimum (not merely adequate) supply, of health professionals in the Indian health system.

Current Law: Section 1611 of current law states the purpose of increasing the number of Indian health professionals and assuring an adequate supply of health professionals to provide health services to Indians.

Section 102. Health professions recruitment program for Indians

This section authorizes grants for recruitment programs, including identifying Indians with potential for entering health professions, publicizing sources of financial aid, and establishing programs to facilitate enrollment in applicable courses of study. This section also addresses funding applications and amount of funding to be provided, as well as outlining the eligibility for these programs.

Amendments: This section maintains current law.

Current Law: This section is Section 1612 of current law.

Section 103. Health professions preparatory scholarship program for Indians

Section 103 authorizes scholarships to Indians for compensatory preprofessional education, as well as pregraduate education leading to a baccalaureate degree in a preparatory field for a health profession. This section specifies certain conditions on these scholarships which include costs which may be covered by the scholarships, and prohibits denial of a scholarship based solely on scholastic achievement if applicant has already been admitted or maintains good standing at an accredited institution, or if the applicant is eligible for assistance under another federal program.

Amendments: This section maintains current law and adds new provisions, authorizing extensions of pregraduate scholarship award terms up to 2 years, according to Secretarial regulations, and authorizing regulations for determining part-time equivalents for the compensatory preprofessional scholarships.

Current Law: This section is Section 1613 in current law.

Section 104. Indian health professions scholarships

Section 104 authorizes scholarships to Indians who are enrolled full- or part-time in accredited schools, pursuing courses of study in the health professions. Such scholarships are designated as Indian Health Scholarships. The section further sets forth how the funding for these scholarships is to be allocated and addresses all the requirements of the active duty service obligation incurred as a result of the scholarship, including breach of contract situations.

Amendments: This section maintains current law and adds new provisions that (1) require a year-for-year service obligation for scholarship recipients; (2) require Secretarial guidelines for fulfilling the service obligation in private practice; and (3) allow a recipient to fulfill the service obligation by teaching in a tribal college or university nursing program if health services to Indians are not diminished

Current Law: This section is Section 1613a of current law.

Section 105. American Indians into psychology program

This section authorizes grants of not more than $300,000 to each of 9 colleges and universities for developing and maintaining Indian psychology career recruitment programs, including a Quentin N. Burdick Program Grant at the University of North Dakota. This section directs the Secretary to issue regulations for competitive funding, and specifies conditions of the grants and active duty service requirements. $2.7 million is authorized for each of FY 2008 through 2017.

Amendments: This section maintains current law and adds new language which (1) sets the number of colleges or universities that may receive grants from at least 3 to 9, and (2) establishes a maximum grant amount of $300,000, for a total of $2.7 million for each of FY 2008 through 2017.

Current Law: The section is Section 1621p of current law.

Section 106. Scholarship programs for Indian tribes

Section 106 authorizes the Secretary to make funds available to Tribal Health Programs for the purpose of educating Indians to serve as health professionals in Indian communities. The requirements for receiving such funds; the course of study; contract requirements; specific parameters for a breach of contract; the relationship of a scholarship under this section to the Social Security Act; and conditions of continuance of funding are all specified in this section. The recipient is required to fulfill service obligations and use the scholarship for tuition and reasonable education or living expenses. The recipient cannot discriminate against patients who receive assistance under Titles XVIII and XIX of the Social Security Act.

Amendments: This section maintains current law and adds new language which (1) amends the source of funds for the scholarship costs by allowing 20% to be from any source instead of only nonfederal sources; (2) requires that licensing and educational requirements be met for all health professions, not only for the doctor and nursing professions; (3) provides that the scholarship may allow the recipient to serve in another Service Area, provided the Tribal Health Program and Secretary approve and services are not diminished to Indians in the Service Area where the Tribal Health Program providing the scholarship is located; and (4) adds Title XXI of the Social Security Act to the non- discriminatory provisions.

Current Law: This section is Section 1616m of current law.

Section 107. Indian Health Service extern programs

Section 107 gives preference for employment with the Service, a Tribal Health Program, Urban Indian Organization or other agencies within the Department, to any recipient of a scholarship pursuant to section 104 or 106. The section specifies that such employment does not count toward any active duty service obligation. It specifies the timing and length of employment and exempts the program from any competitive personnel system or agency personnel limitation. The section further specifies that an individual employed under this section will receive practical experience in the health profession in which he or she is engaged in study.

Amendments: This section maintains current law and adds the following new provisions: (1) extends the extern program to Tribal

Health Programs, Urban Indian Organizations or urban Indian health providers (on a discretionary basis) or other Department agencies, instead of only the IHS; and (2) gives the extern, including an extern in a high school program, a preference for employment with the IHS, instead of entitling them to employment.

Current Law: This section is Section 1614 of current law.

Section 108. Continuing education allowances

This section permits the Secretary to provide programs or allowances to (a) transition in to an Indian Health Program, including licensing, board or certification examination and technical assistance, in fulfilling service obligations, and (b) health professionals employed in an Indian Health Program to enable them to take leave of their duty stations for a period of time each year for professional consultation and refresher training courses.

Amendments: This section maintains current law, but also deletes the set-aside of not more than $1 million for postdoctoral training contained in current law, and adds language which extends the continuing education allowances to Tribal Health Programs and Urban Indian Organizations, in addition to the IHS, and includes all health professionals, rather than specified select health professionals.

Current Law: This section is Section 1615 of current law.

Section 109. Community Health Representative Program

Section 109 authorizes the Community Health Representative Program for training and using Indians as community health representatives. The section specifies the duties of the Service regarding this program, including providing a high standard of training for Community Health Representatives to ensure that these representatives provide quality health services to Indian communities served by this program. This program may also promote traditional health care practices consistent with IHS standards for health care.

Amendments: This section maintains current law, and adds language which formally identifies the health paraprofessionals as Community Health Representatives (CHRs) and extends the use of CHRs to Tribal Health Programs and Urban Indian Organizations as well as IHS programs.

Current Law: The section is Section 1616 of current law.

Section 110. Indian Health Service Loan Repayment Program

This section directs the Secretary to establish and administer the Service Loan Repayment Program in order to ensure an adequate supply of trained health professionals needed to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and Urban Indian Organizations. The section includes provisions addressing eligibility for the program; application information; priorities; recipient contracts; deadlines for decisions on applications; a loan repayment program; a waiver from any employment ceiling; a recruitment program; non-applicability of Section 214 of the Public Health Service Act (which concerns employees or officers being assigned to other agencies) during the period of obligated service; assignment of individuals; breach of contract; waiver or suspension of obligation; and the requirement of an annual report to Congress under Section 801.

Amendments: This section maintains current law. In addition, it (1) eliminates the set-asides during FY 1993–1995 for nursing and mental health professions; and (2) establishes priorities among applications rather than requiring the priorities be subject to the list of positions established by the Secretary, and sets a 21-day notice requirement instead of merely prompt notice.

Current Law: This section is Section 1616a of current law.

Section 111. Scholarship and Loan Repayment Recovery Fund

Section 111 establishes an Indian Health Scholarship and Loan Repayment Recovery Fund within the Treasury of the United States. The section specifies the use of these funds, the investment of the funds, and the sale of obligations by the Secretary of the Treasury.

Amendments: This section maintains current law, and adds provisions expanding the source of funds for this Recovery Fund to include funds collected from individuals for breach of contract under the scholarship or loan repayment programs and interest, in addition to appropriations. Tribal Health Programs may also use payments received to provide scholarships, in addition to the current uses of recruitment and employment of health care professionals. The Secretary of Health and Human Services may now determine what amounts are not required to meet current withdrawals from the Fund, rather than the Secretary of the Treasury, as in current law.

Current Law: This section is Section 1616a–1 of current law. It establishes an Indian Health Scholarship and Loan Repayment Recovery Fund within the Treasury of the United States, wherein funds collected for breaches of contractual obligations under the IHS or tribal scholarships or loan repayment programs are placed.

Section 112. Recruitment activities

Section 112 permits the Secretary to reimburse certain travel expenses to health professionals seeking positions with Indian Health Programs or Urban Indian Organizations. Potential candidates for contracts under section 110 and their spouses are all eligible for such reimbursement of travel. In addition, this section requires the Secretary to assign one individual in each Area Office to have full-time responsibility for recruitment activities.

Amendments: This section maintains current law and adds language to allow reimbursement for health professionals seeking positions with Tribal and Urban Indian Health Programs, in addition to the IHS.

Current Law: This section is Section 1616b of current law.

Section 113. Indian recruitment and retention program

Section 113 requires the Secretary to fund innovative demonstration projects to enable Tribal Health Programs and Urban Indian Organizations to recruit, place, and retain health professionals to meet their staffing needs. The section also specifies that any Tribal Health Program or Urban Indian Organization is eligible to apply for these funds.

Amendments: This section maintains current law and adds language which (1) sets a time limit of three years for demonstration projects funded under this section instead of an open-ended time-

frame under current law; and (2) clarifies that the entities eligible to compete are Tribal Health Programs and Urban Indian Organizations.

Current Law: This section is Section 1616c of current law.

Section 114. Advanced training and research

This section establishes a demonstration project to enable health professionals who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time to pursue advanced training or research areas of study, where a need exists. Each individual who participates shall incur a service obligation. The section also specifies equal opportunity for participating in the program.

Amendments: This section maintains current law and adds language which limits the advanced training or research opportunities to health professionals who have worked for the IHS, tribal or urban Indian health programs for a substantial period of time, instead of merely being employed by one of these programs at the time of application.

Current Law: This section is Section 1616d of current law.

Section 115. Quentin N. Burdick American Indians into Nursing Program

Section 115 authorizes the Quentin N. Burdick American Indians into Nursing Program for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians. The section specifies potential grant recipients; how grants may be used; information which must be included in applications for the grant; preferences for grant recipients; establishment and maintenance of a program at the University of North Dakota; and an active duty service obligation.

Amendments: This section maintains current law and adds language which (1) includes advanced practice nurse programs in addition to nurse practitioners; (2) authorizes grants for midwife or nursing programs at tribal colleges and universities or, in their absence, other colleges and universities, instead of only at the other public or private institutions; and (3) includes tribal colleges and universities in the preferences among grant applicants.

Current Law: This section is Section 1616e of current law.

Section 116. Tribal cultural orientation

This section requires certain employees of the Service who serve Indian Tribes in each Service Area to receive instruction in the history and culture of the Indian Tribes they serve. The section requires that the program be developed in consultation with the affected Indian entities, be implemented through tribal colleges or universities, include instruction in American Indian studies, and describe the use and place of traditional health care practices of the Indian Tribes in the Service Area.

Amendments: This section maintains current law and adds language which (1) ensures that employees in each Service Area obtain cultural orientation, rather than merely establishing a program for cultural orientation; (2) requires the program to include instruction on the relationship of the Indian Tribes with the IHS, rather than simply a history of the IHS, and a description of the

traditional health care practices of the Indian tribes in the Service Area; and (3) requires consultation with affected Tribes, Tribal Organizations and Urban Indian Organizations.

Current Law: This section is Section 1616f of current law.

Section 117. INMED Program

Section 117 authorizes the Secretary to provide grants to colleges and universities to maintain and expand the Indian health careers recruitment program known as the Indians Into Medicine Program (INMED). The Quentin N. Burdick Grant at the University of North Dakota is to be one of the authorized grants. This section also specifies requirements for institutional applicants for these grants.

Amendments: This section maintains current law and adds language which (1) authorizes grants to an unspecified number of colleges or universities instead of the previous mandate of at least 3 schools; (2) clarifies that the regulations govern the grants, including substantive provisions, such as criteria and application requirements, rather than govern only the competitive award process; and (3) eliminates an old 1988 requirement of a report to Congress on the program and recommendations for changes.

Current Law: This section is Section 1616g of current law.

Section 118. Health training programs of community colleges

This section requires the Secretary to award grants to accredited, accessible community colleges to assist in establishing health profession education leading to a degree or diploma for individuals who desire to practice such profession on or near a reservation or in an Indian Health Program. The Secretary is also required to award grants to accredited, accessible community colleges that already have these programs. The Secretary must provide technical assistance to encourage community colleges to establish and maintain such programs. Any program receiving assistance under this section is required to provide advanced training for health professionals. Grant award priority is provided to tribal colleges and universities in Service Areas where they exist.

Amendments: This section maintains current law and adds language which (1) recognizes accredited and accessible community colleges as eligible recipients of grants; (2) requires the colleges to have a relationship with a hospital, rather than merely having access to a hospital; (3) requires Indian preference for program participants; (4) increases the ceiling amount of the grant from $100,000 to $250,000; and (5) establishes priority for tribally-controlled colleges in Service Areas where they exist, if other requirements in the section are met.

Current Law: This section is Section 1616h of current law.

Section 119. Retention bonus

Section 119 permits the Secretary to provide retention bonuses to any health professional where recruitment or retention is difficult or is needed by Indian Health Programs and Urban Indian Organizations, if the individual has completed 2 years of employment with an Indian Health Program or Urban Indian Organization or any service obligation from federal scholarships or loan repayment programs, and enters into an agreement with an Indian

Health Program or Urban Indian Organization for continued employment for a period of not less than 1 year. Rates for retention bonuses may cover multiple years, but not exceed an annual rate of $25,000. Refunds shall be required if the health professional does not complete the term of service under any retention agreement, unless the default is not the fault of the individual.

Amendments: This section maintains current law and adds language expanding the bonuses (1) to any health professional, rather than only doctors and nurses, so language specifying funding set-asides between these 2 professions has been deleted; and (2) to health professionals employed by the tribal or urban health programs, rather than employed only by the Service. Language also eliminates the current requirement that the retention bonus be paid at the beginning of the term of service.

Current Law: This section is Section 1616j in current law.

Section 120. Nursing residency program

This section establishes a program to enable Indians who are nurses working for an Indian Health Program or Urban Indian Organization to pursue advanced training. The participants are required to enter a service obligation to serve in an Indian Health Program or Urban Indian Organization. The program shall include a combination of education and work study leading to either an associate or bachelor's degree or advanced degrees or certifications.

Amendments: This section maintains current law and adds language which establishes this program for Indian nurses and includes advanced degrees or certifications in nursing or public health as eligible programs, instead of a Master's degree, as appropriate post-baccalaureate training.

Current Law: This section is Section 1616k of current law.

Section 121. Community Health Aide Program

Section 121 directs the Secretary to develop and operate a Community Health Aide Program in Alaska. Requirements are specified for the Alaska program. Dental Health Aide Therapists under the Program would be prohibited from performing all oral and jaw surgeries except pulpal therapy or extraction of adult teeth after consultation with a licensed dentist in a dental emergency. In addition, the Secretary is directed to establish a neutral panel to conduct a study of the dental health aide therapist services provided by the Community Health Aide Program. Specifications of the study, which will lead to a report to Congress, are delineated. This section also allows the Secretary to establish a national Community Health Aide Program, which shall not include dental health aide therapist services, and shall not reduce funds for the Alaska program.

Amendments: This section maintains current law and adds provisions which (1) require the Secretary to establish a neutral panel, whose membership is also set forth in this section, to study the dental health aide therapist program in Alaska Native communities and to submit a report on the study to appropriate Congressional Committees and (2) authorizes the expansion of the Community Health Aide Program, except for the dental health aide therapist program, to Indian communities in the lower 48 states.

Current Law: This section is Section 1616l of current law.

Section 122. Tribal Health Program administration

This section requires the Secretary to provide training for Indians in the administration and planning of Tribal Health Programs.

Amendments: This section maintains current law and adds language which specifies that the training shall be for individuals who are Indian.

Current Law: This section is Section 1616n of current law.

Section 123. Health professional chronic shortage demonstration programs

This section permits the Secretary to fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals. Each demonstration program shall incorporate a program advisory board, which is to be composed of representatives from the Indian Tribes and Indian communities which are served by the program.

Amendments: This section amends current law by changing a single pilot program at the School of Medicine at the University of South Dakota to address health professional shortages into a national demonstration project.

Current Law: This section is Section 1616o in current law. Current law authorizes the Secretary to make a grant to the School of Medicine at the University of South Dakota to fund a pilot program on an Indian reservation at one or more Service Units in South Dakota to address the chronic manpower shortages in the Aberdeen Area of the IHS.

Section 124. National Health Service Corps

This section prohibits the Secretary from removing a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization or withdrawing funding used to support such member, unless the Secretary ensures that Indians will experience no reduction in services. The section also exempts Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service from full-time equivalent limitations when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

Amendments: This section maintains current law and adds Urban Indian organizations. Language which exempts National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service from full-time equivalent limitations when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization is new to current law.

Current Law: This section is Section 1680b of current law.

Section 125. Substance abuse counselor educational curricula demonstration programs

Section 125 allows the Secretary to enter into contracts with or make grants to accredited colleges and universities (including tribal) to establish demonstration programs developing curricula for substance abuse counseling. Duration and renewal of the grants is specified. The section also states the criteria for review and approval of the applications; requires the Secretary to provide technical and other assistance to grant recipients; requires the Sec-

retary to submit an annual report to the President under section 801; and defines the term "educational curriculum."

Amendments: This section maintains current law, and adds language including accredited and accessible qualifications for the community colleges eligible for these programs and extending the initial grant period from one year to three years and the renewal periods from one year to two years.

Current Law: This section is Section 1665j of current law.

Section 126. Behavioral health training and community education programs

This section requires the Secretary, with the Secretary of the Interior and in consultation with Indian Tribes and Tribal Organizations, to conduct a study and compile a list of certain types of staff positions within the Bureau of Indian Affairs, the Service, Indian Tribes, Tribal Organizations and Urban Indian Organizations, which should include training in any aspect of mental illness, dysfunction, or self-destructive behavior.

The Secretary is then required to provide training criteria appropriate for each type of position and ensure that this training is provided. Upon request of the appropriate Indian entity, the Secretary is required to develop and implement a program of community education on mental illness, as well as to provide technical assistance to tribal entities to obtain and develop community education materials.

Within 90 days of enactment of this Act, the Secretary is required to develop a plan to increase behavioral health services by at least 500 staff positions within 5 years, with at least 200 of such positions being devoted to child, adolescent, and family services.

Amendments: This section maintains current law and (1) adds Tribal Organizations and Urban Indian Organizations as participants in the program; (2) clarifies that Tribal Organizations are to be part of the consultation process; (3) changes the focus from solely on mental health to behavioral health; and (4) eliminates the requirement that the staff be assigned primarily to the IHS Service Units.

Current Law: This section is Section 1621h(d) of current law.

Section 127. Authorization of appropriations

Section 127 authorizes to be appropriated such sums as may be necessary to carry out this title for each fiscal year through 2017.

Amendments: The section updates the authorization period through fiscal year 2017, instead of fiscal year 2000.

Current Law: This section is Section 1616p of current law.

TITLE II—HEALTH SERVICES

Section 201. Indian Health Care Improvement Fund

This section authorizes the use of funds for the purposes of eliminating the deficiencies in health status and resources for tribes; eliminating backlogs and meeting the needs in health care services; eliminating the inequities in funding for direct care and contract health service programs; and augmenting the ability of the Indian Health Service to meet its various responsibilities. Funding authorized by this section may not be used to offset appropriated funds

and must be used to improve the health status and reduce the resource deficiencies of tribes.

This section also defines "health status and resource deficiency" and requires that Tribal Health Programs be equally eligible for funds as programs administered by the Indian Health Service. A report is required to be submitted to Congress 3 years after enactment which addresses the current health status and resource deficiency for each Service Unit. Funds appropriated under this section are to be included in the base budget of the Indian Health Service for determining appropriations in subsequent years.

Nothing in this section is intended to diminish the primary responsibility of the Indian Health Service to eliminate backlogs in unmet health care, or to discourage additional efforts of the Service to achieve equity among Tribes and Tribal Organizations.

Funds appropriated under this section are to be designated as the "Indian Health Care Improvement Fund."

Amendments: This section maintains current law and adds provisions clarifying that the Secretary may expend funds either directly or through contracts or compacts under the Indian Self-Determination and Education Assistance Act, as well as provisions regarding the use of telehealth and telemedicine. Language has been added specifying the kinds of injury prevention programs that may be offered.

Current Law: This section is Section 1621 of current law.

Section 202. Catastrophic Health Emergency Fund

Section 202 establishes the Catastrophic Health Emergency Fund (CHEF), which is to be administered by the Secretary through the headquarters of the Indian Health Service in order to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. No part of the CHEF or the administration thereof is to be subject to contract or grant, nor shall these funds be apportioned on an Area Office, Service Unit, or other similar basis. The Secretary is required to promulgate regulations for the administration of these funds. This section prohibits funds appropriated to CHEF from being used to offset or limit other appropriations made to the Indian Health Service. It also requires that all reimbursements to which the Service is entitled from any source by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF shall be deposited into CHEF.

Amendments: This section maintains current law.

Current Law: This section is Section 1621a in current law.

Section 203. Health promotion and disease prevention services

This section finds that health promotion and disease prevention activities improve health and well-being and reduce the expenses for health care. It requires the Secretary to provide these services and, with input from the affected Tribal Health Programs, to report to Congress on an evaluation statement of the status, capacity and resources needed to promote health and prevent disease.

Amendments: This section maintains current law, but moves the definition of health promotion and disease prevention to the definitions section and adds Congressional findings.

Current Law: This section is Section 1621b of current law.

Section 204. Diabetes prevention, treatment, and control

Section 204 requires the Secretary to determine the incidence of diabetes and its complications among Indians and the measures needed to prevent, treat and control this disease. The Secretary is also required, when medically indicated and with informed consent, to screen Indians for diabetes and for conditions which indicate a high risk for diabetes.

The Secretary is required to continue to fund model diabetes projects and dialysis programs. To the extent that funding is available, the Secretary is required to work with each Area Office to consult with Tribes and Tribal Organizations regarding diabetes programs; establish patient registries in Area Offices; and ensure that data collected are disseminated to other Area Offices, subject to privacy laws. The Secretary is also allowed to maintain diabetes control officers, but if these positions and activities are administered by the Tribes or Tribal Organizations, then the funding and activities would not be divisible under the Indian Self-Determination and Education Assistance Act.

Amendments: This section maintains current law and (1) adds (a) Tribal Organizations as eligible participants in these programs, (b) effective ongoing monitoring of disease indicators, (c) the requirement that screening shall be to the extent medically indicated and with informed consent, and (d) funding for dialysis programs; (2) changes the model diabetes projects into permanent programs to be continued along with any new programs developed with recurring funding; and (3) still allows for diabetes control officers in each Area Office, but provides that if these positions and activities are administered by the Tribes or Tribal Organizations, then the funding and activities would not be divisible under the Indian Self-Determination and Education Assistance Act.

Current Law: This section is Section 1621c of current law.

Section 205. Shared services for long-term care

This section allows the Secretary to enter into funding agreements with Tribes and Tribal Organizations for the delivery of long-term care services to Indians. Contents of these funding agreements are specified. Any nursing facility funded under this section must meet the requirements for such facilities under section 1919 of the Social Security Act. In addition, the Secretary is required to provide necessary technical and other assistance to enable applicants to comply with the provisions of this section. The Secretary shall encourage the use of existing underused facilities or allow the use of swing beds for long-term or similar care.

Amendments: This section amends current law by changing a demonstration project into a permanent program and adding new provisions which (1) include health care services associated with long- term care provided in a facility for Indians; and (2) encourage the use of existing underused facilities or allow the use of swing beds for long-term or similar care.

Current Law: This section is Section 1680l of current law.

Section 206. Health services research

This section requires the Secretary to make funding available for both clinical and nonclinical research to further the delivery of Indian health services, and to coordinate the activities of other agen-

cies within the Department to address this need. Tribal Health Programs are to be given equal opportunity to compete for these research funds. The Secretary shall also periodically evaluate the impact of research conducted under this section, and disseminate to Tribal Health Programs information regarding that research.

Amendments: This section amends current law by (1) eliminating the specific set-aside of $200,000 for research and replacing it with general authority to fund research for Indian health programs, instead of only the IHS; (2) requiring the Secretary to coordinate, to the extent practical, the resources and activities for Indian health research needs; (3) authorizing funding for both clinical and non-clinical research; and (4) providing for a periodic evaluation and dissemination of the research to Tribal Health Programs.

Current Law: This section is Section 1621g of current law.

Section 207. Mammography and other cancer screening

This section requires the Secretary to provide for mammography and other cancer screening, consistent with the screening recommendations of the United States Preventive Services Task Force.

Amendments: This section amends current law by authorizing other cancer screening, and eliminating the minimum age requirement of 35 for Indian women and opening the mammography screening to all Indian women, at a frequency under appropriate national standards.

Current Law: This section is Section 1621k of current law.

Section 208. Patient travel costs

Section 208 requires the Secretary to provide funds for the travel costs of patients and their qualified escorts, associated with receiving health care services. A definition of "qualified escort" for purposes of accompanying a patient who is traveling to receive health care services is provided.

Amendments: This section maintains current law and adds language which allows the use of qualified escorts and transportation by private vehicle (where no other transportation is available), specially equipped vehicle, ambulance or by other means required when air or motor vehicle transport is not available.

Current Law: This section is Section 1621l of current law.

Section 209. Epidemiology centers

This section directs the Secretary to establish an epidemiology center in each Service Area. The functions of these centers are delineated. The Director of the Centers for Disease Control and Prevention is required to provide technical assistance to the centers. The Secretary is also authorized to make grants to Tribes, Tribal Organizations, Urban Indian Organizations and eligible intertribal consortia to conduct epidemiological studies of Indian communities. Eligibility requirements for consortia, application requirements and use of grant funds are specified. This section also authorizes the Secretary to provide access to information in the possession of the Secretary to an epidemiology center operated by a grantee pursuant to a grant awarded under this section.

Amendments: This section amends current law by (1) maintaining the centers in existence on the date of passage of this Act, but

still requiring the establishment of centers in the remaining Areas; (2) allowing new centers to be operated under a grant under this section, but the funding under such a grant shall not be divisible; (3) eliminating the requirements in current law that the Secretary establish the data and formats for reporting and establish the system for monitoring progress toward the health objectives; and (4) providing that an epidemiology center operated under this section shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996 and directing the Secretary to grant grantees access to and use of data and other protected health information in the possession of the Secretary.

Current Law: This section is Section 1621m of current law.

Section 210. Comprehensive school health education programs

Section 210 allows the Secretary to provide grants to Indian Tribes, Tribal Organizations and Urban Indian Organizations to develop comprehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of Indian and Urban Indian children. The specific purposes for which grant funds may be used are delineated. Upon request, the Secretary shall provide technical assistance in the development and dissemination of comprehensive health education plans, materials and information. The Secretary, through the Service and in consultation with Tribes, Tribal Organizations and Urban Indian Organizations, shall establish criteria for review and approval of applications for this funding. For Bureau of Indian Affairs-funded schools, the Secretary of the Interior shall develop a similar school health education program.

Amendments: This section maintains current law and adds language which (1) clarifies the types of purposes for which the funds may be used, such as for both regular school and after school programs, for the benefit of Indian and urban Indian children, for oral health programs, for violence prevention and for other health issues, as appropriate; (2) expands the grants to include Tribal Organizations and Urban Indian Health Organizations as eligible for funding, as well as Tribes; (3) deletes the reporting requirements of current law; and (4) requires that the application criteria be established in consultation with Indian Tribes, Tribal Organizations and Urban Indian Organizations.

Current Law: This section is Section 1621n of current law.

Section 211. Indian youth program

This section authorizes the Secretary to establish and administer a program for innovative mental and physical disease prevention and health promotion and treatment for Indian and Urban Indian preadolescent and adolescent youths. Allowable and prohibited uses of the funds authorized by this section are delineated. The Secretary is required to disseminate information regarding models for delivery of comprehensive health care services to Indian youth; to encourage the implementation of these models; and to provide technical assistance upon request. The Secretary will establish criteria for review and approval of applications under this section in consultation with Tribes, Tribal Organizations and Urban Indian Organizations.

Amendments: This section maintains current law and adds Tribal Organizations and Urban Indian Organizations as participants in the program and consultation, and includes urban Indian youth as beneficiaries of program services. The specific authorization of this program in current law is deleted.

Current Law: This section is Section 1621o of current law.

Section 212. Prevention, control, and elimination of communicable and infectious diseases

Section 212 authorizes the Secretary to make grants available to projects specifically for the purpose of preventing, controlling and eliminating communicable and infectious diseases. Funding is also authorized for public information and education programs; education, training and clinical skills improvement activities for health professionals; and demonstration projects for the screening, treatment and prevention of the hepatitis C virus. Funding under this section requires an application or proposal to be submitted. Entities which receive funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention, as well as with state and local health agencies. Finally, in carrying out this section, the Secretary may provide technical assistance, upon request, and shall submit a biennial report to Congress on the use of the funds and the progress made toward prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

Amendments: This section amends current law by (1) including Urban Indian Organizations; (2) expanding the communicable diseases from simply tuberculosis to other communicable and infectious diseases; (3) by encouraging, rather than requiring, that entities funded under this section coordinate with the Centers for Disease Control and state and local health agencies; and (4) by eliminating provisions of current law which would reduce the grant amount for expenses incurred by the federal government or for supplies or equipment furnished to the grant recipient.

Current Law: This section is Section 1621q of current law.

Section 213. Other authority for provision of services

This section authorizes the Secretary to fund other activities which meet the objectives set forth in Section 3 of this Act through health care-related services and programs not otherwise described in the Act, including hospice care, assisted living, long-term health care, and home- and community-based services. Services are to be in provided in accordance with accepted and appropriate standards relating to the service, including any licensing term or condition. The Secretary is authorized to establish standards, by regulation, for a service provided under this section, provided that those standards are not more stringent than the standards required by the state in which the service is provided. If the Secretary does not establish standards by regulation, state standards shall apply. If a service under this section is provided by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act, the verification by the Secretary that the service meets any standards required by the state in which the service is or will be provided shall be considered to meet the terms and conditions required. The individuals who are eligible to receive

long-term care under this section are specified, and the terms "home- and community-based services" and "hospice care" are defined. This section also authorizes the Secretary to provide funding to meet the objectives set forth in Section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).

Amendments: This section amends current law by making permanent a demonstration project for home- and community-based care. New provisions also (1) add standards; (2) add several definitions and deletes the definition of "functionally disabled" found in current law; and (3) eliminates the exclusion of cash payments, room and board, construction and nursing facility services. The provision authorizing the Secretary to provide funding to meet the objectives set forth in Section 3 of this Act for convenient care services programs is new.

C*urrent Law*: Section 1680k authorizes the Secretary to establish not more than 24 demonstration projects for home-and community-based care (excluding cash payments, room and board, construction and nursing facility services), for functionally disabled Indians. Discretion is provided to the Indian Health Service, Indian Tribes, or Tribal Organizations to provide such care to persons otherwise ineligible for the health care benefits of the Indian Health Service (on a cost basis). The Secretary is required to submit to the President for inclusion in a report to Congress the findings of these projects. "Home- and community-based services" and "functionally disabled" are defined.

Section 214. Indian women's health care

This section requires the Secretary, acting through the Service, Indian Tribes, Tribal Organizations and Urban Indian Organizations, to monitor and improve health care for Indian women of all ages through the planning and delivery of programs administered by the Service.

Amendments: This section amends current law by eliminating the Office of Indian Women's Health and, instead, requiring the Secretary to monitor and improve the quality of Indian women's health through the various programs administered by IHS.

Current Law: Section 1621v establishes an Office of Indian Women's Health Care to oversee efforts of the IHS to monitor and improve health care for Indian women of all ages.

Section 215. Environmental and nuclear health hazards

Section 215 requires the Secretary, in conjunction with other Federal agencies and in consultation with concerned Tribes and Tribal Organizations, to conduct studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and other Indians as a result of environmental hazards, such as nuclear resource development, petroleum contamination, and contamination of water sources and the food chain. Upon completion of such studies, the Secretary shall develop health care plans to address these health problems. The Secretary is required to submit the study to Congress 18 months after the date of enactment and a report no later than 1 year after the study which shall include recommendations for the implementation of the health care plan and evaluation activities. This section establishes an Intergovernmental Task Force to identify environmental hazards and to

take corrective action. The Secretary is to chair this Task Force, which shall meet at least twice yearly. If an Indian who is employed in or around any environmental hazard suffers from a work-related condition, the Indian Health Program which treats him may be reimbursed by the Indian's employer.

Amendments: This section maintains current law and adds language which (1) requires ongoing monitoring of trends in health hazards to Indians and other environmental hazards to Indian communities; and (2) provides additional elements of the studies conducted under this section.

Current Law: This section is Section 1677 of current law.

Section 216. Arizona as a contract health service delivery area

This section designates the State of Arizona as a contract health service delivery area for providing contract health care services to members of federally recognized Indian Tribes of Arizona. The Indian Health Service is not to curtail any services as a result of this provision.

Amendments: This section maintains current law and extends the date to 2017, instead of 2000, for the designation as a contract health service delivery area.

Current Law: This section is Section 1678 of current law.

Section 216A. North Dakota and South Dakota as contract health service delivery area

This section designates the States of North Dakota and South Dakota as one contract health service delivery area for providing contract health care services to members of federally recognized Indian Tribes in North and South Dakota. The Indian Health Service is not to curtail any services as a result of this provision.

Amendments: This section is new to the Act and is not contained in current law.

Section 217. California contract health services program

This section authorizes the Secretary to fund a program using the California Rural Indian Health Board (CRIHB) as a contract care intermediary to improve the accessibility of health services to California Indians. The Secretary will reimburse the CRIHB for costs incurred pursuant to this section. Not more than 5 percent of the amounts provided under this section to the CRIHB in any fiscal year may be for administrative expenses. No payment may be made for treatment under this section to the extent payment may be made under the Indian Catastrophic Health Emergency Fund or from amounts appropriated or otherwise made available to the California contract health service delivery area. This section also establishes an Advisory Board to advise the CRIHB in carrying out this section. The Advisory Board shall be comprised of representatives from not less than 8 Tribal Health Programs serving California Indians covered under this section, and at least one-half of whom are not affiliated with the CRIHB.

Amendments: This section amends current law by turning the demonstration project for the California Indians into a permanent program.

Current Law: This section is Section 1621j of current law.

Section 218. California as a contract health service delivery area

This section designates the State of California, excluding certain specified counties, as a contract health service delivery area for the purpose of providing contract health care services to California Indians. The excluded counties may be included only if funding is specifically provided by the Indian Health Service for such services in those counties.

Amendments: This section maintains current law, but allows the excluded counties to become a part of the contract service delivery area if funding is specifically provided for such services in those counties.

Current Law: This section is Section 1680 of current law.

Section 219. Contract health services for the Trenton service area

This section directs the Secretary to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians who reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in North Dakota and the counties of Richland, Roosevelt, and Sheridan in Montana. Nothing in this section is to be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for these services that applied on May 1, 1986.

Amendments: This section maintains current law.

Current Law: This section is Section 1680e of current law.

Section 220. Programs operated by Indian tribes and tribal organizations

This section requires the Indian Health Service to provide funds to Tribal Health Programs for health care programs and facilities on the same basis as funds are provided to these programs operated directly by the Indian Health Service.

Amendments: This section maintains current law, but eliminates language which specifies the particular use of funds for which the Indian Tribes and Tribal Organizations can receive funding on the same basis as the IHS.

Current Law: Section 1680a requires the Indian Health Service to provide funds to tribes and tribal organizations health care programs and facilities to (1) maintain and repair clinics, (2) train employees, (3) provide cost-of-living expenses, and (4) provide for other expenses related to health services on the same basis as funds are provided to these programs operated directly by the Indian Health Service.

Section 221. Licensing

Section 221 requires that health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program provides the services.

Amendments: This section is new to the Act and is not contained in current law.

Section 222. Notification of provision of emergency contract health services

This section allows 30 days (as a condition of payment) for an elderly or disabled Indian to notify the Service of any emergency medical care or services received from a non-Service provider or in a non-Service facility.

Amendments: This section maintains current law.

Current Law: This section is Section 1646 of current law.

Section 223. Prompt action on payment of claims

Section 223 provides a deadline for the Service to respond to notification of a claim by a provider of a contract care service. The section also provides that if the Service fails to respond within the required time, the Service shall accept the claim submitted by the provider as valid. The IHS shall pay a valid claim within 30 days after the completion of the claim.

Amendments: This section maintains current law, but changes the requirement of a completed claim to a valid claim.

Current Law: This section is Section 1621s of current law.

Section 224. Liability for payment

This section provides that a patient who receives authorized contract health care services will not be held liable for any charges or costs associated with those authorized services. The Secretary is required to notify the contract care provider and the patient who receives such services that the patient is not liable within a specified time. Following receipt of this notice or an acceptable claim under the previous section, the provider shall have no further recourse against the patient who received the health care.

Amendments: This section maintains current law and adds language which limits the recourse against the patient if the claim has been deemed accepted under Section 223.

Current Law: This section is Section 1621u of current law.

Section 225. Office of Indian Men's Health

This section provides that the Secretary may establish the Office of Indian Men's Health to coordinate and promote the health status of Indian men. The Office will be headed by a director, who is to be appointed by the Secretary. The Secretary is also required to submit a report to Congress within two years of enactment, describing any activity and finding about the health of Indian men of the director.

Amendments: This section is new to the Act and is not contained in current law.

Section 226. Authorization of appropriations

This section authorizes to be appropriated such sums as may be necessary to carry out this title for each fiscal year through fiscal year 2017.

Amendments: This section maintains current law, but extends the authorization from fiscal year 2000 to fiscal year 2017 and eliminates the references to specific sections which had a separate authorization period.

Current Law: This section is Section 1621w of current law.

TITLE III—FACILITIES

Section 301. Consultation; Construction and renovation of facilities; Reports

This section requires that prior to expending construction funds, the Secretary shall consult with impacted Indian Tribes, and ensure that facilities built pursuant to this section meet certain construction standards within one year after the date on which the construction or renovation of such facility is completed. In addition, Section 301 sets forth requirements to be met prior to closing any facility.

This section also directs the Secretary to maintain a health care facility priority system which shall be developed in consultation with Indian Tribes and Tribal Organizations and meet other requirements. The priority of any project established under the construction priority system in effect on the date of enactment, if the project meets certain criteria, is protected. Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary shall submit to Congress a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian Tribes, and Tribal Organizations. Beginning in calendar year 2011, the Secretary shall update this report not less frequently than once every 5 years. Annual reports are also required under this section.

Not later than 1 year after the establishment of the health care facilities construction priority system under this section, the Comptroller General of the United States shall prepare and finalize a report to Congress, that reviews the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the priority system. This section also directs the Secretary to consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities.

Amendments: This section maintains current law and builds on it substantially. Language is added which (1) requires an evaluation of the impact of a proposed closure prior to closing; (2) requires the Secretary to maintain a health care facility priority system developed through consultation, which prioritizes certain facilities; (3) adds specific requirements for the initial, comprehensive report to Congress and subsequent annual reports; (4) requires the Secretary to consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to meet facilities needs; and (5) requires the Comptroller General to prepare a report to Congress which reviews the methodology used for the health facilities construction priority list.

Current Law: This section is Section 1631 of current law.

Section 302. Sanitation facilities

This section provides findings, certain responsibilities of the Service for sanitation, authorized uses of sanitation funding and facilities, and reporting requirements, and establishes the deficiency levels for those facilities. This section requires training or technical assistance in the operation and maintenance of sanitation facilities,

and priority funding for operation and maintenance or emergency repairs.

Section 302 authorizes the Secretary to accept funds from any source, including funds appropriated under the Native American Housing Assistance and Self-Determination Act, for construction of sanitation facilities. The Secretary, after consulting with the Secretary of Housing and Urban Development and Indian Tribes, Tribal Organizations and tribally designated housing entities, is also required to submit a report to Congress on the sanitation facilities priority system and a 10-year plan to provide sanitation facilities to new and renovated Indian homes. Deficiency levels for sanitation facilities are defined.

Amendments: This section maintains current law and adds language which (1) establishes priority funding for emergency repairs and operation or maintenance to avoid imminent health threats or to protect the investment in health benefits gained through the sanitation facilities; (2) prohibits the use of IHS funding to provide sanitation facilities to new homes constructed using Department of Housing and Urban Development funds; (3) allows the Secretary to accept funds from any source, including federal and state agencies, for sanitation facilities and services, and to place those funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act; (4) authorizes the Secretary to allow certain funding to be used to fund tribal loans or matching or cost participation requirements to construct sanitation facilities; (5) requires the Secretary enter into interagency agreements for financial assistance; (6) requires consultation in preparation of the report to Congress, and clarifies the information required to be in the annual report; and (7) establishes an Indian Tribe's primary responsibility for collecting user fees and the Secretary's responsibility in assisting tribes when the facility is threatened with imminent failure.

Current Law: This section is Section 1632 of current law.

Section 303. Preference to Indians and Indian firms

This section authorizes the Secretary to give preference to Indians or Indian or tribal enterprises or other businesses in the construction and renovation of Service facilities pursuant to section 301, and in the construction of sanitation facilities pursuant to section 302. Compliance with certain labor standards is required.

Amendments: This section maintains current law and adds new language to clarify rates of pay requirements and other wage requirements similar to local rates as determined by the Indian tribes or Tribal Organizations to be served by the construction.

Current Law: This section is Section 1633 of current law.

Section 304. Expenditure of non-service funds for renovation

This section authorizes the Secretary to accept any expansion, renovation or modernization of any Service or tribal health facility funded with non-Service funds in accordance with certain criteria. The Secretary is required to maintain a separate priority list for these facilities, which shall be submitted to Congress as part of the annual report to Congress. Indian Tribes or Tribal Organizations are required to meet certain requirements for expansions, renovations or modernizations. This section also provides that if any Serv-

ice facility which has been expanded, renovated, or modernized under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation, or modernization is completed, such Indian Tribe or Tribal Organization shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation, or modernization bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

Amendments: This section maintains current law and adds language which (1) includes major expansion as an authorized use of funds, in addition to renovation and modernization, but requires the Indian Tribes or Tribal Organizations to provide certain information to the Secretary regarding staffing, equipment and other costs associated with the expansion; and (2) requires the methodology for determining priorities to be developed through regulations.

Current Law: This section is Section 1634 of current law.

Section 305. Funding for the construction, expansion and modernization of small ambulatory care facilities

This section authorizes the Secretary to make grants to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services. Use of funds, grant application requirements, priorities, and conditions for reversion of facilities are set forth.

Amendments: This section maintains current law and adds language which (1) requires the funding to be used for the portion of costs which benefits the eligible population, but exempts from the specific eligibility requirements applicants whose principal health administration offices are located where there is no road system providing direct access to inpatient hospitals; (2) adds additional capacity requirements for a facility constructed with a grant under this section; (3) makes reduction of an outstanding debt for construction, expansion or modernization an additional allowable use of funds; and (4) authorizes peer review panels to be established to evaluate applications and proposals.

Current Law: This section is Section 1636 of current law.

Section 306. Indian health care delivery demonstration projects

This section authorizes the Secretary to establish a health care delivery demonstration project to test alternative means of delivering health care and services to Indians through facilities. There would be two kinds of demonstration projects. General projects would be authorized, with priority given to projects located in specific Service Areas, if they meet the specified criteria, such as the need for such facility, number of Indians to be served, the economic viability of the project, and the administrative and financial capability of Indian Tribes or Tribal Organizations to administer the project. Health care delivery demonstration projects would also be authorized that include a convenient care services program as an alternative means of delivering health care services to Indians. This section also requires technical assistance and use of the same criteria in evaluating tribal and IHS facilities.

Amendments: This section maintains current law and adds language which (1) permits the use of IHS funds to match other funds; (2) authorizes the convenient care services demonstration projects; and (3) authorizes peer review panels to be established to review and evaluate applications. Language of current law authorizing reports to Congress on the findings and conclusions of the demonstration projects has been deleted.

Current Law: This section is Section 1637 of current law.

Section 307. Land transfer

This section authorizes the Secretary to accept any land and improvements transferred, at no cost, from the Bureau of Indian Affairs or other federal agencies for the provision of health care services.

Amendments: This section amends current law by changing a specific authorization into a general authorization whereby federal agencies may transfer land and improvements to the IHS for the provision of health care services.

Current Law: Section 1638 provides specific authorization for transferring 5 acres of land at the Chemawa Indian School in Salem, OR, to the IHS.

Section 308. Leases, contracts and other agreements

This section authorizes the Secretary to enter into leases, contracts and other agreements with Indian Tribes and Tribal Organizations which have facilities for the delivery of health services at those facilities. The agreements may also include provisions for construction, renovation and compensation.

Amendments: This section essentially maintains current law. The provision of current law authorizing the Secretary to enter into 20–year leases with Tribes that may specify reconstruction or renovation of property has been deleted.

Current Law: This section is Section 1674 of current law.

Section 309. Study for loans, loan guarantees and loan repayment

This section directs the Secretary to conduct a study to determine the feasibility of establishing a loan fund to provide Indian Tribes and Tribal Organizations direct loans or loan guarantees for health care facilities construction. A number of study requirements are delineated. The results of the study shall be reported to Congress.

Amendments: This section is new and is not now contained in current law.

Section 310. Tribal leasing

This section authorizes a tribal health program to lease permanent structures for the purpose of providing health care services without obtaining prior approval in appropriation Acts.

Amendments: This section maintains current law, and expands the program to include Tribal Organizations.

Current Law: This section is Section 1680j of current law.

Section 311. Indian Health Service/Tribal Facilities Joint Venture Program.

This section authorizes the Secretary to make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects, under which an Indian Tribe or Tribal Organization would expend tribal, private, or other available funds for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease. In exchange, the Service will agree to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. Certain capabilities and other requirements are set forth. There are provisions for breach of agreement by either the Tribe or Tribal Organization or the IHS.

Amendments: This section maintains current law and adds (1) Tribal Organizations to the eligible participants and those Tribes that have begun, but not completed the process of acquisition or construction of a health care facility; (2) requires negotiation for the continued operation of the facility at the end of the 10-year lease; (3) authorizes recovery in a proportional amount from the IHS if the IHS ceases to use the facility within the 10-year lease period; and (4) includes staff quarters in the definition of the health facilities under this section.

Current Law: This section is Section 1680h(e) of current law.

Section 312. Location of facilities

This section directs the Bureau of Indian Affairs and the Service to give priority to locating health care facilities and employment projects in economically depressed areas to Indian and Alaska Native lands, if requested by the Indian owner and Indian Tribe with jurisdiction over such lands.

Amendments: This section maintains current law and adds language to (1) include lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native; and (2) gives top priority to Indian land owned by 1 or more Indian Tribes. The definition of "Indian lands" is modified from current law.

Current Law: This section is Section 1680n of current law.

Section 313. Maintenance and improvement of health care facilities

This section requires the Secretary to report to Congress on the backlog of maintenance and repair work required at both Service and tribal health care facilities. This section also authorizes an Indian Tribe or Tribal Organization to use maintenance and improvement funds for construction of a replacement facility, as well as for renovation, modernization, and expansion of facilities, under certain circumstances.

Amendments: This section is new and is not now contained in current law.

Section 314. Tribal management of federally-owned quarters

This section authorizes Tribal Health Programs operating a health care facility and federally-owned quarters pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act to establish reasonable rental rates for the

federally-owned quarters, and to collect the rent directly from federal employees who occupy such quarters. These quarters shall remain eligible for improvement and repair funds as other federally-owned quarters. The Tribal Health Program operating the quarters is required to provide at least 60 days notice before changing the rental rate.

Amendments: This section is new and is not now contained in current law.

Section 315. Applicability of Buy American Act requirement

This section requires application of the Buy American Act for all procurements under this title. Indian Tribes and Tribal Organizations are exempt from this requirement.

Amendments: This section maintains current law, but exempts Indian Tribes and Tribal Organizations from the requirements of the Buy American Act, and eliminates the reporting requirement contained in current law.

Current Law: This section is Section 1638b of current law.

Section 316. Other funding for facilities

This section authorizes the Secretary to accept funds from other sources for the construction of health care facilities and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act. The Secretary is also authorized to enter into interagency agreements with other federal or state agencies for the planning, design and construction of health care facilities to be administered by Indian Health Programs.

Amendments: This section is new and is not now contained in current law.

Section 317. Authorization of appropriations

This section authorizes to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

Amendments: This section maintains current law but extends the authorization for appropriations beyond fiscal year 2000 through fiscal year 2017.

Current Law: This section is Section 1638a of current law.

TITLE IV—ACCESS TO HEALTH SERVICES

Section 401. Treatment of payments under Social Security Act health care benefits programs

This section requires that any Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) payments received by an Indian Health Program or Urban Indian Organization for services provided to eligible Indians shall not be considered in determining appropriations for the provision of health care and services. Indians without Medicare, Medicaid or SCHIP coverage are to be given equal consideration as Indians who are covered by these Social Security Act health benefit programs. Payments to which a facility of the Service is entitled by reason of a provision of the Social Security Act are to be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary is to ensure that each Service Unit receives 100% of the amount to

which the facility of the Service, for which such Service Unit makes collections, is entitled. How funds collected from Medicare, Medicaid, or SCHIP are to be used is specified. This section also allows Tribal Health Programs to elect to directly bill for, and receive payment for, health care items and services provided by that Tribal Health Program for which payment is made under Medicare, Medicaid, SCHIP, or third party payors.

Amendments: This section maintains current law and (1) adds Tribal Organizations and Urban Indian Organizations, in addition to Tribes and the IHS, for whom reimbursements would not be considered in determining appropriations; (2) authorizes the 100% pass-through of payments due to Service facilities from the special fund; and (3) expands the authorized uses of the reimbursements from improvements only to hospitals or skilled facilities to also include programs and the excess used to reduce health deficiencies, subject to consultation by the Indian Tribes served. However, this provision authorizing the Secretary to determine the uses shall not apply when the Indian Tribes elect to receive reimbursements directly.

Current Law: Sections 1641 and 1642 address treatment of payments under Medicare or Medicaid. Section 1645 established a program under which tribes could elect to directly bill and be reimbursed for health care services provided under Medicare, Medicaid or other third parties.

Section 402. Grants to and contracts with the service, Indian tribes, tribal organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs

This section directs the Secretary to make grants to or enter into contracts with Tribes and Tribal Organizations to improve enrollment and participation in Medicare, Medicaid or SCHIP programs, including paying premiums or cost sharing (which terms are defined in this section). In doing so, the Secretary shall place such conditions as are deemed necessary to affect the purpose of this section, including certain requirements of the Indian Tribe or Tribal Organization. Specifications for applying this section to Urban Indian Organizations are included. This section also directs the Secretary, acting through the Centers for Medicare and Medicaid Services, to take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians and to improving the enrollment of Indians under Social Security Act health benefits programs. This section also provides a cross-reference to the relevant section of the Social Security Act for provisions related to agreements between the Secretary and Indian Tribes, Tribal Organizations, and Urban Indian Organizations for the collection, preparation, and submission of applications by Indians for assistance under Medicare, Medicaid and SCHIP.

Amendments: This section maintains current law and adds provisions which outline the agreements between the Secretary and the Tribes, Tribal or Urban Indian Organizations to improve the enrollment of Indians in Social Security Act programs.

Current Law: This section is Section 1644 of current law.

Section 403. Reimbursement from certain third parties of costs of health services

Section 403 provides that the United States, an Indian Tribe, or Tribal Organization has the right to recover from an insurance company, health maintenance organization, employee benefit plan, or any third party the reasonable charges billed by the Secretary, an Indian Tribe, or Tribal Organization in providing health services to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification. This right of recovery is extended against any state, under certain conditions. Certain state or local laws are deemed nonapplicable to prevent or hinder this right of recovery. This section has no effect on private rights of action. Enforcement measures for the right of recovery, notice, costs and attorneys' fees are all specified in this section. Section 403 limits the Indian Health Service right of recovery against a tribal self-insured plan absent written consent from the Tribe. Other items covered in this section include nonapplication of claims filing requirements; application to Urban Indian Organizations; statute of limitations; and a savings clause.

This section adds a new provision which would extend to Tribes and Tribal Organizations the same authority the U.S. has under the Federal Medical Care Recovery Act (FMCRA) to recover the costs of medical care from a tortfeasor whose action caused an injury or disease to a patient whom a federal health care provider is obliged to treat. While the Department of Justice brings such suits against tortfeasors for federal health care providers such as the IHS, it does not currently do so for Tribes which operate IHS-funded health programs.

Amendments: This section maintains current law and adds language (1) to enable Urban Indian Organizations to seek recovery from third parties; (2) to require reasonable efforts be taken to provide notice to the patient either before or during the pendency of the action; (3) to limit the IHS right of recovery against a tribal self-insured plan absent written consent; (4) to include awards of reasonable attorneys' fees and costs of litigation; (5) to prohibit denial of reimbursement on the basis of a different format or form; and (6) to extend to Tribes and Tribal Organizations the same authority the U.S. has under the Federal Medical Care Recovery Act (FMCRA) to recover the costs of medical care from a tortfeasor.

Current Law: This section is Section 1621e of current law.

Section 404. Crediting of reimbursements

This section authorizes the retention of the reimbursements received or recovered under this Act, Medicare, Medicaid or SCHIP and other provisions of law, from third parties and specifies the use of those reimbursements. This section also disallows any offset or limitation of amount obligated to any Service Unit, Indian Tribe or Tribal or Urban Indian Organization because of the receipt of reimbursements under this section.

Amendments: This section maintains current law and adds language which specifies which programs are included in the reimbursements.

Current Law: This section is Section 1621f of current law.

Section 405. Purchasing health care coverage

Section 405 allows Tribes, Tribal Organizations and Urban Indian Organizations to use funding for health benefits for Indians to be used to purchase health benefits coverage for Service beneficiaries in any manner (including through a tribally owned and operated health care plan, a state or locally authorized or licensed health care plan, a health insurance provider or managed care organization, or a self-insured plan), based on the financial needs of such beneficiaries.

Amendments: This section replaces a provision of current law which authorized a managed care feasibility study.

Current Law: Section 1621i of current law authorized the Secretary to conduct a study to assess the feasibility of allowing an Indian Tribe to purchase managed care coverage for tribal members from a tribally owned and operated managed care plan or a state or licensed managed care plan.

Section 406. Sharing arrangements with Federal agencies

This section allows the Secretary to enter into or expand arrangements to share medical facilities and services with the Departments of Veterans Affairs and Defense, with certain limitations. If health care services are provided to beneficiaries eligible for services from either the Department of Veterans Affairs or the Department of Defense, then the Service, Indian Tribe, or Tribal Organization providing the service shall be reimbursed from the appropriate Department. The Secretary shall not take action which would impair priority access to or quality of care for Indians at IHS or priority of veterans to care by the VA.

Amendments: This section amends current law by (1) authorizing the Secretary to enter agreements for sharing of medical facilities with the Departments of Veterans Affairs (VA) and Defense, instead of merely examining the feasibility of entering agreements with the VA; (2) requiring consultation with the affected Indian Tribes prior to entering the agreements; (3) requiring reimbursement to the IHS, Tribes, or Tribal Organizations; and (4) eliminating the specific cross-utilization of services in Utah only (expanding it, generally).

Current Law: Section 1680f of current law authorizes the Secretary to examine the feasibility of entering agreements to share medical facilities and services with the Department of Veterans Affairs, with a specific agreement for Utah.

Section 407. Payor of last resort

This section specifies that Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to eligible persons.

Amendments: This section is new and is not contained in current law.

Section 408. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services

Section 408 provides that a federal health care program must accept an entity that is operated by the Service, an Indian Tribe,

Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable state or other requirements for participation as a provider of health care services under the program. This section also provides that state or local licensure or recognition requirements by a provider of health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such state or local law. Certain entities operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or individuals who have been excluded from participation in any federal health care program or for which a license is under suspension or has been revoked by the state where the entity or individual is located, shall not be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

Amendments: This section is new and is not contained in current law.

Section 409. Consultation

This section provides a cross-reference to the relevant section of the Social Security Act for provisions related to consultation with representatives of Indian Health Programs and Urban Indian Organizations with respect to the health care programs established under Medicare, Medicaid and SCHIP.

Amendments: This section is new and is not contained in current law.

Section 410. State Children's Health Insurance Program (SCHIP)

This section provides cross-references to relevant sections of the Social Security Act for provisions relating to outreach to families of Indian children likely to be eligible for child health assistance under SCHIP, and ensuring that child health assistance is provided under such program to targeted low-income children who are Indians and that payments are made under that program.

Amendments: This section is new and is not contained in current law.

Section 411. Exclusion waiver authority for affected Indian health programs and safe harbor transactions under the Social Security Act

This section provides cross-references to relevant sections of the Social Security Act for provisions relating to exclusion waiver authority for affected Indian Health Programs, and certain transactions involving Indian Health Programs deemed to be in safe harbors under the Social Security Act.

Amendments: This section is new and is not contained in current law.

Section 412. Premium and cost sharing protections and eligibility determinations under Medicaid and SCHIP and protection of certain Indian property from Medicaid estate recovery

This section provides cross-references to relevant sections of the Social Security Act for provisions relating to premiums or cost sharing protections for Indians furnished items or services directly by Indian Health Programs or through referral under the contract health service under Medicaid; rules regarding the treatment of certain property for purposes of determining eligibility under Social Security Act programs; and the protection of certain property from estate recovery provisions under Medicaid.

Amendments: This section is new and is not contained in current law.

Section 413. Treatment under Medicaid and SCHIP managed care

Section 413 provides cross-references to relevant sections of the Social Security Act for provisions relating to the treatment of Indians enrolled in a managed care entity under Medicaid, and Indian Health Programs and Urban Indian Organizations that are providers of items or services to such Indian enrollees.

Amendments: This section is new and is not contained in current law.

Section 414. Navajo Nation Medicaid Agency feasibility study

Section 414 requires the Secretary to conduct a study to determine the feasibility of treating the Navajo Nation as a State for Medicaid purposes. Considerations for a report to Congress on the results of the study are described in this section.

Amendments: This section is new and is not contained in current law.

Section 415. General exceptions

Section 415 provides that the requirements of this title shall not apply to any excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act, which relates to supplemental insurance products.

Amendments: This is a new provision and is not contained in current law.

Section 416. Authorization of appropriations

Section 416 authorizes to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

Amendments: This section extends the authorization beyond FY fiscal year 2000 to fiscal year 2017.

Current Law: The authorization of appropriations section for the Access to Health Services title of current law is Section 1647, and extends through fiscal year 2000.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Section 501. Purpose

This section sets forth the purpose of the title as establishing and maintaining programs in Urban Centers to make health services more accessible and available to Urban Indians.

Amendments: This section maintains current law and adds language to maintain the programs and make health services available, in addition to being accessible, to Urban Indians.

Current Law: This section is Section 1651 of current law.

Section 502. Contracts with, and grants to, urban Indian organizations

This section provides that the Secretary shall enter into contracts with, or make grants to, Urban Indian Organizations to assist such organizations in the establishment and administration, within Urban Centers, of programs which meet the requirements set forth in this title.

Amendments: This section maintains current law.

Current Law: This section is Section 1652 of current law.

Section 503. Contracts and grants for the provision of health care and referral services

This section sets forth the authority of the Secretary to enter into contracts with or make grants to Urban Indian Organizations to establish and administer programs under this title, which shall meet certain requirements. This section prescribes the criteria for selecting Urban Indian Organizations for contracts or grants. Such contracts or grants shall facilitate access to or provide services for health promotion and disease prevention, immunization services, behavioral health services, prevention of child abuse, and other services to Urban Indians.

Amendments: This section maintains current law, generally, while (1) modifying contract and grant requirements and criteria; and (2) deleting factors to be considered for immunization services contracts or grants that are set forth in current law.

Current Law: This section is Section 1653 of current law.

Section 504. Contracts and grants for the determination of unmet health care needs

This section authorizes the Secretary to enter into contracts with or make grants to Urban Indian Organizations for which contracts or grants have not been entered into under the prior section. The purpose of these contracts/grants would be to determine unmet health care needs of urban Indians. Grant and contract requirements are set forth.

Amendments: This section maintains current law.

Current Law: This section is Section 1654 of current law.

Section 505. Evaluations; renewals

This section authorizes the Secretary to develop evaluation and renewal procedures and standards for the various contracts and grants entered into by Urban Indian Organizations under this title, including considerations for renewals of contracts/grants. The Secretary shall also evaluate the urban Indian programs through onsite annual evaluations.

Amendments: This section maintains current law and adds a provision which would allow the Secretary to evaluate the urban Indian organization through acceptance of evidence of the organization's accreditation as an alternative to the onsite annual evaluation.

Current Law: This section is Section 1655 of current law.

Section 506. Other contract and grant requirements

This section sets forth other specific contract and grant requirements, such as payment methods, revisions and amendments to contracts, and assurance of the fair and uniform provision of services to Urban Indians.

Amendments: This section maintains current law and adds provisions which (1) would allow a single advance payment, unless the urban Indian organization is not capable of administering the payments in their entirety and allows the funding to be carried forward; and (2) would allow payments to be made in semiannual or quarterly payments or by way of reimbursement. This section deletes provisions of current law allowing an Urban Indian Organization to use existing federal facilities.

Current Law: This section is Section 1656 of current law.

Section 507. Reports and records

This section sets forth certain reporting and recordkeeping requirements for Urban Indian Organizations. This section also provides that not later than 18 months after the date of enactment, the Secretary, in consultation with Urban Indian Organizations, shall submit to Congress a report evaluating the health status of Urban Indians; the services provided to Indians pursuant to this title; and areas of unmet needs in the delivery of health services to Urban Indians. This section also provides that reports and records of the Urban Indian Organization shall be subject to audit by the Secretary and the Comptroller General of the United States.

Amendments: This section maintains current law and (1) adds language which extends the reporting period to semi-annual, rather than quarterly; (2) adds the requirement of a minimum set of data using uniform elements; (3) adds that the audits may also be conducted by a certified public accounting firm; and (4) deletes the requirement that IHS and the Department of the Interior report to Congress by March 31, 1992, on the health status, unmet needs and welfare of urban Indian children.

Current Law: This section is Section 1657 of current law.

Section 508. Limitation on contract authority

This section limits the authority of the Secretary to enter into contracts or to award grants under this title to the extent and amount provided for in appropriations Acts.

Amendments: This section maintains current law and adds language which includes the Secretary's authority to award grants under this title.

Current Law: This section is Section 1658 of current law.

Section 509. Facilities

This section provides that the Secretary, acting through the Service, may make grants for the lease, purchase, renovation, construction, or expansion of facilities. This section also allows the Secretary to carry out a study to determine the feasibility of establishing a loan fund to provide direct loans or guarantees for loans to Urban Indian Organizations for the construction of health care facilities.

Amendments: This section replaces current law by adding provisions which would allow for leasing, purchasing, renovating, constructing and expanding, in addition to repairing, facilities. The provision regarding the feasibility study of a loan fund to construct facilities is new.

Current Law: Section 1659 of current law authorizes the Secretary to make funds available to contractors or grant recipients to make minor renovations to the urban health facilities to meet or maintain compliance with the requirements of the Joint Commission on Accrediting Health Care Organizations.

Section 510. Division of Urban Indian Health

This section establishes a Division of Urban Indian Health within the Service to carry out the provisions of this title, provide oversight of the programs, and provide technical assistance to Urban Indian Organizations.

Amendments: This section maintains current law, but (1) changes the Branch of Urban Indian programs into an Office within the IHS; (2) adds technical assistance; and (3) deletes provisions of current law regarding staffing, services and equipment.

Current Law: This section is Section 1660 of current law.

Section 511. Grants for alcohol and substance abuse-related services

This section provides that the Secretary may make grants to Urban Indian Organizations for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education regarding, alcohol and substance abuse in Urban Centers. Goals and criteria are set forth.

Amendments: This section essentially maintains current law.

Current Law: This section is Section 1660a of current law.

Section 512. Treatment of certain demonstration projects

This section makes permanent the Tulsa Clinic and Oklahoma City Clinic demonstration projects in Oklahoma and parallels the language of the Interior Appropriations Act which first contained this provision (Public Law 108–447).

Amendments: This section maintains provisions which make permanent certain demonstration projects in Oklahoma, but modifies the language of current law of this Act to parallel the language of the Interior Appropriations Act which first contained this provision (Public Law 108–447).

Current Law: This section is Section 1660b of current law.

Section 513. Urban NIAAA transferred programs

This section authorizes the Secretary, through the Division of Urban Indian Health, to make grants to or enter into contracts with Urban Indian Organizations, to take effect not later than September 30, 2010, for the administration of Urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (NIAAA). Use of funds, eligibility and reporting requirements are set forth.

Amendments: This section maintains current law, but (1) changes references to the Branch of Urban Indian Health to the Division; and (2) deletes the provision of current law allowing the Secretary to combine NIAAA alcohol funds with other substance abuse funds.

Current Law: This section is Section 1660c of current law.

Section 514. Consultation with urban Indian organizations

This section provides that the Secretary shall ensure that the Service consults, to the greatest extent practicable, with Urban Indian Organizations, and defines "consultation."

Amendments: This section is new and is not contained in current law.

Section 515. Urban youth treatment center demonstration

This section authorizes the Secretary to fund the construction and operation of at least 2 Indian youth residential treatment centers in certain states to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

Amendments: This section is new and is not contained in current law.

Section 516. Grants for diabetes prevention, treatment, and control

This section authorizes the Secretary to make grants to Urban Indian Organizations to provide services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians, based on certain grant criteria that are set forth.

Amendments: This section is new and is not contained in current law.

Section 517. Community health representatives

This section authorizes the Secretary to make grants to or enter into contracts with Urban Indian Organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program.

Amendments: This section is new and is not contained in current law.

Section 518. Effective date

This section establishes that the amendments made by the Act to this title shall take effect on the date of enactment, regardless of whether the Secretary has promulgated regulations implementing these amendments.

Amendments: This section is new and is not contained in current law.

Section 519. Eligibility for services

This section provides that Urban Indians shall be eligible for, and the ultimate beneficiaries of, health care or referral services provided pursuant to this title.

Amendments: This section is new and is not contained in current law.

Section 520. Authorization of appropriations

This section authorizes to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

Amendments: This section maintains current law and extends the authorization from fiscal year 2000 to fiscal year 2017.

Current Law: This section is Section 1660d of current law.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Section 601. Establishment of the Indian Health Service as an agency of the Public Health Service

This section establishes the Indian Health Service within the Public Health Service of the Department, and elevates the position of Director of the Indian Health Service to that of the Assistant Secretary for Indian Health. The Assistant Secretary for Indian Health shall be confirmed by the Senate with a term of four years, and shall administer the Indian Health Service. This section also specifies the duties and responsibilities of the Assistant Secretary and deems that any reference to the Director of the Indian Health Service in any Federal law, Executive order, rule, regulation, or delegation of authority, is deemed to refer to the Assistant Secretary.

Amendments: This section amends current law to (1) change the position of the Director into an Assistant Secretary; (2) provide that the individual serving in the position of Director of the Service on the day before the date of enactment shall serve as Assistant Secretary; (3) provide that the position of Assistant Secretary is established to facilitate advocacy and promote consultation on matters relating to Indian health; (4) give the Assistant Secretary additional duties; and (5) deem current law or regulatory references to the Director to refer to the Assistant Secretary.

Current Law: This section is Section 1661 of current law.

Section 602. Automated management information system

Section 602 requires the Secretary to establish automated management information systems for the Service and each Tribal Health Program which meets certain requirements. This section also requires that patients have access to their own health records, and authorizes the Secretary to enter in to contracts, agreements, or joint ventures with other federal agencies, states, private and nonprofit organizations for the purpose of enhancing information technology in Indian Health Programs and facilities.

Amendments: This section maintains current law and adds Secretarial authority to enter contracts or joint ventures to enhance information technology in Indian health programs.

Current Law: This section is Section 1662 of current law.

Section 603. Authorization of appropriations

This section authorizes to be appropriated such sums as may be necessary to carry out this title, for each fiscal year through fiscal year 2017.

Amendments: This section maintains current law and extends the authorization from fiscal year 2000 to fiscal year 2017.

Current Law: This section is Section 1663 of current law.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

Section 701. Behavioral health prevention and treatment services

Section 701 states the purposes of the section, including directing the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. This section also requires the Secretary to encourage the development of plans for areawide Indian Behavioral Health Services; directs the Secretary to coordinate with existing national clearinghouses and information centers to include plans and reports of outcomes of such behavioral health plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas; directs the Secretary to provide comprehensive behavioral health care programs; facilitates the governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization to establish community behavioral health plans; requires the Secretary to coordinate behavioral health planning with other federal and state agencies; and directs the Secretary to assess the need, availability and cost for inpatient mental health care for Indians within 1 year.

Amendments: This section maintains current law and adds language which (1) authorizes the Secretary, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop programs which emphasize collaboration for behavioral health; (2) requires technical assistance to Indian Tribes, Tribal Organizations and Urban Indian Organizations; and (3) requires a continuum of care for behavioral health to the extent feasible, including acute hospitalization, detoxification, and emergency shelter.

Current Law: This section is Section 1621h and Section 1665 of current law.

Section 702. Memoranda of agreement with the Department of the Interior

This section requires the Secretary and the Secretary of the Interior to develop and enter, or review and update, within 1 year, memoranda of agreement to, among other things, make a comprehensive assessment, coordination, and annual review of all the behavioral health care needs and services available or unavailable to Indians. Specific provisions that are required in this memorandum are delineated. Each memorandum of agreement under this section shall be published in the Federal Register. This section also directs the Secretaries to address a strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service, including the coordination of alcohol and substance abuse programs of the Service, the BIA, and Indian Tribes and Tribal Organizations developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 with behavioral health initiatives pursuant to this Act.

Amendments: This section maintains current law and adds language which (1) requires the Secretary to update existing memoranda of agreement; and (2) includes Tribal Organizations.

Current Law: This section is Section 1621h(b) of current law.

Section 703. Comprehensive behavioral health prevention and treatment program

Section 703 requires the Secretary to provide a program of comprehensive behavioral health, prevention, treatment, and aftercare. Elements to be included in this program and target populations are specified. The Secretary may provide these services through Contract Health Services.

Amendments: This section amends current law by (1) expanding beyond the alcohol and substance abuse focus to comprehensive behavioral health; and (2) adding more specific types of treatment. Language of current law, authorizing a grant to the Standing Rock Sioux Tribe to develop a community-based demonstration project, has been deleted.

Current Law: This section is Section 1665a of current law.

Section 704. Mental health technician program

This section directs the Secretary to establish and maintain a mental health technician program within the Service to train and employ Indians as mental health technicians. The Secretary is to provide high-standard paraprofessional training in mental health care, supervise and evaluate the technicians, and ensure that the program involves the use and promotion of traditional health care practices of the Indian Tribes to be served.

Amendments: This section maintains current law.

Current Law: This section is Section 1621h(g) of current law.

Section 705. Licensing requirement for mental health care workers

This section requires that any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act to be licensed to provide these services. This section also sets forth requirements for individuals who may be employed as trainees in psychology, social work, or marriage and family therapy to provide mental health care services.

Amendments: This section maintains current law.

Current Law: This section is Section 1621h(l) of current law.

Section 706. Indian women treatment programs

This section authorizes the Secretary, consistent with section 701, to make grants to Tribes, Tribal Organizations and Urban Indian Organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically address the cultural, historical, social, and child care needs of Indian women. Use of grant funds, criteria for applications for funding, and a specified amount of funding for grants to Urban Indian Organizations are also specified.

Amendments: This section maintains current law and (1) adds language which requires the implementation of this section to be consistent with section 701; (2) recognizes the behavioral health focus, beyond just alcohol and substance abuse; and (3) requires consultation with Indian Tribes and Tribal Organizations in establishing criteria for the review and approval of applications.

Current Law: This section is Section 1665b of current law.

Section 707. Indian youth program

This section requires the Secretary to develop and implement, consistent with section 701, a program for acute detoxification and treatment for Indian youth. The construction and staffing of alcohol and substance abuse treatment centers or facilities for Indian youths, including behavioral health services, is authorized. Additional provisions addressed in this section are: Construction and staffing of at least 1 youth regional treatment center in each IHS Area; the provision of intermediate adolescent behavioral health services; use of federally-owned structures for local residential or regional behavioral health treatment for Indian youths; the development and implementation of community-based rehabilitation and aftercare services; inclusion of family in youth treatment programs; programs and services to prevent and treat the abuse of multiple forms of substances among Indian youth; and data collection and a report to Congress concerning Indian youth and mental health services.

Amendments: This section maintains current law and adds language which (1) requires implementation of this section to be consistent with section 701; (2) recognizes the behavioral health focus, beyond alcohol and substance abuse; (3) includes programs developed at the local tribal level; (4) includes treatment networks in addition to treatment programs; (5) includes sober or transitional housing in the intermediate adolescent services; (6) requires community reintegration as part of the rehabilitation and aftercare services; (7) establishes a program to prevent and treat multi-drug abuse; and (8) requires the Secretary to collect data for an Indian youth mental health report.

Current Law: This section is Section 1665c of current law.

Section 708. Indian youth telemental health demonstration project

This section authorizes the Secretary to carry out a four-year demonstration project under which five Tribes or Tribal Organizations with telehealth capabilities could use telemental health services in youth suicide prevention and treatment. In awarding the grants, the Secretary would give priority to Tribes and Tribal Organizations serving a particular tribal community where there is a demonstrated need to address Indian youth suicide or which is isolated and has limited access to mental health services; entering into collaborative partnerships to provide the services; or operating a detention facility at which Indian youth are detained. The demonstration project would permit the use of telemedicine for psychotherapy, psychiatric assessments and diagnostic interviews of Indian youth; the provision of clinical expertise and other medical advice to frontline health care providers working with Indian youth; training and related support for community leaders, family members and health and education workers who work with Indian youth; the development of culturally-relevant educational materials on suicide prevention and intervention; and data collection and reporting.

Amendments: This section is new and is not contained in current law.

Section 709. Inpatient and community-based mental health facilities design, construction, and staffing

This section allows the Secretary, not later than 1 year after the date of enactment, to provide, in each IHS Area, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. The Secretary shall consider the possible conversion of existing underutilized hospital beds into psychiatric units to meet the needs.

Amendments: This section amends current law by (1) requiring the establishment in each Area of at least 1 inpatient mental health facility, rather than an assessment of the need; and (2) providing that California shall be considered two Area Offices.

Current Law: Section 1621h(i) of current law provides that within one year after enactment, the Secretary shall make an assessment of the need for inpatient mental health care facilities.

Section 710. Training and community education

Section 710 requires that the Secretary, in cooperation with the Secretary of the Interior, develop and implement, or assist Indian Tribes and Tribal Organizations to develop and implement, a program of community education and involvement in the area of behavioral health. This section also addresses specifics of instruction and the development of community-based training models.

Amendments: This section maintains current law and (1) adds language which authorizes the Indian Tribes and Tribal Organizations to develop training and community education programs; (2) adds child sexual abuse to the types of training authorized; and (3) recognizes the behavioral health focus of the program.

Current Law: This section is Section 1621h(d) of current law.

Section 711. Behavioral health program

This section allows the Secretary, consistent with section 701, to plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians. The section sets forth criteria to be used for grant awards for such programs, and requires that the same criteria as are used in evaluating other funding proposals be used for programs under this section.

Amendments: This section maintains current law and adds Tribal Organizations as eligible recipients for funding under this section.

Current Law: This section is Section 1621h of current law.

Section 712. Fetal alcohol disorder programs

Section 712 authorizes the Secretary, consistent with section 701, to establish and operate fetal alcohol disorder programs, to include the development and provision of services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities. Use of funds and criteria for applications are specified. In addition, the Secretary is directed to establish a Fetal Alcohol Disorder Task Force to advise the Secretary. This section also authorizes funding for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat or provide rehabilitation and aftercare for Indians affected by this disorder. Urban Indians are to receive a certain amount of funds appropriated for this program.

Amendments: This section maintains current law and adds language (1) requiring these programs to be implemented consistent with section 701; (2) consolidating fetal alcohol syndrome and fetal alcohol effects into fetal alcohol disorders (FAD); (3) authorizing appropriate psychological services, early childhood intervention projects, community-based support services and housing as allowable uses of funding under this section; and (4) including the National Institute for Child Health and Human Development and the Centers for Disease Control and Prevention in the national Fetal Alcohol Disorder Task Force. Provisions of current law establishing a national clearinghouse for prevention and educational materials and other information on FAS and FAE effect in Indian and Alaska Native communities, and requirements for a report to Congress contained in current law have been deleted.

Current Law: This section is Section 1665g of current law.

Section 713. Child sexual abuse and prevention treatment programs

This section directs the Secretary to establish, consistent with section 701, treatment programs in every IHS Area for both Indian victims of child sexual abuse and Indian perpetrators of child sexual abuse. This section specifies the use of funds for these programs, and directs that they be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

Amendments: This section amends current law by (1) turning two specific demonstration projects into permanent programs; (2) making the establishment of these programs consistent with section 701; (3) authorizing services for Indian child victims of sexual abuse and perpetrators of child sexual abuse who are members of an Indian household; (4) including authorized uses of funds such as developing community education, identifying and providing treatment to victims, developing culturally-sensitive prevention models and diagnostic tools, and providing treatment to the perpetrators; and (5) providing that these programs are carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act.

Current Law: Section 1680i of current law establishes demonstration programs involving treatment for child sexual abuse through the Hopi Tribe and the Assiniboine and Sioux Tribes of the Fort Peck Reservation. The Secretary may establish other demonstration projects, but must have an equal number of projects for the IHS Areas.

Section 714. Behavioral health research

Section 714 authorizes the Secretary to make grants to, or enter into contracts with, Indian Tribes, Tribal Organizations, and Urban Indian Organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians. Research priorities are specified, including youth suicide, the interrelationship of mental disorders with alcoholism, suicide, homicide, and the incidence of family violence, and prevention models.

Amendments: This section maintains current law and adds language which emphasizes the focus on behavioral health instead of only mental health problems.

Current Law: This section is Section 1621h of current law.

Section 715. Definitions

This section provides definitions for the following terms used in this title: assessment; alcohol-related neurodevelopmental disorders or ARND; behavioral health aftercare; dual diagnosis; fetal alcohol disorders; fetal alcohol syndrome or FAS; partial FAS; rehabilitation; and substance abuse.

Amendments: This section is new and is not contained in current law.

Section 716. Authorization of appropriations

This section authorizes to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

Amendments: This section maintains current law and extends the authorization from fiscal year 2000 to fiscal year 2017 and eliminates the exceptions for sections that had specific terms of authorization.

Current Law: This section is Section 1621w of current law.

TITLE VIII—MISCELLANEOUS

Section 801. Reports

This section outlines requirements under this Act for various reports (and their contents) and audits which shall be submitted to Congress.

Amendments: This section maintains current law and adds provisions which either establish new reporting requirements or consolidate the information required in other sections in one organized list, such as requiring as part of the annual reports to Congress information on services provided under Indian Self-Determination Act agreements, loan repayment programs, infectious diseases, environmental hazards, status of health care and sanitation facilities, sharing of services between the IHS and other federal agencies, and urban Indian programs.

Current Law: This section is Section 1671 of current law.

Section 802. Regulations

This section sets forth the various requirements for regulations, including regulations developed through negotiated rulemaking, for selected titles and sections, and timelines for issuance of regulations under this Act. The membership of the negotiated rulemaking committee and its procedures are delineated.

Amendments: This section is new and is not contained in current law.

Section 803. Plan of implementation

This section requires the Secretary, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to submit to Congress a plan of implementation of this Act within 9 months.

Amendments: This section is new and is not contained in current law.

Section 804. Availability of funds

This section authorizes funds appropriated pursuant to this Act to remain available until expended.

Amendments: This section maintains current law.

Current Law: This section is Section 1675 of current law.

Section 805. Limitation on use of funds appropriated to Indian Health Service

This section provides that any limitation on the use of funds contained in an Act that provides appropriations for the Department of Health and Human Services with respect to the performance of abortions shall apply for that fiscal year to the performance of abortions using funds contained in an Act providing appropriations for the Service.

Amendments: This section maintains current law.

Current Law: This section is Section 1676 of current law.

Section 806. Eligibility of California Indians

This section clarifies the eligibility of California Indians for health services provided by the Service to include members of federally-recognized tribes, descendants of Indians residing in California as of June 1, 1852, Indians holding trust interests in certain types of land, and Indians listed on the plans for assets distribution in California.

Amendments: This section maintains current law, but eliminates the report to Congress developing data on the Indians located in California, health status and needs and other information.

Current Law: This section is Section 1679 of current law.

Section 807. Health services for ineligible persons

This section authorizes services for certain persons (such as children and spouses) and other individuals otherwise ineligible for health services provided by the Service under limited circumstances, and outlines criteria for providing and paying for those services.

Amendments: This section maintains current law and adds compacts, in addition to contracts, entered in to under the Indian Self-Determination Act.

Current Law: This section is Section 1680c of current law.

Section 808. Reallocation of base services

This section requires the Secretary to submit a report to Congress on any allocation of Service funds for a fiscal year that reduces by 5% or more from the previous fiscal year the funding for any recurring program, project, or activity of a Service Unit.

Amendments: This section maintains current law.

Current Law: This section is Section 1680g of current law.

Section 809. Results of demonstration projects

This section requires the Secretary to disseminate to Indian Tribes, Tribal Organizations, and Urban Indian Organizations the

findings and results of demonstration projects conducted under this Act.

Amendments: This section maintains current law, and adds Tribal Organizations and Urban Indian Organizations.

Current Law: This section is Section 1680m of current law.

Section 810. Provision of services in Montana

This section recognizes a court decision governing the provision of services and benefits for certain Indians in Montana.

Amendments: This section is new and is not contained in current law.

Section 811. Moratorium

This section authorizes the Service to provide certain health care services according to eligibility criteria in effect on a certain date until the Service submits to Congress and the Congress enacts an appropriations Act that reflects the increased costs associated with the Department's proposed final rule, implementing other eligibility criteria.

Amendments: This section is new and is not contained in the current Indian health law. However, similar language has appeared for several years in Interior Appropriations Acts.

Section 812. Tribal employment

This section provides that an Indian Tribe or Tribal Organization carrying out a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act shall not be considered an "employer."

Amendments: This section is new and is not contained in current law.

Section 813. Severability provisions

This section retains remaining provisions of the Act if other provisions are stricken by any court.

Amendments: This section is new and is not contained in current law.

Section 814. Establishment of national bipartisan commission on Indian health care

This section establishes a Commission to study the delivery of health care services to Indians, and sets forth the duties, membership, compensation, and meeting, hearing and reporting requirements. This section also authorizes the appointment of a Director and staff for the Commission; establishes their compensation; and authorizes details of federal employees, hearings, use of mails, technical assistance and administrative support services. $4 million is authorized for the Commission.

Amendments: This section is new and is not contained in current law.

Section 815. Confidentiality of medical quality assurance records; qualified immunity for participants

This section would establish requirements for quality assurance such as confidentiality, privacy, disclosure and liability. Section 815 also sets forth the limits of such disclosure.

Amendments: This section is new and is not contained in current law.

Section 816. Appropriations; availability

This section subjects new spending authority to amounts provided in appropriations Acts.

Amendments: This section is new and is not contained in current law.

Section 817. Authorization of appropriations

This section authorizes to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

Amendments: This section maintains current law and extends the authorization through fiscal year 2017.

Current Law: Section 1680o authorizes appropriations through fiscal year 2000.

Section 101(b). Indian Health Care Improvement Act amended

Section 101(b) includes provisions amending other laws for the references to the "Director of Indian Health Service" which would be changed to "Assistant Secretary for Indian Health".

Amendments: This section is new and is not contained in current law.

Section 102. Soboba sanitation facilities

Section 102 authorizes sanitation facilities and services to be provided to the Soboba Band of Mission Indians and the Soboba Indian Reservation.

Amendments: This section is new and is not contained in current law.

Section 103. Native American Health and Wellness Foundation

Section 103 amends the Indian Self-Determination and Education Assistance Act to include a new Title VIII under which a Native American Health and Wellness Foundation would be established, in the following sections:

Section 801. Definitions

This section includes definitions for the Board, Committee, Foundation, and other terms used in this section.

Section 802. Native American Health and Wellness Foundation

This section establishes the perpetual existence of the Foundation, the nature and duties of the Foundation and the place of incorporation. This section also authorizes the Secretary to establish an initial Committee to assist in establishing the Foundation. Section 802 establishes the authority of the Board of Directors, including their terms, the officers (including the extent of their liabilities) and the powers of the Foundation. This section also establishes limits on the administrative costs, audit requirements, and authorizes $500,000 for the fiscal years.

Section 803. Administrative services and support

This section authorizes the Secretary to provide administrative support to the Foundation and initial operating funds on a reimbursement basis for up to five years.

Amendments: This section is new and is not contained in current law.

Title II

Title II of the bill is amendments to the Social Security Act that is under the jurisdiction of the Senate Finance Committee. These provisions include waivers of cost-sharing and premiums for Medicaid for Indians receiving services at IHS, tribal or urban Indian health programs, Medicaid managed care provisions, and safe harbor protections from the anti-kickback statutes.

Section 201. Expansion of payments under Medicare, Medicaid and SCHIP for all covered services furnished by Indian health programs

Section 201 authorizes IHS, tribal and urban Indian health programs to be reimbursed for Medicaid, if the services meet the conditions and requirements generally applicable to the delivery of such care. In addition, this section requires IHS, tribal or urban Indian health facilities to make improvements to achieve or maintain compliance. The Secretary is also authorized to enter into an agreement with a State to reimburse the State for Medicaid services provided by the IHS, tribal or urban Indian health programs. This section cross-references the special fund to which Medicaid reimbursements are placed for IHS and direct billing requirements for the IHS and tribal health programs under the Act. This section also authorizes Medicare payments to IHS, tribal and urban Indian health programs so long as they are compliant with Medicare requirements. The section cross-references the Act's provisions under which Medicare payments made are placed in a special fund for the purpose of making improvements to maintain compliance.

Section 202. 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

Section 202 authorizes the Secretary to encourage States to take steps to increase enrollment and outreach for Indian children in the State Children's Health Insurance Program and requires the Secretary to facilitate cooperation between States and the IHS, tribal and urban Indian health programs.

Section 203. Additional provisions to increase outreach to, and enrollment of, Indians in SCHIP and Medicaid for outreach

Section 203 excludes certain activities, such as outreach activities for families of Indian children likely to be eligible for SCHIP and enrollment assistance activities, from the current 10% cap on certain SCHIP payments.

Section 204. Premiums and cost sharing protections under Medicaid, eligibility determinations under Medicaid and SCHIP, and protection of certain Indian property from Medicaid estate recovery

Section 204 prohibits the imposition of enrollment fees, premiums and cost-sharing on Indians served at the IHS, tribal or urban Indian health programs or through the referrals to contract health and the reduction of the reimbursement to the IHS, tribal or urban Indian health program for the fees or cost-sharing. In addition, this section exempts certain Indian property, such as trust land, from being included in determining eligibility of an individual who is an Indian for Medicaid, and continues protections of certain Indian property from Medicaid estate recovery.

Section 205. Nondiscrimination in qualifications for payment for services under Federal health care programs

Section 205 allows the IHS, Tribal or urban Indian health programs to be accepted on the same basis as any other provider eligible for reimbursement, if the program meets generally applicable participation requirements. The provision would prohibit payments if the program was excluded from any other Federal health care program and if any State licenses were suspended or revoked.

Section 206. Consultation on Medicaid, SCHIP, and other health care programs funded under the Social Security Act involving Indian health programs and urban Indian organizations

Section 206 maintains the Tribal Technical Advisory Group established to provide technical assistance or advice to the Centers for Medicare and Medicaid Services. This section also requires the States to establish a process for consultation with the tribal or urban Indian health programs on matters relating to Medicaid which are likely to have a direct effect on Indians or Indian health programs.

Section 207. Exclusion waiver authority for affected Indian health programs and safe harbor transactions under the Social Security Act

Section 207 establishes a process whereby the administrator of an Indian Health Program may request a waiver of sanctions imposed on a health provider. This section also specifies that certain transactions not be considered remuneration under Section 1128B(b) of the Social Security Act for certain transfers between the Indian health programs or patient for the purpose of providing necessary health care services to the patient.

Section 208. 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

Section 208 allows Indians, enrolled in a non-Indian Medicaid managed care entity (MCE) with an Indian health program participating in the network, to choose the Indian health program as the primary care provider. It also requires MCEs with significant Indian enrollees to meet other requirements. The Indian health programs would also be required to comply with all generally applicable Medicaid requirements to the extent the requirements do not

conflict with other Federal statutes applicable to the Indian health programs. This section also sets forth special rules applicable to Indian MCEs, such as the ability to restrict enrollment to Indians and other enrollment rules. In regard to 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 would be deemed to satisfy such a requirement if it is an FQHC covered under the Federal Tort Claims Act, a provider that delivers services pursuant to a contract under the Indian Self-Determination and Education Assistance Act, or the Indian Health Service, which is covered under the Federal Tort Claims Act.

Section 209. Annual report on Indians served by Social Security Act health benefit programs

Section 209 requires annual reports to Congress regarding the enrollment and health status of Indians receiving items or services under the health benefit programs.

LEGISLATIVE HISTORY

On April 24, 2007, Senators Dorgan, Thomas, Boxer, Reid, Cantwell, Johnson, Tester, Inouye, Domenici, Bingaman, Baucus, Klobuchar, Obama and Murkowski introduced S. 1200, the Indian Health Care Improvement Act Amendments of 2007. Senators Cochran and Murray were added as cosponsors on April 26, 2007; Senator Clinton on May 3, 2007; and Senators Brown and Stevens on May 21, 2007. Senator Stabenow was added as a cosponsor on September 4, 2007.

The Committee held a hearing on the Indian Health Care Improvement Act on March 8, 2007. This was the tenth hearing since the 106th Congress on the reauthorization of the Act.

On May 10, 2007, the Committee on Indian Affairs convened a business meeting to consider S. 1200 and other measures that had been referred to it, and ordered the bill favorably reported.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

On May 10, 2007, the Committee on Indian Affairs convened a business meeting to consider S. 1200 and other measures, and voted to have the bill favorably reported to the full Senate, without amendment, with the recommendation that the bill do pass.

REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires that each report accompanying a bill evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee has concluded that S. 1200 will not require the promulgation of regulations so the regulatory and paperwork impact should be minimal.

EXECUTIVE COMMUNICATIONS

On May 1, 2007, Chairman Dorgan sent letters to both Secretary Michael Leavitt and Attorney General Gonzales, asking the De-

partment of Health and Human Services and the Department of Justice to provide the Committee with their views on S. 1200.

The Department of Justice submitted a letter of comments on June 13, 2007, which is attached, below.

DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AFFAIRS,
Washington, DC, June 13, 2007.

Hon. BYRON L. DORGAN,
Chairman, Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for the opportunity to comment upon S. 1200, the Indian Health Care Improvement Act Amendments of 2007. The Department of Justice fully supports the purposes of this legislation—improving access to health care for American Indians and Alaska natives. The Department has worked with the Committee on Indian Affairs on previous versions of this legislation and believes that most of its prior concerns have been addressed by S. 1200. The Department does, however, continue to have a few concerns with the legislation that we have noted in the past. As explained below, the Department believes that these concerns can be addressed with relatively modest changes to bill language that would not detract from the overall goal of improving health care for Native Americans but would, in the Department's view, benefit both the Native American community specifically and taxpayers generally.

1. The legislation authorizes funding and encourages the use of traditional health care practices. The Department does not oppose the provision of traditional health care practices as an adjunct to "Western" medical practices. We note that on March 8, 2007, Ms. Rachel Joseph, Co-Chairperson of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act, testified that "[t]raditional health care practices are usually provided as complementary services to Western medical practices at the request of family members." Ms. Joseph also testified that "[i]n most cases, the traditional health care practitioners are not employees of the IHS or tribes so FTCA coverage would not apply in the event that a malpractice claim was ever filed."

A prior version of this legislation contained language clarifying that traditional health care practitioners are not covered by the Federal Tort Claims Act ("FTCA"), and we recommend that this language be added back to S. 1200. Specifically, we recommend the following provision as an addition to section 805:

(b) NO LIABILITY.—Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this Act, the United States is not liable for the acts or omissions of any person in providing traditional health care practices under this Act that result in damage, injury, death, or any outcome to any patient.

This language is intended to confirm existing law that there is no valid cause of action under the FTCA for injuries resulting from traditional tribal healing practices provided pursuant to self determination contracts because state law generally does not make private parties liable for "malpractice" involving traditional tribal

healing practices. See 28 U.S.C. § 2674. Thus, this provision would ensure that the United States would not face potential tort liability for the provision of treatment through traditional health care practices for which no state standard of care exists and would prevent costly litigation about whether the United States could be held liable under the FTCA for such practices. Moreover, it would preclude intrusive discovery regarding the nature and purpose of traditional health care practices. Such litigation would almost certainly raise questions as to the advisability of Tribal health practices and potentially create unnecessary conflict between these practices and Western medical standards. Additionally, we believe the proposed language would ameliorate any Tribal sovereignty concerns that would arise in FTCA litigation regarding inquiry into traditional health care practices. At the same time, this language would not scale back in any way the current liability protections that the Tribes enjoy in carrying out self-determination contracts.

We also have concerns regarding changes made to section 213 of the legislation. The current version of section 213(b)(1) was modified to provide:

(b) TERMS AND CONDITIONS.—

(1) IN GENERAL.—Any service provided under this section shall be in accordance with such terms and conditions as are consistent with accepted and appropriate standards relating to the service, including any licensing term or condition required under this Act.

The previous version of the legislation, unlike S. 1200, made explicit that the Secretary "shall require" that any service provided be in accordance with terms and conditions that the Secretary determined to be consistent with accepted and appropriate standards relating to the service. We think S. 1200 is unclear in this regard, as it fails to explicitly specify who is responsible for requiring that any services provided are in accordance "with such terms and conditions as are consistent with the accepted and appropriate standards relating to the service." We suggest revising subsection 213(b)(1) to provide:

(1) IN GENERAL.—The Secretary shall require that any service provided pursuant to this Act is in compliance with the accepted and appropriate standards relating to the service, including any licensing term or condition under this Act.

Relatedly, S. 1200 made changes to the prior language of subsection 213(b)(2). That subsection now reads:

(b)(2)(A) STANDARDS.—

IN GENERAL.—The Secretary may establish, by regulation, the standards for a service provided under this section, provided that such standards shall not be more stringent than the standards required by the State in which the service is provided.

We have concerns about this language. For the purposes of tort liability under the FTCA, state law provides the standards governing the conduct at issue. If the Secretary, by regulation, establishes standards that fall below the standards required by the State, there is a risk the United States could be held liable under the FTCA, even if the care complied with the standards promulgated by the Secretary. Moreover, and more likely troublesome, if the Secretary approves services for which there are no applicable state standards, subsection (b)(2), by its plain language, would appear to prevent the Secretary from establishing any appropriate

standards because those standards would, by their very existence, be more stringent than what is required by the State. Where no state standards are applicable, it is in the interests of both the United States and the Tribes to whom such services might be provided to have some applicable and appropriate standards of care set by the Secretary. Thus, along with the Department of Health and Human Services, we propose working with the Committee to revise subsection (b)(2)(A) to address this concern.

Finally, S. 1200 also includes this new provision to section 213:

(b)(2)(B) USE OF STATE STANDARDS.—

If the Secretary does not, by regulation, establish standards for a service provided under this section, the standards required by the State in which the service is or will be provided shall apply to such service.

We agree that state standards should be applicable, since liability under the FTCA would be measured by those standards. Again, however, if there is no applicable state standard, the Secretary should be permitted to set some meaningful and appropriate standard of care, which is arguably not possible given the limitation of subsection (b)(2)(A).

2. The Department believes that the legislation continues to raise a constitutional concern to the extent that it provides government benefits to individuals who are not members of, or closely affiliated with, a Federally recognized Indian tribe. As the Department has noted in the past, the Supreme Court has held that classifications based on affiliation with a Federally recognized tribe are "political rather than racial," and therefore will be upheld as long as there is a rational basis for them. To the extent, however, that programs benefiting "Urban Indians" under this legislation could be viewed as authorizing the award of grants and other Government benefits on the basis of racial or ethnic criteria, rather than tribal affiliation, these programs would be subject to strict scrutiny under the equal protection component of the Due Process Clause. Both this bill and the current statute broadly define "Urban Indian" to include individuals who are not necessarily affiliated with a federally recognized Indian tribe. Under the Supreme Court's decisions, there is a substantial likelihood that legislation providing special benefits to individuals of Indian or Alaska Native descent who do not have a clear and close affiliation with a federally recognized tribe would be regarded by the courts as creating a racial preference subject to strict constitutional scrutiny, rather than a political preference subject to rational basis review. In the event the legislation is regarded as awarding Government benefits based on a racial classification, it would be constitutional only if the bill is supported by a factual record demonstrating that its use of race-based criteria to award the benefits at issue is "narrowly tailored" to serve a "compelling" Government interest.

The bill's extension of benefits to members of State-recognized tribes raise the same concern. As a threshold matter, it is not clear whether the courts would agree that Congress can constitutionally delegate its tribal recognition authority to the States and, even if Congress can do so as a general matter, the delegation in this bill would allow States to designate as "tribal members" eligible for Federal benefits individuals who: (i) do not belong to a "distinctly Indian community" or other group that conforms to the Supreme

Court's definitions of "the Indian tribes" referenced in the Commerce Clause, but instead are considered a member of a State "tribe" solely on the basis of race or affiliation with a group that lacks the sovereign attributes the Supreme Court has identified as important to classification as an "Indian tribe" for purposes of Commerce Clause legislation; and/or (ii) are otherwise outside the class of beneficiaries that Congress intended to reach with this bill. In this regard, as you may know, the American Indian Heritage Support Center ("AIHSC"), in a March 29, 2007, letter to the Department, with copies to Members of Congress, voiced concerns about the extension of benefits under this legislation to "state recognized tribes" because, according to the AIHSC, some of these "tribes" "have no historical background past the last 10 to 20 years" and simply seek "tribal" recognition to take advantage of certain recent Government benefits such as gaming privileges.

The Department recommends that, consistent with the settled practice of avoiding unnecessary constitutional issues, Congress revise the bill to extend benefits only to individuals who, in addition to satisfying whatever other criteria Congress may wish to impose, qualify as "members of, or individuals having a clear and close affiliation with, a federally-recognized tribe." Such a revision would avoid the constitutional concerns outlined above in a way that the Department believes would not detract from the overall goal of improving health care for Native Americans, and might actually better ensure that benefits under the bill would extend only to the class of beneficiaries contemplated by Congress and the Constitution.

Thank you for the opportunity to comment upon this very important legislation. We are committed to working with the Committee to have this legislation passed. The Office of Management and Budget has advised us that there is no objection to this letter from the perspective of the Administration's program.

Sincerely,

RICHARD A. HERTLING,
Principal Deputy Assistant Attorney General.

The Committee has not received any formal communication on S. 1200 from the Department of Health and Human Services other than the testimony presented to the Committee at the hearing on reauthorization of the Indian Health Care Improvement Act on March 8, 2007, which is also attached, below.

STATEMENT OF ADMIRAL JOHN O. AGWUNOBI, MD, MBA, MPH, ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: My name is John Agwunobi and I am the Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS). As the Assistant Secretary, I serve as the Secretary's primary advisor on matters involving the nation's public health. I also oversee the U.S. Public Health Service and its Commissioned Corps for the Secretary.

This landmark legislation forms the backbone of the system through which Federal health programs serve American Indians/Alaska Natives and encourages participation

of eligible American Indians/Alaska Natives in these and other programs.

The IHS has the responsibility for the delivery of health services to more than 1.8 million Federally-recognized American Indians/Alaska Natives through a system of IHS, tribal, and urban (I/T/U) health programs governed by judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indian/Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold the Federal government's responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major statutes are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L. 67–85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94–437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the Federal government programs that deliver health services to Indian people, but it also provides additional guidance in several areas. The IHCIA contains specific language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services; the construction, replacement, and repair of health care facilities; access to health services; and the provision of health services for urban Indian people.

DHHS ACTIVITIES

Since enactment of the IHCIA in 1976, Congress has substantially expanded the statutory authority for programs and activities in order to keep pace with changes in healthcare services and administration. Federal funding for the IHCIA has contributed billions of dollars to improve the health status of American Indians/Alaska Natives. And, much progress has been made particularly in the areas of infant and maternal mortality.

The Department under this Administration's leadership reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide for a consistent HHS policy when working with the more than 560 Federally recognized Tribes. This Council's vice chairperson is the IHS Director, giving him a highly visible role within the Department on Indian policy.

In January of 2005 the Department completed work ushering through a revised HHS Tribal consultation policy and involving Tribal leaders in the process. This policy further emphasizes the unique government-to-government relationship between Indian Tribes and the Federal government and assists in improving services to the Indian community through better communications. Consultation may take place at many different levels. To ensure the active participation of Tribes in the development of the Department's budget request, an HHS-wide budget consultation session is held annually. This meeting provides Tribes with an opportunity to meet directly with leadership from all Department agencies and identify their priorities for upcoming program requests. For FY 2008, Tribes identified population growth and increases in the cost of providing health care as their top budget priorities and IHS's FY 2008 budget request included an increase of $88 million for these items.

Through the Centers for Medicare & Medicaid Services (CMS), a Technical Tribal Advisory Group was established which provides Tribes with a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. And the IHS has been vigilant about improving outcomes for Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to, or struggling with, this potentially disabling disease. In addition, a Tribal Leaders Diabetes Committee continues to meet several times a year at the direction of the IHS Director to review information on the progress of the Special Diabetes Program for Indians activities and to provide general recommendations to IHS.

It is clear the Department has not been a passive observer of the health needs of eligible American Indians/Alaska Natives. Yet, we recognize that health disparities among this population do exist and are among some of the highest in the Nation for certain diseases (e.g., alcoholism, cardiovascular disease, diabetes, and injuries), and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

The IHCIA was enacted to provide primary and preventive services in recognition of the Federal government's unique relationship with members of Federally recognized Tribes. Members of Federally recognized Tribes and their descendants are also eligible for other Federal health programs (such as Medicare, Medicaid and SCHIP) on the same basis as other Americans, and many also receive health care through employer-sponsored or other healthcare coverage.

It is within the context of current law and programs that we turn our attention to reauthorization of the "Indian Health Care Improvement Act."

REAUTHORIZATION

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. In December of 2006, the Department submitted to this Committee comments on proposed legislation that the 109th Congress was considering. These comments are the basis for our testimony today, and any changes introduced by the bill under review in the 110th Congress will be considered once we have had an opportunity to review newly introduced legislation. Improving access to healthcare for all eligible American Indians and Alaska Natives is a priority for all those involved in the administration of the IHS program. We have worked closely with this Committee in the past and we have made progress in moving toward a program supportive of existing authority while maintaining the Secretary's flexibility to effectively manage the IHS program. However, in the last bill, S. 1057, there continued to be provisions which could negatively impact our ability to provide needed access to services. Such provisions established program mandates and burdensome requirements that could, or would, divert resources from important services. To the extent that those provisions are included in the new legislation, we hope to work with you to continue to address these concerns.

The Department is supportive of reauthorization of the IHCIA and supports provisions that maintain or increase the Secretary's flexibility to work with Tribes, and to increase the availability of health care. Committee leadership previously responded to some concerns raised about certain provisions and some of the changes went a long way toward improving the Secretary's ability to effectively manage the program within current budgetary resources.

I would like to note for you today our particular interest in provisions previously reported out of this Committee.

OVERARCHING CONCERNS

We have a number of general objections to previous language, including, expanded requirements for negotiated rulemaking and consultation; new requirements using "shall" instead of "may"; use of the term "funding" in place of "grant"; expansion of authorities for Urban Indian Organizations; new permissive authorities; provisions governing traditional health care practices; new reporting requirements; establishment of the Bipartisan Commission on Indian Health Care; and new provisions that contemplate the Secretary exercising authority through the Service, Tribes and Tribal Organizations which is not tied to agreements entered into under the Indian Self-Determination and Education Assistance Act (ISDEAA). In addition, we noted concerns in previous language about modifying current law with respect to Medicaid and the State Children's Health Insurance Program (SCHIP) and, in some cases, we believe maintaining the current structure of Medicaid and

the State Children's Health Insurance Program (SCHIP) preserves access, delivery, efficiency, and quality of services to American Indians.

We also have some more specific comments on proposals we have previously reviewed for comment.

In the area of behavioral health, proposed title VII provisions provided for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes language in Sections 704, 706, 711(b) and 712 that requires the establishment or expansion of specific additional services. The Department should be given the flexibility to provide for all Behavioral Health Programs in a manner that supports the local control and priorities of Tribes, and to address their specific needs within IHS overall budgetary levels.

REPORTING REQUIREMENTS

The last version of S. 1057 that we reviewed contained various new requirements for reporting to Congress, including requirements for specific information to be included within the President's Budget and a new annual report to Congress by the Centers for Medicare & Medicaid Services and the IHS on Indians served by Social Security Act health benefit programs. The IHS, CMS, and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance and other Indian health matters. However, we recommend striking language that requires additional specificity about what should be included in the President's budget request and new requirements for annual reports.

FACILITIES

Sanitation facilities construction is conducted in 38 States with Federally recognized Tribes who take ownership of the facilities to operate and maintain them once completed. IHS and Tribes operate 49 hospitals, 247 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to Indian people.

HEALTH CARE FACILITIES NEEDS ASSESSMENT & REPORT

One provision in last year's bill, section 301(d)(1), required Government Accountability Office (GAO) to complete a report, after consultation with Tribes, on the needs for health care facilities construction, including renovation and expansion needs. However, efforts are currently underway to develop a complete description of need similar to what would have been required by the bill. The IHS plan is to base our future facilities construction priority system methodology application on a more complete listing

of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

We recommend the deletion of the reference to the Government Accountability Office undertaking the report because it would be redundant of and a setback for IHS's current efforts to develop an improved facilities construction methodology.

RETROACTIVE FUNDING OF JOINT VENTURE CONSTRUCTION PROJECTS

In last year's bill, section 311(a)(1) would permit a tribe that has "begun or substantially completed" the process of acquisition of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. A Joint Venture Program agreement implies that all parties have participated in the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient or ineffective to operate. We, therefore, would oppose such a provision.

SANITATION FACILITIES DEFICIENCY DEFINITIONS

Another section 302(h)(4) would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. As previously proposed "deficiency level III" could be interpreted to mean all methods of service delivery (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two.

In addition, the definition for deficiency level V and deficiency level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas, level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law to distinguish the various levels of deficiencies which determine the allocation of existing resources.

THRESHOLD CRITERIA FOR SMALL AMBULATORY PROGRAM

Yet another Section 305(b)(1) would amend current law to set two minimum thresholds for the Small Ambulatory Program—one for number of patient visits and another for the number of eligible Indians. In order to be eligible for the Small Ambulatory Program under the previously proposed criteria, a facility must provide at least 150 patient visits annually in a service area with no fewer than 1,500 eligible Indians. Aside from the fact that these are both minimum thresholds and so somewhat contradictory, the proposed provisions would make implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource Patient Management System (RPMS). Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term "eligible Indians" refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity.

NEW NEGOTIATED RULEMAKING AND CONSULTATION REQUIREMENTS

In addition, we are concerned about the requirements for negotiated rulemaking and increased requirements for consultation in the bill because of the high cost and staff time associated with this approach. We are committed to our on-going consultation with Tribes under current Executive Orders, as well as using the authority of Chapter V of title 5, United States Code (commonly known as the Administrative Procedures Act) to promulgate regulations where necessary to carry out IHCIA.

The comments expressed today in this testimony do not represent a comprehensive list of our current concerns. And, we will be reviewing legislation introduced in this Congress for any provisions that might be addressed in the future.

I reiterate our commitment to working with you to reauthorize the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. And we will continue to work with the Committee, other Committees of Congress, and representatives of Indian country to develop a bill that all stakeholders in these important programs can support. Again, I appreciate the opportunity to appear before you today to discuss reauthorization of the "Indian Health Care Improvement Act" and I will answer any questions that you may have at this time. Thank you.

COST ESTIMATES

The Congressional Budget Office prepared a cost estimate for S. 1200, dated June 8, 2007. However, an error was made in that estimate, so a revised estimate was sent to the Committee on September 11, 2007, which follows.

S. 1200—Indian Health Care Improvement Act Amendments of 2007

Summary: S. 1200 would authorize the appropriation of such sums as are necessary through 2017 for activities under the Indian Health Care Improvement Act, the primary authorizing legislation for the Indian Health Service (IHS). The bill also contains specific authorizations for a program to encourage Indians to pursue careers related to behavioral health, a demonstration project to provide suicide prevention services, a commission on Indian health care, and administrative costs for a new nonprofit corporation. Enacting the bill also would affect direct spending, primarily through provisions affecting the Medicaid program.

CBO estimates that implementing S. 1200 would have discretionary costs of $2.7 billion in 2008, about $16 billion over the 2008–2012 period, and about $35 billion over the 2008–2017 period, assuming appropriation of the necessary amounts. We also estimate that enacting the bill would increase direct spending by $9 million in 2008, $53 million over the 2008–2012 period, and $129 million over the 2008–2017 period.

S. 1200 would preempt state licensing laws in certain cases, and this preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA); however, CBO estimates that the costs of that mandate would be small and would not approach the threshold established in UMRA ($66 million in 2007, adjusted annually for inflation). The bill also would place new requirements on Medicaid that would result in additional spending of about $80 million over the 2008–2017 period. Those requirements, however, would not be intergovernmental mandates as defined by UMRA. Other provisions of the bill would benefit tribal governments by establishing new or expanding existing programs for Indian health care. This bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 1200 is summarized in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF S. 1200

	By fiscal year, in millions of dollars—				
	2008	2009	2010	2011	2012
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Estimated Authorization Level	3,257	3,326	3,402	3,481	3,558
Estimated Outlays	2,682	3,141	3,310	3,449	3,534
CHANGES IN DIRECT SPENDING [a]					
Estmated Budget Authority	9	10	11	12	12
Estimated Outlays	9	10	11	12	12

[a] Direct spending changes through 2017 are shown in Table 3.

Basis of estimate: For the purpose of this estimate, CBO assumes that S. 1200 will be enacted near the start of fiscal year 2008 and that the necessary amounts will be appropriated for each year.

Spending subject to appropriation

The estimated effects of S. 1200 on spending subject to appropriation for the next five years are detailed in Table 2. Imple-

menting the legislation would result in discretionary costs of about $16 billion over the 2008–2012 period. Because the bill would authorize funding through 2017, such discretionary cost would continue, with an estimated cost of about $35 billion over the 2008–2017 period.

TABLE 2.—ESTIMATED EFFECTS OF S. 1200 ON DISCRETIONARY SPENDING

	By fiscal year, in millions of dollars—					
	2007	2008	2009	2010	2011	2012
SPENDING SUBJECT TO APPROPRIATION						
IHS Spending Under Current Law [a]						
Budget Authority	3,169	0	0	0	0	0
Estimated Outlays	3,203	553	164	72	12	2
Proposed Changes:						
Existing Indian Health Service Activities:						
Estimated Authorization Level	0	3,247	3,320	3,396	3,475	3,554
Estimated Outlays	0	2,679	3,134	3,303	3,443	3,529
Recruitment Program for Behavioral Health Careers:						
Authorization Level	0	3	3	3	3	3
Estimated Outlays	0	2	3	3	3	3
Mental Health Demonstration Project:						
Authorization Level	0	2	2	2	2	0
Estimated Outlays	0	*	1	2	2	1
Commission on Indian Health Care:						
Authorization Level	0	4	0	0	0	0
Estimated Outlays	0	1	2	1	0	0
Native American Health and Wellness Foundation:						
Authorization Level	0	1	1	1	1	1
Estimated Outlays	0	*	1	1	1	1
Total Changes:						
Estimated Authorization Level	0	3,257	3,326	3,402	3,481	3,558
Estimated Outlays	0	2,682	3,141	3,310	3,449	3,534
Spending Under S. 1200						
Estimated Authorization Level [a]	3,169	3,257	3,326	3,402	3,481	3,558
Estimated Outlays	3,203	3,235	3,305	3,382	3,461	3,536

[a] The 2007 level is the amount appropriated for that year for IHS.

*Note: *=less than $500,000.

Existing Indian Health Service Activities. S. 1200 would authorize the appropriation of such sums as are necessary for the Indian Health Service through 2017. The agency's responsibilities under the bill would be broadly similar to those in current law. In 2007, the agency received an appropriation of $3.2 billion. CBO's estimate of the authorized level for IHS programs is the appropriated amount for 2007 adjusted for inflation in later years. (That level would grow to nearly $4 billion by 2017.) The estimated outlays reflect historical spending patterns for IHS activities.

Recruitment Program for Behavioral Health Careers. Section 105 of the bill would authorize the appropriation of $2.7 million annually through 2017 for grants to develop and maintain programs that encourage Indians to pursue careers in a field related to behavioral health. Assuming the appropriation of the authorized amounts, CBO estimates that implementing this provision would cost $2 million in 2008, $13 million over the 2008–2012 period, and $26 million over the 2008–2017 period.

Mental Health Demonstration Project. Section 708 would authorize the appropriation of $1.5 million annually for fiscal years 2008 through 2011 for grants to examine the feasibility of using telecommunication technology to provide suicide prevention services to Indians. Assuming the appropriation of the authorized amounts,

CBO estimates that implementing this provision would cost less than $500,000 in 2008 and about $6 million over the 2008–2012 period.

Commission on Indian Health Care. Section 814 would authorize the appropriation of $4 million for a commission that would examine how the federal government provides health care services to Indians. The members of the commission would have to be appointed within eight months of the bill's enactment and would be required to submit a final report to the Congress no later than 18 months after that. Assuming the appropriation of the authorized amount, CBO estimates that implementing this provision would cost $1 million in 2008, $2 million in 2009, and $1 million in 2010.

Native American Health and Wellness Foundation. S. 1200 would establish a charitable and nonprofit corporation called the Native American Health and Wellness Foundation to assist federal, state, tribal, and other entities in efforts to further health and wellness activities and opportunities for Indians. The bill would authorize the appropriation of $500,000 annually for the foundation's administrative expenses; this amount would be adjusted in later years for inflation. Assuming the appropriation of the authorized amounts, CBO estimates that implementing this provision would cost less than $500,000 in 2008 and about $2 million over the 2008–2012 period.

Direct spending

S. 1200 contains several provisions, primarily related to the Medicaid program, that would affect direct spending. The bill's estimated effects on direct spending are shown in Table 3. Overall, CBO estimates that enacting the bill would increase direct spending by $9 million in 2008 and $129 million over the 2008–2017 period.

TABLE 3.—ESTIMATED EFFECTS OF S. 1200 ON DIRECT SPENDING

	By fiscal year, in millions of dollars—											
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
CHANGES IN DIRECT SPENDING												
Exemption from Medicaid Cost Sharing and Premiums:												
Estimated Budget Authority	5	6	6	7	7	8	8	9	9	10	31	74
Estimated Outlays	5	6	6	7	7	8	8	9	9	10	31	74
Consultation with Indian Health Programs:												
Estimated Budget Authority	*	*	1	1	1	1	1	1	1	1	3	7
Estimated Outlays	*	*	1	1	1	1	1	1	1	1	3	7
Medicaid Managed Care Provisions:												
Estimated Budget Authority	3	3	4	4	4	5	5	5	6	6	18	45
Estimated Outlays	3	3	4	4	4	5	5	5	6	6	18	45
Scholarship and Loan Repayment Recovery Fund:												
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*	2	4
Estimated Outlays	*	*	*	*	*	*	*	*	*	*	2	4
Total Changes:												
Estimated Budget Authority	9	10	11	12	12	14	14	15	16	17	53	129
Estimated Outlays	9	10	11	12	12	14	14	15	16	17	53	129

* = costs savings of less than $500,000.

Notes: Components may not sum to totals because of rounding.

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

Exemption from Medicaid Cost Sharing and Premiums. Section 204 would prohibit Medicaid programs from charging premiums or other cost-sharing payments to Indians for services that are provided directly or upon referral by Indian health programs. The provision also would prohibit states from reducing payments to providers for those services by the amount of cost sharing that Indians otherwise would pay.

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

Using Medicaid administrative data, CBO estimates that about 280,000 Indians are Medicaid recipients who also use IHS, and that federal Medicaid spending on affected services would be about $225 per person annually in 2008. The amount of affected spending would be relatively low because Medicaid already prohibits cost sharing in many instances, such as long-term care services, emergency services, and services for many children and pregnant women. For the affected spending, CBO assumes that cost-sharing payments by individuals equal 2 percent of total spending—Medicaid law limits the extent to which states can impose cost sharing and that eliminating cost sharing would increase total spending by about 5 percent as individuals consume more services. Overall, CBO estimates that the provision would increase federal Medicaid spending by $5 million in 2008 and by $74 million over the 2008–2017 period.

Consultation with Indian Health Programs. Section 206 would encourage state Medicaid programs to consult regularly with Indian health programs on outstanding Medicaid issues by allowing states to receive federal matching funds for the cost of those consultations. Those costs would be treated as an administrative expense under Medicaid and divided equally between the federal government and the states. CBO anticipates that a small number of states would take advantage of this provision, increasing federal Medicaid spending by less than $500,000 in 2008 and by $7 million over the 2008–2017 period.

Medicaid Managed Care Provisions. Section 208 would make several changes to improve the ability of Indian health programs to receive payments for Indians who receive Medicaid benefits through managed care arrangements. Those changes include:

- Managed care organizations (MCOs) would have to pay Indian health programs at least the rates used for non-preferred providers. States also would have the option of making those payments directly to Indian health programs.

• MCOs would have to accept claims submitted by Indian health programs instead of requiring enrollees to submit claims personally.

• Some requirements that MCOs must now meet to participate in Medicaid would be waived or modified for Indian health programs that seek to operate as MCOs. (For example, MCOs run by Indian health programs would be able to limit enrollment to Indians only.)

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

Based on administrative data on Medicaid enrollment and spending for Indians who receive benefits via managed care, CBO estimates that those provisions would increase federal Medicaid spending by $3 million in 2008 and $45 million over the 2008–2017 period. We anticipate that the additional costs would be relatively modest because some states already use similar rules in their Medicaid managed care programs and Indian health programs would have a limited interest in participating as MCOs.

Scholarship and Loan Repayment Recovery Fund. S. 1200 would allow the Secretary of Health and Human Services to spend amounts collected for breach of contract from recipients of certain IHS scholarships. Under current law, those funds are deposited in the Treasury and not spent. Because the Secretary's ability to spend those funds would not be subject to appropriation, the provision would increase direct spending. Based on historical information from IHS, CBO estimates that the provision would increase spending by less than $500,000 a year, but would total about $4 million over the 2008–2017 period.

Estimated impact on state, local, and tribal governments:

Intergovernmental mandates

S. 1200 would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a contract or compact with a tribal health program. This preemption would be an intergovernmental mandate as defined in the UMRA; however, CBO estimates that the loss of any licensing fees resulting from the mandate would be small and would not approach the threshold established in UMRA ($66 million in 2007, adjusted annually for inflation).

Other impacts

S. 1200 would reauthorize and expand grant and assistance programs available to Indian tribes, tribal organizations, and urban Indian organizations for a range of health care programs, including prevention, treatment, and ongoing care. The bill also would allow IHS and tribal entities to share facilities, and it would authorize joint ventures between IHS and Indian tribes or tribal organizations for the construction and operation of health facilities. The bill would authorize funding for a variety of health services including hospice care, long-term care, public health services, and home and community-based services.

The bill would prohibit states from charging cost sharing or premiums in the Medicaid program to Indians who receive services or benefits through an Indian health program. CBO estimates that the new requirements in the bill would result in additional spend-

ing by states of about $80 million over the 2008–2017 period. Those requirements, however, would not be intergovernmental mandates as defined by UMRA because Medicaid provides states with significant flexibility to make programmatic adjustments to accommodate the changes. Some tribal entities, particularly those operating managed care systems, may realize some savings as a result of these provisions.

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

Previous CBO estimate: This estimate supersedes the cost estimate for S. 1200 that CBO transmitted on June 8, 2007. Our June 8 cost estimate erroneously indicated that section 204 of the bill (exempting Indians from paying certain types of cost sharing and premiums) would apply to both Medicaid and the State Children's Health Insurance Program. The provision would apply only to Medicaid, and we have lowered our estimate of the bill's impact on direct spending by $4 million over the 2008–2012 period and by $8 million over the 2008–2017 period as a result.

On September 11, 2007, CBO also issued a revised estimate for H.R. 1328, the Indian Health Care Improvement Act Amendments of 2007, as ordered reported by the House Committee on Natural Resources on April 25, 2007. There are only minor differences between the two bills, and CBO's revised estimates for them are identical.

Estimate prepared by: Federal Costs: Eric Rollins; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Paige Shevlin.

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

CHANGES IN EXISTING LAW

In accordance with subsection 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill S. 1200, as ordered reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new language to be added in italic, existing law to which no change is proposed is shown in roman):

UNITED STATES CODE ANNOTATED

TITLE 25. INDIANS

CHAPTER 18—INDIAN HEALTH CARE

[§1601. Congressional]

S 1200 IS
110th CONGRESS
1st Session
S. 1200
To amend the Indian Health Care Improvement Act to revise and extend that Act.
IN THE SENATE OF THE UNITED STATES
April 24, 2007

Mr. DORGAN (for himself, Mrs. BOXER, Mr. REID, Ms. CANTWELL, Mr. JOHNSON, Mr. TESTER, Mr. INOUYE, Mr. DOMENICI, Mr. BINGAMAN, Mr. BAUCUS, Ms. KLOBUCHAR, Mr. THOMAS, Mr. OBAMA, and Ms. MURKOWSKI) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

A BILL

To amend the Indian Health Care Improvement Act to revise and extend that Act.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Indian Health Care Improvement Act Amendments of 2007".

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

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS TO INDIAN LAWS

Sec. 101. Indian Health Care Improvement Act amended.
Sec. 102. Soboba sanitation facilities.
Sec. 103. Native American Health and Wellness Foundation.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

Sec. 201. Expansion of payments under Medicare, Medicaid, and SCHIP for all covered services furnished by Indian Health Programs.
Sec. 202. 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.
Sec. 203. Additional provisions to increase outreach to, and enrollment of, Indians in SCHIP and Medicaid.
Sec. 204. Premiums and cost sharing protections under Medicaid, eligibility determinations under Medicaid and SCHIP, and protection of certain Indian property from Medicaid estate recovery.
Sec. 205. Nondiscrimination in qualifications for payment for services under Federal health care programs.
Sec. 206. Consultation on Medicaid, SCHIP, and other health care programs funded under the Social Security Act involving Indian Health Programs and Urban Indian Organizations.
Sec. 207. Exclusion waiver authority for affected Indian Health Programs and safe harbor transactions under the Social Security Act.
Sec. 208. 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.
Sec. 209. Annual report on Indians served by Social Security Act health benefit programs.

TITLE I—AMENDMENTS TO INDIAN LAWS

SEC. 101. INDIAN HEALTH CARE IMPROVEMENT ACT AMENDED.

(a) IN GENERAL.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Indian Health Care Improvement Act".

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Declaration of national Indian health policy.
Sec. 4. Definitions.

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

Sec. 101. Purpose.
Sec. 102. Health professions recruitment program for Indians.
Sec. 103. Health professions preparatory scholarship program for Indians.
Sec. 104. Indian health professions scholarships.
Sec. 105. American Indians Into Psychology Program.
Sec. 106. Scholarship programs for Indian Tribes.
Sec. 107. Indian Health Service extern programs.
Sec. 108. Continuing education allowances.
Sec. 109. Community Health Representative Program.
Sec. 110. Indian Health Service Loan Repayment Program.
Sec. 111. Scholarship and Loan Repayment Recovery Fund.
Sec. 112. Recruitment activities.
Sec. 113. Indian recruitment and retention program.
Sec. 114. Advanced training and research.
Sec. 115. Quentin N. Burdick American Indians Into Nursing Program.
Sec. 116. Tribal cultural orientation.
Sec. 117. INMED Program.
Sec. 118. Health training programs of community colleges.
Sec. 119. Retention bonus.
Sec. 120. Nursing residency program.
Sec. 121. Community Health Aide Program.
Sec. 122. Tribal Health Program administration.
Sec. 123. Health professional chronic shortage demonstration programs.
Sec. 124. National Health Service Corps.
Sec. 125. Substance abuse counselor educational curricula demonstration programs.
Sec. 126. Behavioral health training and community education programs.
Sec. 127. Authorization of appropriations.

TITLE II—HEALTH SERVICES

Sec. 201. Indian Health Care Improvement Fund.
Sec. 202. Catastrophic Health Emergency Fund.
Sec. 203. Health promotion and disease prevention services.
Sec. 204. Diabetes prevention, treatment, and control.
Sec. 205. Shared services for long-term care.
Sec. 206. Health services research.
Sec. 207. Mammography and other cancer screening.
Sec. 208. Patient travel costs.
Sec. 209. Epidemiology centers.
Sec. 210. Comprehensive school health education programs.
Sec. 211. Indian youth program.
Sec. 212. Prevention, control, and elimination of communicable and infectious diseases.
Sec. 213. Other authority for provision of services.
Sec. 214. Indian women's health care.
Sec. 215. Environmental and nuclear health hazards.
Sec. 216. Arizona as a contract health service delivery area.
Sec. 216A. North Dakota and South Dakota as contract health service delivery area.
Sec. 217. California contract health services program.
Sec. 218. California as a contract health service delivery area.
Sec. 219. Contract health services for the Trenton service area.
Sec. 220. Programs operated by Indian Tribes and Tribal Organizations.
Sec. 221. Licensing.
Sec. 222. Notification of provision of emergency contract health services.
Sec. 223. Prompt action on payment of claims.
Sec. 224. Liability for payment.
Sec. 225. Office of Indian Men's Health.
Sec. 226. Authorization of appropriations.

TITLE III—FACILITIES

Sec. 301. Consultation; construction and renovation of facilities; reports.
Sec. 302. Sanitation facilities.
Sec. 303. Preference to Indians and Indian firms.
Sec. 304. Expenditure of non-Service funds for renovation.
Sec. 305. Funding for the construction, expansion, and modernization of small ambulatory care facilities.
Sec. 306. Indian health care delivery demonstration projects.
Sec. 307. Land transfer.

Sec. 308. Leases, contracts, and other agreements.
Sec. 309. Study on loans, loan guarantees, and loan repayment.
Sec. 310. Tribal leasing.
Sec. 311. Indian Health Service/tribal facilities joint venture program.
Sec. 312. Location of facilities.
Sec. 313. Maintenance and improvement of health care facilities.
Sec. 314. Tribal management of Federally-owned quarters.
Sec. 315. Applicability of Buy American Act requirement.
Sec. 316. Other funding for facilities.
Sec. 317. Authorization of appropriations.

TITLE IV—ACCESS TO HEALTH SERVICES

Sec. 401. Treatment of payments under Social Security Act health benefits programs.
Sec. 402. Grants to and contracts with the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs.
Sec. 403. Reimbursement from certain third parties of costs of health services.
Sec. 404. Crediting of reimbursements.
Sec. 405. Purchasing health care coverage.
Sec. 406. Sharing arrangements with Federal agencies.
Sec. 407. Payor of last resort.
Sec. 408. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services.
Sec. 409. Consultation.
Sec. 410. State Children's Health Insurance Program (SCHIP).
Sec. 411. Exclusion waiver authority for affected Indian Health Programs and safe harbor transactions under the Social Security Act.
Sec. 412. Premium and cost sharing protections and eligibility determinations under Medicaid and SCHIP and protection of certain Indian property from Medicaid estate recovery.
Sec. 413. Treatment under Medicaid and SCHIP managed care.
Sec. 414. Navajo Nation Medicaid Agency feasibility study.
Sec. 415. General exceptions.
Sec. 416. Authorization of appropriations.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Sec. 501. Purpose.
Sec. 502. Contracts with, and grants to, Urban Indian Organizations.
Sec. 503. Contracts and grants for the provision of health care and referral services.
Sec. 504. Contracts and grants for the determination of unmet health care needs.
Sec. 505. Evaluations; renewals.
Sec. 506. Other contract and grant requirements.
Sec. 507. Reports and records.
Sec. 508. Limitation on contract authority.
Sec. 509. Facilities.
Sec. 510. Division of Urban Indian Health.
Sec. 511. Grants for alcohol and substance abuse-related services.
Sec. 512. Treatment of certain demonstration projects.
Sec. 513. Urban NIAAA transferred programs.
Sec. 514. Consultation with Urban Indian Organizations.
Sec. 515. Urban youth treatment center demonstration.
Sec. 516. Grants for diabetes prevention, treatment, and control.
Sec. 517. Community Health Representatives.
Sec. 518. Effective date.
Sec. 519. Eligibility for services.
Sec. 520. Authorization of appropriations.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Sec. 601. Establishment of the Indian Health Service as an agency of the Public Health Service.
Sec. 602. Automated management information system.
Sec. 603. Authorization of appropriations.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

Sec. 701. Behavioral health prevention and treatment services.
Sec. 702. Memoranda of agreement with the Department of the Interior.

Sec. 703. Comprehensive behavioral health prevention and treatment program.
Sec. 704. Mental health technician program.
Sec. 705. Licensing requirement for mental health care workers.
Sec. 706. Indian women treatment programs.
Sec. 707. Indian youth program.
Sec. 708. Indian youth telemental health demonstration project.
Sec. 709. Inpatient and community-based mental health facilities design, construction, and staffing.
Sec. 710. Training and community education.
Sec. 711. Behavioral health program.
Sec. 712. Fetal alcohol disorder programs.
Sec. 713. Child sexual abuse and prevention treatment programs.
Sec. 714. Behavioral health research.
Sec. 715. Definitions.
Sec. 716. Authorization of appropriations.

TITLE VIII—MISCELLANEOUS

Sec. 801. Reports.
Sec. 802. Regulations.
Sec. 803. Plan of implementation.
Sec. 804. Availability of funds.
Sec. 805. Limitation on use of funds appropriated to Indian Health Service.
Sec. 806. Eligibility of California Indians.
Sec. 807. Health services for ineligible persons.
Sec. 808. Reallocation of base resources.
Sec. 809. Results of demonstration projects.
Sec. 810. Provision of services in Montana.
Sec. 811. Moratorium.
Sec. 812. Tribal employment.
Sec. 813. Severability provisions.
Sec. 814. Establishment of National Bipartisan Commission on Indian Health Care.
Sec. 815. Confidentiality of medical quality assurance records; qualified immunity for participants.
Sec. 816. Appropriations; availability.
Sec. 817. Authorization of appropriations.

SEC. 2. FINDINGS.

Congress makes the following findings*:*

[The Congress finds the following:

[(a**]** *(1)* Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

[(b**]** *(2)* A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

[(c**]** *(3)* Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

[(d**]** *(4)* Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

[§ 1602. Declaration of health objectives]

SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

[(a) The**]** Congress **[**hereby**]** declares that it is the policy of this Nation, in fulfillment of its special *trust* responsibilities and legal

[obligation to the American Indian people,] *obligations to Indians—*

(1) to assure the highest possible health status for Indians and [urban]*Urban* Indians and to provide all resources necessary to effect that policy[.]*;*

[(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians and urban Indians by the year 2000:

[(1) Reduce coronary heart disease deaths to a level of no more than 100 per 100,000.

[(2) Reduce the prevalence of overweight individuals to no more than 30 percent.

[(3) Reduce the prevalence of anemia to less than 10 percent among children aged 1 through 5.

[(4) Reduce the level of cancer deaths to a rate of no more than 130 per 100,000.

[(5) Reduce the level of lung cancer deaths to a rate of no more than 42 per 100,000.

[(6) Reduce the level of chronic obstructive pulmonary disease related deaths to a rate of no more than 25 per 100,000.

[(7) Reduce deaths among men caused by alcohol-related motor vehicle crashes to no more than 44.8 per 100,000.

[(8) Reduce cirrhosis deaths to no more than 13 per 100,000.

[(9) Reduce drug-related deaths to no more than 3 per 100,000.

[(10) Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents.

[(11) Reduce suicide among men to no more than 12.8 per 100,000.

[(12) Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17.

[(13) Reduce to less than 10 percent the prevalence of mental disorders among children and adolescents.

[(14) Reduce the incidence of child abuse or neglect to less than 25.2 per 1,000 children under age 18.

[(15) Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples.

[(16) Increase years of healthy life to at least 65 years.

[(17) Reduce deaths caused by unintentional injuries to no more than 66.1 per 100,000.

[(18) Reduce deaths caused by motor vehicle crashes to no more than 39.2 per 100,000.

[(19) Among children aged 6 months through 5 years, reduce the prevalence of blood lead levels exceeding 15ug/dl and reduce to zero the prevalence of blood lead levels exceeding 25 ug/dl.

[(20) Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 45 percent among children aged 6 through 8 and no more than 60 percent among adolescents aged 15.

[(21) Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6

through 8 and no more than 40 percent among adolescents aged 15.

[(22) Reduce to no more than 20 percent the proportion of individuals aged 65 and older who have lost all of their natural teeth.

[(23) Increase to at least 45 percent the proportion of individuals aged 35 to 44 who have never lost a permanent tooth due to dental caries or periodontal disease.

[(24) Reduce destructive periodontal disease to a prevalence of no more than 15 percent among individuals aged 35 to 44.

[(25) Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth.

[(26) Reduce the prevalence of gingivitis among individuals aged 35 to 44 to no more than 50 percent.

[(27) Reduce the infant mortality rate to no more than 8.5 per 1,000 live births.

[(28) Reduce the fetal death rate (20 or more weeks of gestation) to no more than 4 per 1,000 live births plus fetal deaths.

[(29) Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births.

[(30) Reduce the incidence of fetal alcohol syndrome to no more than 2 per 1,000 live births.

[(31) Reduce stroke deaths to no more than 20 per 100,000.

[(32) Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) to attain an incidence of no more than 13 per 100,000.

[(33) Reduce breast cancer deaths to no more than 20.6 per 100,000 women.

[(34) Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women.

[(35) Reduce colorectal cancer deaths to no more than 13.2 per 100,000.

[(36) Reduce to no more than 11 percent the proportion of individuals who experience a limitation in major activity due to chronic conditions.

[(37) Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000.

[(38) Reduce significant visual impairment to a prevalence of no more than 30 per 1,000.

[(39) Reduce diabetes-related deaths to no more than 48 per 100,000.

[(40) Reduce diabetes to an incidence of no more than 2.5 per 1,000 and a prevalence of no more than 62 per 1,000.

[(41) Reduce the most severe complications of diabetes as follows:

[(A) End-stage renal disease, 1.9 per 1,000.

[(B) Blindness, 1.4 per 1,000.

[(C) Lower extremity amputation, 4.9 per 1,000.

[(D) Perinatal mortality, 2 percent.

[(E) Major congenital malformations, 4 percent.

[(42) Confine annual incidence of diagnosed AIDS cases to no more than 1,000 cases.

[(43) Confine the prevalence of HIV infection to no more than 100 per 100,000.

[(44) Reduce gonorrhea to an incidence of no more than 225 cases per 100,000.

[(45) Reduce chlamydia trachomatis infections, as measured by a decrease in the incidence of nongonococcal urethritis to no more than 170 cases per 100,000.

[(46) Reduce primary and secondary syphilis to an incidence of no more than 10 cases per 100,000.

[(47) Reduce the incidence of pelvic inflammatory disease, as measured by a reduction in hospitalization for pelvic inflammatory disease to no more than 250 per 100,000 women aged 15 through 44.

[(48) Reduce viral hepatitis B infection to no more than 40 per 100,000 cases.

[(49) Reduce indigenous cases of vaccine-preventable diseases as follows:

[(A) Diphtheria among individuals aged 25 and younger, 0.

[(B) Tetanus among individuals aged 25 and younger, 0.

[(C) Polio (wild-type virus), 0.

[(D) Measles, 0.

[(E) Rubella, 0.

[(F) Congenital Rubella Syndrome, 0.

[(G) Mumps, 500.

[(H) Pertussis, 1,000.

[(50) Reduce epidemic-related pneumonia and influenza deaths among individuals aged 65 and older to no more than 7.3 per 100,000.

[(51) Reduce the number of new carriers of viral hepatitis B among Alaska Natives to no more than 1 case.

[(52) Reduce tuberculosis to an incidence of no more than 5 cases per 100,000.

[(53) Reduce bacterial meningitis to no more than 8 cases per 100,000.

[(54) Reduce infectious diarrhea by at least 25 percent among children.

[(55) Reduce acute middle ear infections among children aged 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children.

[(56) Reduce cigarette smoking to a prevalence of no more than 20 percent.

[(57) Reduce smokeless tobacco use by youth to a prevalence of no more than 10 percent.

[(58) Increase to at least 65 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay.

[(59) Increase to at least 75 percent the proportion of mothers who breast feed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breast feeding until their babies are 5 to 6 months old.

[(60) Increase to at least 90 percent the proportion of pregnant women who receive prenatal care in the first trimester of pregnancy.

[(61) Increase to at least 70 percent the proportion of individuals who have received, as a minimum within the appro-

priate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the United States Preventive Services Task Force.]

(2) to raise the health status of Indians and Urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 or successor objectives;

(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

[(c) It is the intent of the Congress that the Nation] *(4) to* increase the proportion of all degrees in the health professions and allied and associated health [profession fields awarded to Indians to 0.6 percent.]*professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;*

[(d) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the progress made in each area of the Service toward meeting each of the objectives described in subsection (b) of this section.]

(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

[§ 1603. Definitions]

(6) to provide funding for programs and facilities operated by Indian Tribes and Tribal Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

SEC. 4. DEFINITIONS.

For purposes of this [chapter—]*Act:*

(1) The term "accredited and accessible" means on or near a reservation and accredited by a national or regional organization with accrediting authority.

(2) The term "Area Office" means an administrative entity, including a program office, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

(3) The term "Assistant Secretary" means the Assistant Secretary for Indian Health.

(4)(A) The term "behavioral health" means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services.

(B) The term "behavioral health" includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

(5) The term "California Indians" means those Indians who are eligible for health services of the Service pursuant to section 806.

(6) The term "community college" means—

(A) a tribal college or university, or

(B) a junior or community college.

(7) The term "contract health service" means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

[(a) "Secretary"**]** *(8) The term "Department" means,* unless otherwise designated, **[**means the Secretary**]***the Department* of Health and Human Services.

[(b) "Service" means the Indian Health Service.**]**

(9) The term "disease prevention" means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

(A) controlling—

(i) the development of diabetes;

(ii) high blood pressure;

(iii) infectious agents;

(iv) injuries;

(v) occupational hazards and disabilities;

(vi) sexually transmittable diseases; and

(vii) toxic agents; and

(B) providing—

(i) fluoridation of water; and

(ii) immunizations.

(10) The term "health profession" means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, and any other health profession.

(11) The term "health promotion" means—

(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

(B) encouraging adequate and appropriate diet, exercise, and sleep;

(C) promoting education and work in conformity with physical and mental capacity;

(D) making available safe water and sanitary facilities;

(E) improving the physical, economic, cultural, psychological, and social environment;

(F) promoting culturally competent care; and

(G) providing adequate and appropriate programs, which may include—

(i) abuse prevention (mental and physical);

(ii) community health;

(iii) community safety;

(iv) consumer health education;

(v) diet and nutrition;

(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

(vii) environmental health;

(viii) exercise and physical fitness;

(ix) avoidance of fetal alcohol disorders;

(x) first aid and CPR education;

(xi) human growth and development;

(xii) injury prevention and personal safety;

(xiii) behavioral health;

(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;

(xv) personal health and wellness practices;

(xvi) personal capacity building;

(xvii) prenatal, pregnancy, and infant care;

(xviii) psychological well-being;

(xix) reproductive health and family planning;

(xx) safe and adequate water;

(xxi) healthy work environments;

(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

(xxiii) stress control;

(xxiv) substance abuse;

(xxv) sanitary facilities;

(xxvi) sudden infant death syndrome prevention;

(xxvii) tobacco use cessation and reduction;

(xxviii) violence prevention; and

(xxix) such other activities identified by the Service, a Tribal Health Program, or an Urban Indian Organization, to promote achievement of any of the objectives described in section 3(2).

[(c) "Indians" or**]** *(12) The term* "Indian", unless otherwise designated, means any person who is a member of an Indian **[**tribe, as defined in subsection (d) of this section,**]** *Tribe or is eligible for health services under section 806,* except that, for the purpose of sections **[**1612 and 1613 of this title, such terms shall mean**]** *102 and 103, the term also means* any individual who **[**(1),**]**—

(A)(i) irrespective of whether **[**he or she**]** *the individual* lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside**[**,**]***;* or **[**who**]**

(ii) is a descendant, in the first or second degree, of any such member**[**, or (2)**]***;*

(B) is an Eskimo or Aleut or other Alaska Native**[**, or (3)**]***;*

(C) is considered by the Secretary of the Interior to be an Indian for any purpose**[**, or (4)**]***; or*

(D) is determined to be an Indian under regulations promulgated by the Secretary.

(13) The term "Indian Health Program" means—

(A) any health program administered directly by the Service;

(B) any Tribal Health Program; or

(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the "Buy Indian Act").

(14) The term "Indian Tribe" has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(15) The term "junior or community college" has the meaning given the term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

[(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or**]** *(16) The term "reservation" means any federally recognized Indian Tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions* established pursuant to the Alaska Native Claims Settlement Act (**[**85 Stat. 688) [**]**43 U.S.C.**[**A § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.**]** *1601 et seq.*).

[(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

[(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.**]**

(17) The term "Secretary", unless otherwise designated, means the Secretary of Health and Human Services.

(18) The term "Service" means the Indian Health Service.

(19) The term "Service Area" means the geographical area served by each Area Office.

(20) The term "Service Unit" means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

(21) The term "telehealth" has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

(22) The term "telemedicine" means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

(23) The term "tribal college or university" has the meaning given the term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059c(b)(3)).

(24) The term "Tribal Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(25) The term "Tribal Organization" has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

[(g)**]** *(26)* **["]***The term* "Urban **[**center"**]** *Center"* means any community which has a sufficient **[**urban**]** *Urban* Indian population with unmet health needs to warrant assistance under **[**subchapter IV**]** *title V* of this **[**chapter**]** *Act*, as determined by the Secretary.

(27) The term "Urban Indian" means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

(A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

(B) The individual is an Eskimo, Aleut, or other Alaska Native.

(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

[(h)**]** *(28) The term* "Urban Indian **[**organization"**]** *Organization"* means a nonprofit corporate body *that (A) is* situated in an **[**urban center,**]** *Urban Center; (B) is* governed by an **[**urban**]** *Urban* Indian-controlled board of directors**[**, and providing**]***; (C) provides* for the **[**maximum**]** participation of all interested Indian groups and individuals**[**, which body**]***; and (D)* is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section **[**1653**]** *503*(a).

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

SEC. 101. PURPOSE.

The purpose of this title**[**.**]**

[(i) "Area office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

[(j) "Service unit" means—

[(1) an administrative entity within the Indian Health Service, or

[(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

[(k) "Health promotion" includes—

[(1) cessation of tobacco smoking,

[(2) reduction in the misuse of alcohol and drugs,

[(3) improvement of nutrition,

[(4) improvement in physical fitness,

[(5) family planning,

[(6) control of stress, and

[(7) pregnancy and infant care (including prevention of fetal alcohol syndrome).

[(l) "Disease prevention" includes—

[(1) immunizations,

[(2) control of high blood pressure,

[(3) control of sexually transmittable diseases,

[(4) prevention and control of diabetes,

[(5) control of toxic agents,

[(6) occupational safety and health,

[(7) accident prevention,

[(8) fluoridation of water, and

[(9) control of infectious agents.

[(m) "Service area" means the geographical area served by each area office.

[(n) "Health profession" means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

[(o) "Substance abuse" includes inhalant abuse.

[(p) "FAE" means fetal alcohol effect.

[(q) "FAS" means fetal alcohol syndrome.

[§ 1611. Congressional statement of purpose The purpose of this subchapter] is to increase*, to the maximum extent feasible*, the number of Indians entering the health professions and *providing health services, and* to assure an [adequate] *optimum* supply of health professionals to the [Service, Indian tribes, tribal organizations, and urban Indian organizations] *Indian Health Programs and Urban Indian Organizations* involved in the provision of health [care] *services* to [Indian people] *Indians*.

[§ 1612. Health professions recruitment program for Indians]

SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

[(a) Grants for education and training]

(a) IN GENERAL.—The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities*, Tribal Health Programs,* or *Urban* Indian [tribes

or tribal organizations] *Organizations* to assist such entities in meeting the costs of—

(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

(A) to enroll in courses of study in such health professions; or

(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) [of this subsection] or who are undertaking training necessary to qualify them to enroll in any such course of study; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1) [of this subsection].

[(b) Application for grant; submittal and approval; preference; payment]

(b) GRANTS.—

[(1) No] *(1) Application.—The Secretary shall not make a* grant [may be made] under this section unless an application [therefor] has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe *pursuant to this Act*. The Secretary shall give a preference to applications submitted by [Indian tribes or tribal organizations] *Tribal Health Programs or Urban Indian Organizations*.

(2) *AMOUNT OF GRANTS; PAYMENT.*—The amount of [any] *a* grant under this section shall be determined by the Secretary. Payments pursuant to [grants under] this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as [the Secretary finds necessary] *provided for in regulations issued pursuant to this Act. To the extent not otherwise prohibited by law, grants shall be for 3 years, as provided in regulations issued pursuant to this Act*.

[§ 1613. Health professions preparatory scholarship program for Indians]

SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

[(a) REQUIREMENTS]

(a) SCHOLARSHIPS AUTHORIZED.—The Secretary, acting through the Service, shall [make] *provide* scholarship grants to Indians who—

(1) have successfully completed their high school education or high school equivalency; and

(2) have demonstrated the [capability] *potential* to successfully complete courses of study in the health professions.

(b) PURPOSES. [and duration of grants; preprofessional and pregraduate education]—Scholarship grants [made] *provided* pursuant to this section shall be for the following purposes:

(1) Compensatory preprofessional education of any [grantee] *recipient*, such scholarship not to exceed [two] *2* years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary *pursuant to regulations issued under this Act*).

(2) Pregraduate education of any [grantee] *recipient* leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years. *An extension of up to 2 years* (or the part-time equivalent thereof, as determined by the Secretary[).] *pursuant to regulations issued pursuant to this Act) may be approved.*

[(c) COVERED EXPENSES]

[Scholarship grants made] *(c) OTHER CONDITIONS.—Scholarships* under this section—

(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a [grantee] *recipient* while attending school[.]*;*

[(d) BASIS FOR DENIAL OF ASSISTANCE]

[The Secretary] *(2)* shall not [deny scholarship assistance to an eligible applicant under this section] *be denied* solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution[.]*; and*

[(e) ELIGIBILITY FOR ASSISTANCE UNDER OTHER FEDERAL PROGRAMS]

[The Secretary] *(3)* shall not [deny scholarship assistance to an eligible applicant under this section] *be denied* solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

[§ 1613a. Indian health professions scholarships]

SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

[(a) GENERAL AUTHORITY] *(a) IN GENERAL.—*

[In order to provide health professionals to Indians, Indian tribes, tribal organizations, and urban Indian organizations, the] *(1) AUTHORITY.—The* Secretary, acting through the Service [and in accordance with this section], shall make scholarship grants to Indians who are enrolled full or part time in [appropriately] accredited schools [and] pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section [254l of Title 42,] *338A of the Public Health Services Act (42 U.S.C. 254l),* except as provided in subsection (b) of this section.

[(b) Recipients; active duty service obligation]

[(1)] *(2) DETERMINATIONS BY SECRETARY.*—The Secretary, acting through the Service, shall determine—

(A) who shall receive [scholarships] *scholarship grants* under subsection (a)*;* and [shall determine]

(B) the distribution of [such] *the* scholarships among [such] health professions on the basis of the relative

needs of Indians for additional service in [such] *the* health professions. [(2) An individual shall be eligible for a scholarship under subsection (a) of this section in any year in which such individual is enrolled full or part time in a course of study referred to in subsection (a) of this section.]

(3) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Assistant Secretary and shall not be delegated in a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(b) ACTIVE DUTY SERVICE OBLIGATION—

[(3)(A)] *(1) OBLIGATION MET.*—The active duty service obligation under a written contract with the Secretary under *this* section [254*l* of Title 42] that an [individual] *Indian* has entered into [under that section] shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice[, by service—] *equal to 1 year for each school year for which the participant receives a scholarship award under this part, or 2 years, whichever is greater, by service in 1 or more of the following:*

[(i) in the Indian Health Service;]

[(ii) in a program conducted under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.];]

(A) In an Indian Health Program.

[(iii)] *(B)* [in] *In* a program assisted under [subchapter IV of this chapter;] *title V of this Act.*

[(iv)] *(C)* [in]*In* the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians[; or].

(D) In a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, the health service provided to Indians would not decrease.

[(B)] *(2) OBLIGATION DEFERRED.*—At the request of any individual who has entered into a contract referred to in [subparagraph (A]*paragraph (1)* and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

[(i)] *(A)* No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service [that is required] under this [section]*subsection*.

[(ii)] *(B)* The active duty service obligation of that individual shall commence not later than 90 days after the

completion of that advanced clinical training (or by a date specified by the Secretary).

[(iii)] *(C)* The active duty service obligation will be served in the health profession of that individual, in a manner consistent with [clauses (i) through (v) of subparagraph (A)] *paragraph (1)*.

[(C)] *(D)* A recipient of [an Indian Health Scholarship]*a scholarship under this section* may, at the election of the recipient, meet the active duty service obligation described in [subparagraph (A)] *paragraph (1)* by service in a program specified [in] *under* that [subparagraph] *paragraph* that—

(i) is located on the reservation of the [tribe] *Indian Tribe* in which the recipient is enrolled; or

(ii) serves the [tribe] *Indian Tribe* in which the recipient is enrolled.

[(D)] *(3) PRIORITY WHEN MAKING ASSIGNMENTS.*—Subject to [subparagraph (C] *paragraph (2)*, the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in [subparagraph (A)] *paragraph (1)*, shall give priority to assigning individuals to service in those programs specified in [subparagraph (A)] *paragraph (1)* that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

[(4)] (c) *PART-TIME STUDENTS.*—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

[(A)] *(1)* such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the Secretary;

[(B)] *(2)* the period of obligated service described in [paragraph (3)(A)] *subsection (b)(1)* shall be equal to the greater of—

[(i)] *(A)* the part-time equivalent of [one] *1* year for each year for which the individual was provided a scholarship (as determined by the Secretary); or

[(ii)] *(B)* [two] *2* years; and

[(C)] *(3)* the amount of the monthly stipend specified in section *338A(g)(1)(B) of the Public Health Service Act (42 U.S.C.* 254l(g)(1)(B) [of Title 42]) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

[(5)(A) An individual who has, on or after October 29, 1992, entered into a written contract with the Secretary under this section and who—]

(d) BREACH OF CONTRACT.—

(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 if that individual—

[(i)] *(A)* fails to maintain an acceptable level of academic standing in the educational institution in which he

or she is enrolled (such level determined by the educational institution under regulations of the Secretary)[,]*;*

[(ii)] *(B)* is dismissed from such educational institution for disciplinary reasons[,]*;*

[(iii)] *(C)* voluntarily terminates the training in such an educational institution for which he *or she* is provided a scholarship under such contract before the completion of such training[,]*;* or

[(iv)] *(D)* fails to accept payment, or instructs the educational institution in which he *or she* is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract[, shall be liable to the United States for the amount which has been paid to him, or on his behalf, under the contract].

[(B)] *(2) OTHER BREACHES.*—If for any reason not specified in [subparagraph (A)] *paragraph (1)* an individual breaches [his] *a* written contract by failing either to begin such individual's service obligation *required* under [this section] *such contract* or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section [1616a(l) of this title] *110* in the manner provided for in such subsection.

[(C)] *(3) CANCELLATION UPON DEATH OF RECIPIENT.*—Upon the death of an individual who receives an Indian Health Scholarship, any *outstanding* obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(4) WAIVERS AND SUSPENSIONS.—

[(D)] *(A) IN GENERAL.*—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

(i) it is not possible for the recipient to meet that obligation or make that payment;

(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

(B) FACTORS FOR CONSIDERATION.—Before waiving or suspending an obligation of service or payment under subparagraph (A), the Secretary shall consult with the affected Area Office, Indian Tribes, Tribal Organizations, or Urban Indian Organizations, and may take into consideration whether the obligation may be satisfied in a teaching capacity at a tribal college or university nursing program under subsection (b)(1)(D).

[(E)] *(5) EXTREME HARDSHIP.*—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

[(F)] *(6) BANKRUPTCY.*—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under [Title] *title* 11, *United States Code,* unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

[(c) Placement Office]

SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

(1) provides outreach and recruitment for health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

(2) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

(7) to the maximum extent feasible, employs qualified Indians in the program.

[The Secretary shall, acting through the Service, establish a Placement Office to develop and implement a national policy for the placement, to available vacancies within the Service, of Indian

Health Scholarship recipients required to meet the active duty service obligation prescribed under section 254m of Title 42 without regard to any competitive personnel system, agency personnel limitation, or Indian preference policy.]

(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

(1) in an Indian Health Program;

(2) in a program assisted under title V of this Act; or

(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,700,000 for each of fiscal years 2008 through 2017.

SEC. 106. SCHOLARSHIP PROGRAMS FOR INDIAN TRIBES.

(a) IN GENERAL.—

(1) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

(3) APPLICATION.—An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(b) REQUIREMENTS.—

(1) IN GENERAL.—A Tribal Health Program receiving a grant under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

(B) 20 percent of such costs may be paid from any other source of funds.

(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in 1 of the health professions contemplated by this Act.

(d) CONTRACT.—

(1) IN GENERAL.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship.

(2) REQUIREMENTS.—Such contract shall—

(A) obligate such recipient to provide service in an Indian Health Program or Urban Indian Organization, in the

same Service Area where the Tribal Health Program providing the scholarship is located, for—

(i) a number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

(ii) such greater period of time as the recipient and the Tribal Health Program may agree;

(B) provide that the amount of the scholarship—

(i) may only be expended for—

(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), with such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and not to exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

(ii) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i);

(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

(3) SERVICE IN OTHER SERVICE AREAS.—The contract may allow the recipient to serve in another Service Area, provided the Tribal Health Program and Secretary approve and services are not diminished to Indians in the Service Area where the Tribal Health Program providing the scholarship is located.

(e) BREACH OF CONTRACT.—

(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level as determined by the educational institution under regulations of the Secretary);

(B) is dismissed from such educational institution for disciplinary reasons;

(C) voluntarily terminates the training in such an educational institution for which he or she is provided a schol-

arship under such contract before the completion of such training; or

(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX or title XXI of such Act; and

(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal Health Program has not complied with the requirements of this section.

[§ 1614. Indian Health Service extern programs]

SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

(a) EMPLOYMENT [of scholarship grantees during nonacademic periods] *PREFERENCE*.—Any individual who receives a scholarship [grant] pursuant to section [1613a of this title] *104 or 106* shall be [entitled to] *given preference for* employment in the Service [during any nonacademic period of the year.], *or may be employed by a Tribal Health Program or an Urban Indian Organization, or*

other agencies of the Department as available, during any nonacademic period of the year.

(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—Periods of employment pursuant to this subsection shall not be counted in determining [the] fulfillment of the service obligation incurred as a condition of the scholarship [grant].

[(b)]*(c) TIMING; LENGTH OF EMPLOYMENT* [of medical and other students during nonacademic periods].—Any individual enrolled in a [course of study in the health professions] *program, including a high school program, authorized under section 102(a)* may be employed by the Service *or by a Tribal Health Program or an Urban Indian Organization* during any nonacademic period of the year. Any such employment shall not exceed [one hundred and twenty] *120* days during any calendar year.

[(c) Employment without regard to competitive personnel system or agency personnel limitation; compensation] *(d) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.*—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department[of Health and Human Services].

[§ 1615. Continuing education allowances]

SEC. 108. CONTINUING EDUCATION ALLOWANCES.

[(a) Discretionary authority; scope of activities]

In order to encourage [physicians, dentists, nurses, and other] *scholarship and stipend recipients under sections 104, 105, 106, and 115 and* health professionals*, including community health representatives and emergency medical technicians,* to join or continue in [the Service] *an Indian Health Program* and to provide their services in the rural and remote areas where a significant portion of [the Indian people resides] *Indians reside*, the Secretary, acting through the Service, may [provide]—

(1) provide programs or allowances to transition into an Indian Health Program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, 106, and 115; and

(2) provide programs or allowances to health professionals employed in [the Service] *an Indian Health Program* to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation*, management, leadership,* and refresher training courses.

[(b) Limitation

[Of amounts appropriated under the authority of this subchapter for each fiscal year to be used to carry out this section, not more than $1,000,000 may be used to establish postdoctoral training programs for health professionals.

[§ 1616. Community Health Representative Program]

SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

(a) *IN GENERAL.*—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] *(commonly* known as the "Snyder Act"), the Secretary*, acting through the Service,* shall maintain a Community Health Representative Program under which [the Service]*Indian Health Programs*—

(1) [provides] *provide* for the training of Indians as [health paraprofessionals, and] *community health representatives; and*

[(2) uses such paraprofessionals] *(2) use such community health representatives* in the provision of health care, health promotion, and disease prevention services to Indian communities.

[(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—]

(b) DUTIES.—The Community Health Representative Program of the Service, shall—

(1) provide a high standard of training for [paraprofessionals to Community Health Representatives] *community health representatives* to ensure that the [Community Health Representatives] *community health representatives* provide quality health care, health promotion, and disease prevention services to the Indian communities served by [such] *the* Program[,]*;*

(2) in order to provide such training, develop and maintain a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care[,]*;* and

(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty[,]*;*

(3) maintain a system which identifies the needs of [Community Health Representatives] *community health representatives* for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for [such] continuing education[,]*;*

(4) maintain a system that provides close supervision of Community Health Representatives[,]*;*

(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated[,]*;* and

(6) promote traditional health care practices of the Indian [tribes] *Tribes* served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

[§1616a. Indian Health Service Loan Repayment Program]

SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

(a) ESTABLISHMENT.—[(1)]The Secretary, acting through the Service, shall establish *and administer* a program to be known as the [Indian Health] Service Loan Repayment Program (hereinafter referred to as the ["]'Loan Repayment Program["]') in order to [assure] *ensure* an adequate supply of trained health professionals

necessary to maintain accreditation of, and provide health care services to Indians through, Indian [health programs] *Health Programs and Urban Indian Organizations.*

[(2) For the purposes of this section—]

[(A) the term "Indian health program" means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

[(i) directly by the Service;

[(ii) by any Indian tribe or tribal or Indian organization pursuant to a contract under—

[(I) the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], or

[(II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47), popularly known as the "Buy-Indian" Act; or

[(iii) by an urban Indian organization pursuant to subchapter IV of this chapter; and

[(B) the term "State" has the same meaning given such term in section 254d of Title 42.]

[(b) ELIGIBILITY] *(b) ELIGIBLE INDIVIDUALS.*—To be eligible to participate in the Loan Repayment Program, an individual must—

(1)(A) be enrolled—

(i) in a course of study or program in an accredited *educational* institution[,] *(*as determined by the Secretary[, within any State] *under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(c)(i)))* and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

(ii) in an approved graduate training program in a health profession; or

(B) have—

(i) a degree in a health profession; and

(ii) a license to practice a health profession [in a State];

(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

(C) meet the professional standards for civil service employment in the [Indian Health] Service; or

(D) be employed in an Indian [health program] *Health Program or Urban Indian Organization* without a service obligation; and

(3) submit to the Secretary an application for a contract described in subsection [(f) of this section] *(e).*

(c) APPLICATION [AND CONTRACT FORMS].—

[(1)] *(1) INFORMATION TO BE INCLUDED WITH FORMS.*—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection [(1)] *(l)*

[of this section] in the case of the individual's breach of [the] contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the [Indian health] Service to enable the individual to make a decision on an informed basis.

(2) *CLEAR LANGUAGE.*—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

[(3)] (3) *TIMELY AVAILABILITY OF FORMS.*—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

[(d) Vacancies; priority]

(d) PRIORITIES.—

(1) *LIST.*—Consistent [with paragraph (3), the Secretary, acting through the Service and in accordance] with subsection (k) [of this section], *the Secretary* shall annually—

(A) identify the positions in each Indian [health program] *Health Program or Urban Indian Organization* for which there is a need or a vacancy[,]*;* and

(B) rank those positions in order of priority.

(2) [Consistent with] *APPROVALS.—Notwithstanding* the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

(A) give *first* priority to applications made by[— (A)] *individual* Indians; and

(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

[(B)] *(i)* individuals recruited through the efforts of *an* Indian [tribes or tribal or Indian organizations.]

[(3)(A) Subject to subparagraph (B), of the total amounts appropriated for each of the fiscal years 1993, 1994, and 1995 for loan repayment contracts under this section, the Secretary shall provide that—

[(i) not less than 25 percent be provided to applicants who are nurses, nurse practitioners, or nurse midwives] *Health Program or Urban Indian Organization*; and

[(ii) not less than 10 percent be provided to applicants who are mental health professionals (other than applicants described in clause (i)).

[(B) The requirements specified in clause (i) or clause (ii) of subparagraph (A) shall not apply if the Secretary does not receive the number of applications from the individuals described in clause (i) or clause (ii), respectively, necessary to meet such requirements.

[(e) Approval]

(ii) other individuals based on the priority rankings under paragraph (1).

(e) RECIPIENT CONTRACTS.—

(1) *CONTRACT REQUIRED.*—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in [subsection (f) of this section.] *paragraph (2).*

[(2) The Secretary shall provide written notice to an individual promptly on—

[(A) the Secretary's approving, under paragraph (1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

[(B) the Secretary's disapproving an individual's participation in such Program.

[(f) Contract terms]

(2) CONTENTS OF CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

[(1)] *(A)* an agreement under which—

[(A)] *(i)* subject to [paragraph (3)] *subparagraph (C),* the Secretary agrees—

[(i)] *(I)* to pay loans on behalf of the individual in accordance with the provisions of this section[,]*;* and

[(ii)]*(II)* to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a [tribe] *Tribal Health Program* or *Urban* Indian [organization] *Organization* as provided in [subparagraph (B)(iii),] *clause (ii)(III);* and

[(B] *(ii)* subject to [paragraph (3] *subparagraph (C)*, the individual agrees—

[(i)] *(I)* to accept loan payments on behalf of the individual;

[(ii)] *(II)* in the case of an individual described in subsection (b)(1)—

[(I)] *(aa)* to maintain enrollment in a course of study or training described in subsection (b)(1)(A) [of this section] until the individual completes the course of study or training[,]*;* and

[(II)] *(bb)* while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); *and*

[(iii)] *(III)* to serve for a time period (hereinafter in this section referred to as the "period of obligated service") equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian [health program] *Health Pro-*

gram or Urban Indian Organization to which the individual may be assigned by the Secretary;

[(2)] *(B)* a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under [paragraph (1)(B)(iii)] *subparagraph (A)(ii)(III)*;

[(3)] *(C)* a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

[(4)] *(D)* a statement of the damages to which the United States is entitled under subsection ([1]*l*) [of this section] for the individual's breach of the contract; and

[(5)] *(E)* such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

[(g) Loan repayment purposes; maximum amount; tax liability reimbursement; schedule of payments]

(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

(2) the Secretary's disapproving an individual's participation in such Program.

(g) PAYMENTS.—

[(1)] *(1) IN GENERAL.*—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

(A) tuition expenses;

(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

(C) reasonable living expenses as determined by the Secretary.

(2) [(A)] *AMOUNT.*—For each year of obligated service that an individual contracts to serve under subsection ([f]*e*), the Secretary may pay up to $35,000 [(]or an amount equal to the amount specified in section [254l–l]*338B*(g)(2)(A) of [Title 42] *the Public Health Service Act, whichever is more,* on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

[(i)] *(A)* affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

[(ii)] *(B)* provides an incentive to serve in Indian [health programs]*Health Programs and Urban Indian Organizations* with the greatest shortages of health professionals; and

[(iii)] *(C)* provides an incentive with respect to the health professional involved remaining in an Indian [health program] *Health Program or Urban Indian Organization* with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

[(B)] *(3) TIMING.*—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

[(3)] *(4) REIMBURSEMENTS FOR TAX LIABILITY.*—For the purpose of providing reimbursements for tax liability resulting from [payments] *a payment* under paragraph (2) on behalf of an individual, the Secretary—

(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

[(4)] *(5) PAYMENT SCHEDULE.*—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

[(h) EFFECT ON EMPLOYMENT CEILING OF DEPARTMENT OF HEALTH AND HUMAN SERVICES]

(h) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section[, while undergoing academic training,] shall not be counted against any employment ceiling affecting the Department [of Health and Human Services] *while those individuals are undergoing academic training.*

(i) [Recruiting programs] *RECRUITMENT.*—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other [health professional] *manpower* programs of the Service at educational institutions training health professionals or specialists identified in subsection (a)[of this section].

(j) [Prohibition of assignment to other government departments.—Section 215 of Title 42] *APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215)* shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

[(k) Staff needs of health programs administered by Indian tribes] *(k) ASSIGNMENT OF INDIVIDUALS.*—The Secretary, in assigning individuals to serve in Indian [health programs] *Health Programs or Urban Indian Organizations* pursuant to contracts entered into under this section, shall—

(1) ensure that the staffing needs of [Indian health programs administered by an Indian tribe or tribal or health organization] *Tribal Health Programs and Urban Indian Organizations* receive consideration on an equal basis with programs that are administered directly by the Service; and

(2) give priority to assigning individuals to Indian [health programs] *Health Programs and Urban Indian Organizations* that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

[(l) Voluntarily termination of study or dismissal from educational institution; collection of damages]

(l) BREACH OF CONTRACT.—

(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section and [who—] *has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract if that individual*—

(A) is enrolled in the final year of a course of study and [who]—

(i) fails to maintain an acceptable level of academic standing in the educational institution in which he *or she* is enrolled (such level determined by the educational institution under regulations of the Secretary);

(ii) voluntarily terminates such enrollment; or

(iii) is dismissed from such educational institution before completion of such course of study; or

(B) is enrolled in a graduate training program[,] *and* fails to complete such training program[, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii), shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.].

[(2)] *(2) OTHER BREACHES; FORMULA FOR AMOUNT OWED.*—If, for any reason not specified in paragraph (1), an individual breaches his *or her* written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection [(f) of this section] *(e)(2)*, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: $A=3Z(t-s/t)$ in which—

(A) "A" is the amount the United States is entitled to recover;

(B) "Z" is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the

amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the [Treasurer] *Secretary* of the [United States] *Treasury*;

(C) "t" is the total number of months in the individual's period of obligated service in accordance with subsection (f) [of this section]; and

(D) "s" is the number of months of such period served by such individual in accordance with this section.

(3) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section [1395ccc of Title 42.] *1892 of the Social Security Act*.

[(3)(A)] *(4) TIME PERIOD FOR REPAYMENT.*—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

(5) RECOVERY OF DELINQUENCY.—

[(B)] *(A) IN GENERAL.*—If damages described in [subparagraph (A)] *paragraph (4)* are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

(i) [utilize] *use* collection agencies contracted with by the Administrator of [the] General Services [Administration]; or

(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

[(C)] *(B) REPORT.*—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of [Title 31] *title 31, United States Code,* shall apply to any such contract to the extent not inconsistent with this subsection.

[(m) Cancellation or waiver of obligations; bankruptcy discharge

[(1) Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.]

(m) WAIVER OR SUSPENSION OF OBLIGATION.—

[(2)]*(1) IN GENERAL.*—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

(3) *HARDSHIP WAIVER.*—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

(4) *BANKRUPTCY*.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under [Title] *title* 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

(n) [Annual report] *REPORT*.—The Secretary shall submit to the President, for inclusion in [each] *the* report required to be submitted to [the] Congress under section [1671 of this title,] *801,* a report concerning the previous fiscal year which sets forth[—] *by Service Area the following:*

(1) *A list of* the health professional positions maintained by [the Service or by tribal or Indian organizations] *Indian Health Programs and Urban Indian Organizations* for which recruitment or retention is difficult[;].

(2) [the] *The* number of Loan Repayment Program applications filed with respect to each type of health profession[;].

(3) [the] *The* number of contracts described in subsection [(f) of this section] (e) that are entered into with respect to each health profession[;].

(4) [the] *The* amount of loan payments made under this section, in total and by health profession[;].

(5) [the] *The* number of [scholarship grants] *scholarships* that are provided under [section 1613a of this title] *sections 104 and 106* with respect to each health profession[;].

(6) [the] *The* amount of scholarship grants provided under section [1613a of this title,] *104 and 106,* in total and by health profession[;].

(7) [the] *The* number of providers of health care that will be needed by Indian [health programs] *Health Programs and Urban Indian Organizations*, by location and profession, during the [three] *3* fiscal years beginning after the date the report is filed[; and].

(8) [the] *The* measures the Secretary plans to take to fill the health professional positions maintained by [the Service or by tribes or tribal or Indian organizations] *Indian Health Programs or Urban Indian Organizations* for which recruitment or retention is difficult.

[§1616a–1. Scholarship and Loan Repayment Recovery Fund]

SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the ["Fund"] *"LRRF"*). The [Fund] *LRRF* shall consist of such amounts as may be [appropriated to the Fund under subsection (b) of this section. Amounts appropriated for the Fund] *collected from individuals under section 104(d), section 106(e), and section 110(l) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF* shall remain available until expended.

[(b) Authorization of appropriations

[For each fiscal year, there is authorized to be appropriated to the Fund an amount equal to the sum of—

[(1) the amount collected during the preceding fiscal year by the Federal Government pursuant to—

[(A) the liability of individuals under subparagraph (A) or (B) of section 1613a(b)(5) of this title for the breach of contracts entered into under 1613a of this title; and

[(B) the liability of individuals under section 1616a(l) of this title for the breach of contracts entered into under section 1616a of this title; and

[(2) the aggregate amount of interest accruing during the preceding fiscal year on obligations held in the Fund pursuant to subsection (d) of this section and the amount of proceeds from the sale or redemption of such obligations during such fiscal year.

[(c)] *(b)* Use of [funds] *FUNDS.*—

(1) *BY SECRETARY.*—Amounts in the [Fund and available pursuant to appropriation Acts] *LRRF* may be expended by the Secretary, acting through the Service, to make payments to an Indian [tribe or tribal organization administering a health care program pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]—] *Health Program—*

(A) to which a scholarship recipient under section [1613a of this title] *104 and 106* or a loan repayment program participant under section [1616a of this title] *110* has been assigned to meet the obligated service requirements pursuant to *such* sections; and

(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section [1613a of this title, or section 1616a of this title.] *104, 106, or section 110.*

[(2) An Indian tribe or tribal organization] *(2) BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program* receiving payments pursuant to paragraph (1) may expend the payments to *provide scholarships or* recruit and employ, directly or by contract, health professionals to provide health care services.

[(d)] *(c)* INVESTMENT OF [excess funds (1)] *FUNDS.*—The Secretary of the Treasury shall invest such amounts of the [Fund] *LRRF* as [such] *the* Secretary *of Health and Human Services* determines are not required to meet current withdrawals from the [Fund] *LRRF*. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

[(2)] *(d) SALE OF OBLIGATIONS.*—Any obligation acquired by the [Fund] *LRRF* may be sold by the Secretary of the Treasury at the market price.

[§ 1616b. Recruitment activities]

SEC. 112. RECRUITMENT ACTIVITIES.

(a) *REIMBURSEMENT FOR TRAVEL.*—The Secretary*, acting through the Service,* may reimburse health professionals seeking positions

[in the Service] *with Indian Health Programs or Urban Indian Organizations*, including individuals considering entering into a contract under section [1616a of this title,] *110* and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

[(b)] *(b) RECRUITMENT PERSONNEL.*—The Secretary, acting through the Service, shall assign [one] *1* individual in each [area office] *Area Office* to be responsible on a full-time basis for recruitment activities.

[§ 1616c. Tribal recruitment and retention program]

SEC. 113. INDIAN RECRUITMENT AND RETENTION PROGRAM.

[(a) Projects funded on competitive basis]

(a) IN GENERAL.—The Secretary, acting through the Service, shall fund, on a competitive basis, *innovative demonstration* projects *for a period not to exceed 3 years* to enable [Indian tribes and tribal and Indian organizations] *Tribal Health Programs and Urban Indian Organizations* to recruit, place, and retain health professionals to meet [the] *their* staffing needs [of Indian health programs (as defined in section 1616a(a)(2) of this title)].

[(b) Eligibility]

[(1) Any Indian tribe or tribal or Indian organization]*(b) ELIGIBLE ENTITIES; APPLICATION.—Any Tribal Health Program or Urban Indian Organization* may submit an application for funding of a project pursuant to this section.

[(2) Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be given an equal opportunity with programs that are administered directly by the Service to compete for, and receive, grants under subsection (a) of this section for such projects.

[§ 1616d. Advanced training and research]

SEC. 114. ADVANCED TRAINING AND RESEARCH

[(a) Establishment of program]

(a) DEMONSTRATION PROGRAM.—The Secretary, acting through the Service, shall establish a [program] *demonstration project* to enable health professionals *who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time* to pursue advanced training or research [in] areas of study for which the Secretary determinates a need exists. [In selecting participants for a program established under this subsection, the Secretary, acting through the Service, shall give priority to applicants who are employed by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations, at the time of the submission of the applications.]

[(b) Obligated service]

(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a) [of this section], where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian [health program (as defined in section 1616a(a)(2) of this title)] *Health Program or Urban Indian Organization* for a period of obligated service equal to at least the period of time during which the individual participates in such program.

In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after [October 29, 1992,] *the date of enactment of the Indian Health Care Improvement Act Amendments of 2007,* the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (1) of section [1616a of this title] *110* in the manner provided for in such subsection.

[(c) Eligibility]

(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—Health professionals from [Indian tribes and tribal and Indian organizations under the authority of the Indian Self Determination Act [25 U.S.C.A. § 450f et seq.] *Tribal Health Programs and Urban Indian Organizations* shall be given an equal opportunity to participate in the program under subsection (a)[of this section].

[§ 1616e. Nursing program]

SEC. 115. QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

(a) GRANTS.

[The Secretary, acting through the Service, shall provide grants to—

[(1) public or private schools of nursing,

[(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 2397h(2) of Title 20), and]

[(3) nurse midwife programs, and nurse practitioner programs, that are provided by any public or private institution, for] *AUTHORIZED.*—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians*, the Secretary, acting through the Service, shall provide grants to the following:*

(1) Public or private schools of nursing.

(2) Tribal colleges or universities.

(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

(b) [Purposes] *USE OF GRANTS.*—Grants provided under subsection (a) [of this section] may be used [to—] *for 1 or more of the following:*

(1) *To* recruit individuals for programs which train individuals to be nurses, nurse midwives, or [nurse practitioners,] *advanced practice nurses.*

(2) *To* provide scholarships to [individuals] *Indians* enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses[,].

(3) *To* provide a program that encourages nurses, nurse midwives, and [nurse practitioners] *advanced practice nurses* to provide, or continue to provide, health care services to Indians[,].

(4) *To* provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and [nurse practitioners, or] *advanced practice nurses.*

(5) *To* provide any program that is designed to achieve the purpose described in subsection (a) [of this section].

(c) [*Application*] *APPLICATIONS.*—Each application for a grant under subsection (a) [of this section] shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

[(d) Preference]

(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a) [of this section], the Secretary shall extend a preference to[—] *the following:*

(1) [programs] *Programs* that provide a preference to Indians[,].

(2) [programs] *Programs* that train nurse midwives or [nurse practitioners,] *advanced practice nurses.*

(3) [programs] *Programs* that are interdisciplinary[, and].

(4) [programs] *Programs* that are conducted in cooperation with a [center] *program* for gifted and talented Indian students [established under section 2624(a) of this title].

(5) Programs conducted by tribal colleges and universities.

(e) QUENTIN N. BURDICK [American Indians Into Nursing] *PROGRAM GRANT.*—The Secretary shall provide [one] *1* of the grants authorized under subsection (a)[of this section] to establish and maintain a program at the University of North Dakota to be known as the "Quentin N. Burdick American Indians Into Nursing Program". Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section [1616g] *117*(b) [of this title] and the Quentin N. Burdick American Indians Into Psychology Program established under section [1621p] *105*(b) [of this title].

(f) ACTIVE DUTY SERVICE [obligation] *OBLIGATION.*—The active duty service obligation prescribed under section [254m of this title] *338C of the Public Health Service Act (42 U.S.C. 254m)* shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) [of this section] that is funded by a grant provided under subsection (a) [of this section]. Such obligation shall be met by service—

[(A)] *(1)* in the [Indian Health] Service;

[(B)] *(2)* in a program *of an Indian Tribe or Tribal Organization* conducted under [a contract entered into under] the Indian Self-Determination *and Education Assistance* Act [[]*(*25 U.S.C.[A. §] 450[f et seq.]; (C] *et seq.) (including programs under agreements with the Bureau of Indian Affairs);*

(3) in a program assisted under [subchapter IV] *title V* of this [chapter; or] *Act;*

[(D)]*(4)* in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health [professional] shortage area and addresses the health care needs of a substantial number of Indians[.]*; or*

[(g) Authorization of appropriations

[Beginning with fiscal year 1993, of the amounts appropriated under the authority of this subchapter for each fiscal year to be used to carry out this section, not less than $1,000,000 shall be used to provide grants under subsection (a) of this section for the training of nurse midwives, nurse anesthetists, and nurse practitioners.

[§1616e–1. Nursing school clinics

[(a) Grants

[In addition to the authority of the Secretary under section 1616e(a)(1) of this title, the Secretary, acting through the Service, is authorized to provide grants to public or private schools of nursing for the purpose of establishing, developing, operating, and administering clinics to address the health care needs of Indians, and to provide primary health care services to Indians who reside on or within 50 miles of Indian country, as defined in section 1151 of Title 18.

[(b) Purposes

[Grants provided under subsection (a) of this section may be used to—

[(1) establish clinics, to be run and staffed by the faculty and students of a grantee school, to provide primary care services in areas in or within 50 miles of Indian country (as defined in section 1151 of Title 18);

[(2) provide clinical training, program development, faculty enhancement, and student scholarships in a manner that would benefit such clinics; and

[(3) carry out any other activities determined appropriate by the Secretary.

[(c) Amount and conditions

[The Secretary may award grants under this section in such amounts and subject to such conditions as the Secretary deems appropriate.

[(d) Design

[The clinics established under this section shall be designed to provide nursing students with a structured clinical experience that is similar in nature to that provided by residency training programs for physicians.

[(e) Regulations

[The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

[(f) Authorization to use amounts

[Out of amounts appropriated to carry out this subchapter for each of the fiscal years 1993 through 2000 not more than $5,000,000 may be used to carry out this section.]

(5) in a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, health services provided to Indians would not decrease.

[§1616f. Tribal culture and history]

SEC. 116. TRIBAL CULTURAL ORIENTATION.

[(a) Program established]

(a) CULTURAL EDUCATION OF EMPLOYEES.—The Secretary, acting through the Service, shall [establish a program under

which]*require that* appropriate employees of the Service who serve [particular] Indian [tribes shall]*Tribes in each Service Area* receive educational instruction in the history and culture of such [tribes and in the history of]*Indian Tribes and their relationship to* the Service.

(b) [Tribally-controlled community collegesTo the extent feasible, the program established under subsection (a) of this section shall] *PROGRAM.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—*

[(1) be carried out through tribally-controlled community colleges (within the meaning of section 1801(4) of this title) and tribally controlled postsecondary vocational institutions (as defined in section 2397h(2) of Title 20),

[(2) be developed in consultation with the affected tribal government, and]

(1) be developed in consultation with the affected Indian Tribes, Tribal Organizations, and Urban Indian Organizations;

(2) be carried out through tribal colleges or universities;

(3) include instruction in Native American *Indian* studies*; and*

(4) describe the use and place of traditional health care practices of the Indian Tribes in the Service Area.

[§1616g.]

SEC. 117.* INMED [program] *PROGRAM.

(a) GRANTS *AUTHORIZED.*—The Secretary*, acting through the Service,* is authorized to provide grants to [at least 3] colleges and universities for the purpose of maintaining and expanding the [Native American] *Indian* health careers recruitment program known as the ["]'Indians [into] *Into* Medicine Program"' (hereinafter in this section referred to as "'INMED"') as a means of encouraging Indians to enter the health professions.

[(b) University of North Dakota]

(b) QUENTIN N. BURDICK GRANT.—The Secretary shall provide one*1* of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota*,* to be known as the ["]'Quentin N. Burdick Indian Health Programs["]', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section [1621p] *105*(b) [of this title] and the Quentin N. Burdick American Indians Into Nursing Program established under section [1616e(e) of this title.] *115.*

(c) REGULATIONS[; contents of recruitment program (1)].—The Secretary*, pursuant to this Act,* shall develop regulations [for the competitive awarding of the] *to govern* grants [provided under] *pursuant to* this section.

[(2)] *(d) REQUIREMENTS.*—Applicants for grants provided under this section shall agree to provide a program which—

[(A)] *(1)* provides outreach and recruitment for health professions to Indian communities including elementary[,] *and* secondary *schools* and community colleges located on [Indian] reservations which will be served by the program[,]*;*

[(B)] *(2)* incorporates a program advisory board comprised of representatives from the [tribes] *Indian Tribes* and *Indian* communities which will be served by the program[,]*;*

[(C)] *(3)* provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions[,]*;*

[(D)] *(4)* provides tutoring, counseling, and support to students who are enrolled in a health career program of study at the respective college or university[,]*;* and

[(E)] *(5)* to the maximum extent feasible, employs qualified Indians in the program.

[(d) Report to Congress

[By no later than the date that is 3 years after November 23, 1988, the Secretary shall submit a report to the Congress on the program established under this section including recommendations for expansion or changes to the program.

[§ 1616h. Health training programs of community colleges]

SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

(a) GRANTS *TO ESTABLISH PROGRAMS*.—

(1) *IN GENERAL*.—The Secretary, acting through the Service, shall award grants to *accredited and accessible* community colleges for the purpose of assisting [the community college] *such community colleges* in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on [an Indian] *or near a* reservation or in [a tribal clinic] *an Indian Health Program*.

(2) *AMOUNT OF GRANTS*.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $[100,000.] *250,000.*

[(b) Eligibility]

(b) GRANTS FOR MAINTENANCE AND RECRUITING.—

[(1)] *(1) IN GENERAL*.—The Secretary, acting through the Service, shall award grants to *accredited and accessible* community colleges that have established a program described in subsection (a)(1) [of this section] for the purpose of maintaining the program and recruiting students for the program.

(2) *REQUIREMENTS*.—Grants may only be made under this section to a community college which—

(A) is accredited[,]*;*

(B) has [access to] *a relationship with* a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals[,]*;*

(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs [which] *that* train health professionals[,]*;* and

(ii) stipulate certifications necessary to approve internship and field placement opportunities at [service unit facilities of the Service or at tribal health facilities,] *Indian Health Programs;*

(D) has a qualified staff which has the appropriate certifications[, and]*;*

(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1) [of]*; and*

(F) agrees to provide for Indian preference for applicants for programs under this section.

[(c) Agreements and technical assistance]

(c) TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) [of this section] to establish and maintain programs described in subsection (a)(1) [of this section] by—

(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs[,]*;* and

(2) providing technical assistance and support to such colleges.

(d) ADVANCED [TRAINING] *TRAINING.*—

(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

[(1)] *(A)* has already received a degree or diploma in such health profession[,]; and

[(2)] *(B)* provides clinical services on [an Indian] *or near a* reservation[, at a Service facility, or at a tribal clinic] *or for an Indian Health Program*.

(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C) [of this section].

[(e) Definitions

[For purposes of this section—

[(1) The term "community college" means—

[(A) a tribally controlled community college, or

[(B) a junior or community college.

[(2) The term "tribally controlled community college" has the meaning given to such term by section 1801(4) of this title.

[(3) The term "junior or community college" has the meaning given to such term by section 1058(e) of Title 20.]

(e) PRIORITY.—Where the requirements of subsection (b) are met, grant award priority shall be provided to tribal colleges and universities in Service Areas where they exist.

[§ 1616i. Additional incentives for health professionals]

SEC. 119. RETENTION BONUS.

[(a) Incentive special pay

[The Secretary may provide the incentive special pay authorized under section 302(b) of Title 37, to civilian medical officers of the Indian Health Service who are assigned to, and serving in, positions included in the list established under subsection (b)(1) of this section for which recruitment or retention of personnel is difficult.

[(b) List of positions; bonus pay

[(1) The Secretary shall establish and update on an annual basis a list of positions of health care professionals] *(a) BONUS*

AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, [the Service for which recruitment or retention is difficult.

[(2)(A) The Secretary may pay a bonus to any commissioned officer or civil service employee, other than a commissioned medical officer, dental officer, optometrist, and veterinarian, who is employed in or assigned to, and serving in, a position in the Service included in the list established by the Secretary under paragraph (1).

[(B) The total amount of bonus payments made by the Secretary under this paragraph to any employee during any 1-year period shall not exceed $2,000.

[(c) Work schedules

[The Secretary may establish programs to allow the use of flexible work schedules, and compressed work schedules, in accordance with the provisions of subchapter II of chapter 61 of Title 5, for health professionals employed by, or assigned to, the Service.

[§ 1616j. Retention bonus

[(a) ELIGIBILITY.—The Secretary may pay a retention bonus to any physician or nurse employed by, or assigned to, and serving in, the Service] *and serving in, an Indian Health Program or Urban Indian Organization* either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

(1) is assigned to, and serving in, a position [included in the list established under section 1616i(b)(1) of this title] for which recruitment or retention of personnel is difficult[,]*;*

(2) the Secretary determines is needed by [the Service,] *Indian Health Programs and Urban Indian Organizations;*

(3) has—

(A) completed [3] *2* years of employment with [the Service, or] *an Indian Health Program or Urban Indian Organization; or*

(B) completed any service obligations incurred as a requirement of—

(i) any Federal scholarship program[,]*;* or

(ii) any Federal education loan repayment program[,]*;* and

(4) enters into an agreement with [the Service] *an Indian Health Program or Urban Indian Organization* for continued employment for a period of not less than 1 year.

[(b) Minimum award percentage to nurses

[Beginning with fiscal year 1993, not less than 25 percent of the retention bonuses awarded each year under subsection (a) of this section shall be awarded to nurses.

[(c)] *(b)* RATES[; maximum rate].—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4)[of this section], but in no event shall the annual rate be more than $25,000 per annum.

[(d) Time of payment

[The retention bonus for the entire period covered by the agreement described in subsection (a)(4) of this section shall be paid at the beginning of the agreed upon term of service.

[(e) Refund; interest

[Any physician or nurse] *(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional* failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section [1616a] *110*(l)(2)(B)[of this title].

[(f) Physicians and nurses employed under Indian Self-Determination Act] *(d) OTHER RETENTION BONUS*.—The Secretary may pay a retention bonus to any [physician or nurse employed by an organization providing health care services to Indians pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.] if such physician or nurse] *health professional employed by a Tribal Health Program if such health professional* is serving in a position which the Secretary determines is—

(1) a position for which recruitment or retention is difficult; and

(2) necessary for providing health care services to Indians.

[§1616k. Nursing residency program]

SEC. 120. NURSING RESIDENCY PROGRAM.

(a) ESTABLISHMENT *OF PROGRAM*.—The Secretary, acting through the Service, shall establish a program to enable *Indians who are* licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian [health program (as defined in section 1616a(a)(2)(A) of this title] *Health Program or Urban Indian Organization*, and have done so for a period of not less than [one] *1* year, to pursue advanced training.

[(b) Program components]Such program shall include a combination of education and work study in an Indian [health program (as defined in section 1616a(a)(2)(A) of this title)] *Health Program or Urban Indian Organization* leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse)[or], a bachelor's degree (in the case of a registered nurse)[or a Master's degree], *or advanced degrees or certifications in nursing and public health*.

[(c)] *(b)* SERVICE [obligation of program participant]*OBLIGATION*.— An individual who participates in a program under subsection (a) [of this section], where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian [health program] *Health Program or Urban Indian Organization* for a period of obligated service equal to [at least three times the period of time during which the individual] *1 year for every year that nonprofessional employee (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicals), or 2 years for every year that professional nurse (associate degree and bachelor-prepared registered nurses),* participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section [1616a of this title] *110* in the manner provided for in such subsection.

[§ 1616l. Community Health Aide Program for Alaska]

SEC. 121. COMMUNITY HEALTH AIDE PROGRAM.

[(a) Maintenance of program]

(a) *GENERAL PURPOSES OF PROGRAM.*—Under the authority of [section 13 of this title] *the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the "Snyder Act",* the Secretary*, acting through the Service,* shall [maintain] *develop and operate* a Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

[(b) Training; curriculum; Certification Board]

(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

(2) in order to provide such training, develop a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

(C) promotes the achievement of the health status objectives specified in section [1602(b) of this title] *3(2)*;

(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; [and]

(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services[.]*; and*

(7) ensure that pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment, and further that dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, provided that uncomplicated extractions shall not be considered oral surgery under this section.

(c) PROGRAM REVIEW.—

(1) NEUTRAL PANEL.—

(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

(2) STUDY.—

(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

(i) the ability of the dental health aide therapist services under this section to address the dental care needs of Alaska Natives;

(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska Tribal Organizations with respect to the adequacy and accuracy of the study.

(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

(A) any determination of the neutral panel under paragraph (2)(C); and

(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

(d) NATIONALIZATION OF PROGRAM.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national

Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

[§ 1616m. Matching grants to tribes for scholarship programs]

(2) EXCEPTION.—The national Community Health Aide Program under paragraph (1) shall not include dental health aide therapist services.

[(a) In general

[(1) The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of assisting such tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

[(2) Amounts available for grants under paragraph (1) for any fiscal year shall not exceed 5 percent of amounts available for such fiscal year for Indian Health Scholarships under section 1613a of this title.

[(3) An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as the Secretary determines are necessary to carry-out this section.

[(b) Compliance with requirements

[(1) An Indian tribe or tribal organization receiving a grant under subsection (a) of this section shall agree to provide scholarships to Indians pursuing education in the health professions in accordance with the requirements of this section.

[(2) With respect to the costs of providing any scholarship pursuant to paragraph (1)—

[(A) 80 percent of the costs of the scholarship shall be paid from the grant made under subsection (a) of this section to the Indian tribe or tribal organization; and

[(B) 20 percent of such costs shall be paid from non-Federal contributions by the Indian tribe or tribal organization through which the scholarship is provided.

[(3) In determining the amount of non-Federal contributions that have been provided for purposes of subparagraph (B) of paragraph (2), any amounts provided by the Federal Government to the Indian tribe or tribal organization involved or to any other entity shall not be included.

[(4) Non-Federal contributions required by subparagraph (B) of paragraph (2) may be provided directly by the Indian tribe or tribal organization involved or through donations from public and private entities.

[(c) Course of study in health professions

An Indian tribe or tribal organization shall provide scholarships under subsection (b) of this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in section 1613a(a) of this title.

[(d) Contract requirements

In providing scholarships under subsection (b) of this section, the Secretary and the Indian tribe or tribal organization shall enter into a written contract with each recipient of such scholarship.

Such contract shall—

[(1) obligate such recipient to provide service in an Indian health program (as defined in section 1616a(a)(2)(A) of this title), in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—

[(A) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

[(B) such greater period of time as the recipient and the Indian tribe or tribal organization may agree;

[(2) provide that the amount of such scholarship—

[(A) may be expended only for—

[(i) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

[(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 254m(g)(1)(B) of Title 42, such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled; and

[(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

[(3) require the recipient of such scholarship to maintain an acceptable level of academic standing (as determined by the educational institution in accordance with regulations issued by the Secretary); and

[(4) require the recipient of such scholarship to meet the educational and licensure requirements necessary to be a physician, certified nurse practitioner, certified nurse midwife, or physician assistant.

[(e) Breach of contract

[(1) An individual who has entered into a written contract with the Secretary and an Indian tribe or tribal organization under subsection (d) of this section and who—

[(A) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary),

[(B) is dismissed from such educational institution for disciplinary reasons,

[(C) voluntarily terminates the training in such an educational institution for which he is provided a scholarship under such contract before the completion of such training, or

[(D) fails to accept payment, or instructs the educational institution in which he is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract, shall be liable to the United States for the Federal share of the amount which has been paid to him, or on his behalf, under the contract.

[(2) If for any reason not specified in paragraph (1), an individual breaches his written contract by failing either to begin

such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 1616a(l) of this title in the manner provided for in such subsection.

[(3) The Secretary may carryout this subsection on the basis of information submitted by the tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary determines to be appropriate.

[(f) Nondiscriminatory practice

The recipient of a scholarship under subsection (b) of this section shall agree, in providing health care pursuant to the requirements of subsection (d)(1) of this section—

[(1) not to discriminate against an individual seeking such care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq] or pursuant to the program established in title XIX of such Act [42 U.S.C.A. § 1396 et seq.]; and

[(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act [42 U.S.C.A. § 1395u(b)(3)(B)(ii)] for all services for which payment may be made under part B of title XVIII of such Act [42 U.S.C.A. § 1395j et seq.], and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX of such Act [42 U.S.C.A. § 1396 et seq.] to provide service to individuals entitled to medical assistance under the plan.

[(g) Payments for subsequent fiscal years

[The Secretary may not make any payments under subsection (a) of this section to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has complied with requirements of this section.]

(3) REQUIREMENT.—In establishing a national program under paragraph (1), the Secretary shall not reduce the amount of funds provided for the Community Health Aide Program described in subsections (a) and (b).

[§ 1616n. Tribal health program administration]

SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

[The Secretary] *The Secretary, acting through the Service,* shall, by contract or otherwise, provide training for [individuals] *Indians* in the administration and planning of [tribal health programs] *Tribal Health Programs.*

SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

[§ 1616o. University of South Dakota pilot program]

(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

[(a) Establishment

[The Secretary may make a grant to the School of Medicine of the University of South Dakota (hereafter in this section referred to as "USDSM") to establish a pilot program on an Indian reservation at one or more service units in South Dakota to address the chronic manpower shortage in the Aberdeen Area of the Service.]

(b) PURPOSES *OF PROGRAMS.*—The purposes of [the program established pursuant to a grant provided] *demonstration programs funded under* subsection (a) [are] *shall be*—

(1) to provide direct clinical and practical experience at a [service unit to medical] *Service Unit to health profession* students and residents from [USDSM and other] medical schools;

(2) to improve the quality of health care for Indians by assuring access to qualified health care professionals; and

(3) to provide academic and scholarly opportunities for physicians, [physician assistants, nurse practitioners, nurses, and other allied] health professionals serving [Indian people] *Indians* by identifying [and utilizing] all academic and scholarly resources of the region.

[(c) Composition; designation

[The pilot program] *(c) ADVISORY BOARD.—The demonstration programs* established pursuant to a [grant provided under] subsection (a) shall[—(1)] incorporate a program advisory board composed of representatives from the [tribes] *Indian Tribes* and *Indian* communities in the area which will be served by the program[; and].

[(2) shall be designated as an extension of the USDSM campus and program participants shall be under the direct supervision and instruction of qualified medical staff serving at the service unit who shall be members of the USDSM faculty.

[(d) Coordination with other schools

[The USDSM shall coordinate the program established pursuant to a grant provided under subsection (a) of this section with other medical schools in the region, nursing schools, tribal community colleges, and other health professional schools.

[(e) Development of additional professional opportunities

[The USDSM, in cooperation with the Service, shall develop additional professional opportunities for program participants on Indian reservations in order to improve the recruitment and retention of qualified health professionals in the Aberdeen Area of the Service.]

SEC. 124. NATIONAL HEALTH SERVICE CORPS.

(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

(1) remove a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization; or

(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

(b) EXEMPTION FROM LIMITATIONS—National Health Service Corps scholars qualifying for the Commissioned Corps in the Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the Service when

serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.

(a) CONTRACTS AND GRANTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 3 years. Such contract or grant may be renewed for an additional 2-year period upon the approval of the Secretary.

(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

(e) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

(g) DEFINITION.—For the purposes of this section, the term "educational curriculum" means 1 or more of the following:

(1) Classroom education.

(2) Clinical work experience.

(3) Continuing education workshops.

SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

(b) POSITIONS.—The positions referred to in subsection (a) are—

(1) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

(A) elementary and secondary education;

(B) social services and family and child welfare;

(C) law enforcement and judicial services; and

(D) alcohol and substance abuse;

(2) staff positions within the Service; and

(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations (without regard to the funding source), and Urban Indian Organizations.

(c) TRAINING CRITERIA.—

(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or Urban Indian Organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, or assist the Indian Tribe, Tribal Organization, or Urban Indian Organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

[§ 1616p. Authorization of appropriations]

(e) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the "Snyder Act").

SEC. 127. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year [2000] *2017* to carry out this [subchapter] *title*.

TITLE II—HEALTH SERVICES

[§ 1621. Indian Health Care Improvement Fund]

SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

[(a) Approved expenditures]

(a) USE OF FUNDS.—The Secretary*, acting through the Service,* is authorized to expend funds*, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.),* which are appropriated under the authority of this section, [through the Service,] for the purposes of—

(1) eliminating the deficiencies in health status and *health* resources of all Indian [tribes,] *Tribes;*

(2) eliminating backlogs in the provision of health care services to Indians[,]*;*

(3) meeting the health needs of Indians in an efficient and equitable manner, [and] *including the use of telehealth and telemedicine when appropriate;*

(4) eliminating inequities in funding for both direct care and contract health service programs; and

[(4)] *(5)* augmenting the ability of the Service to meet the following health service responsibilities[, either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],] with respect to those Indian [tribes] *Tribes* with the highest levels of health status *deficiencies* and resource deficiencies:

(A) [clinical] *Clinical* care [(direct and indirect)]*,* including *inpatient care, outpatient care (including audiology*, clinical eye, and vision care[;]*), primary care, secondary and tertiary care, and long-term care.*

(B) [preventive] *Preventive* health, including [screening] mammography *and other cancer screening* in accordance with section [1621k of this title;] *207.*

[(C) dental care (direct and indirect);] *(C) Dental care.*

(D) [mental] *Mental* health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional [Indian] *health care* practitioners[;].

(E) [emergency] *Emergency* medical services[;].

(F) [treatment] *Treatment* and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians[;].

(G) [accident] *Injury* prevention programs[;]*, including data collection and evaluation, demonstration projects, training, and capacity building.*

(H) [home] *Home* health care[;].

(I) [community] *Community* health representatives[; and].

[(J) maintenance and repair.]

[(b) Effect of other appropriations; allocation to service units]

(J) Maintenance and improvement.

[(1)] *(b) NO OFFSET OR LIMITATION.*—Any funds appropriated under the authority of this section shall not be used to offset or limit any *other* appropriations made to the Service under [section 13 of this title] *this Act or the Act of November 2, 1921 (25 U.S.C.*

13) (commonly known as the "Snyder Act"), or any other provision of law.

(c) ALLOCATION; USE.—

[(2)] *(1)*[(A)] *IN GENERAL.*—Funds appropriated under the authority of this section [may] *shall* be allocated [on a service unit basis] *to Service Units, Indian Tribes, or Tribal Organizations.* The funds allocated to each [service unit] *Indian Tribe, Tribal Organization, or Service Unit* under this [subparagraph] *paragraph* shall be used by the [service unit to reduce] *Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve* the health status and *reduce the* resource deficiency of each [tribe] *Indian Tribe* served by such [service unit] *Service Unit, Indian Tribe, or Tribal Organization.*

[B] *(2) APPORTIONMENT OF ALLOCATED FUNDS.*—The apportionment of funds allocated to a [service unit under subparagraph (A)] *Service Unit, Indian Tribe, or Tribal Organization under paragraph (1)* among the health service responsibilities described in subsection (a)[(4) of this section] *(5)* shall be determined by the Service in consultation with, and with the active participation of, the affected Indian [tribes] *Tribes and Tribal Organizations.*

[(c) Health Resources Deficiency Levels.—For] *(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.*—For the purposes of this section—*, the following definitions apply:*

(1) *DEFINITION.*—The term "health status and resource deficiency" means the extent to which—

(A) the health status objectives set forth in section [1602(b) of this title] *3(2)* are not being achieved; and

(B) the Indian [tribe] *Tribe or Tribal Organization* does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) *AVAILABLE RESOURCES.*—The health resources available to an Indian [tribe] *Tribe or Tribal Organization* include health resources provided by the Service as well as health resources used by the Indian [tribe] *Tribe or Tribal Organization*, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

(3) *PROCESS FOR REVIEW OF DETERMINATIONS.*—The Secretary shall establish procedures which allow any Indian [tribe] *Tribe or Tribal Organization* to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such [tribe] *Indian Tribe or Tribal Organization.*

[(d) Programs administered by Indian tribe]

[(1) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination Act] *(e) ELIGIBILITY FOR FUNDS.*—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

[(2) If any funds allocated to a tribe or service unit under the authority of this section are used for a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.], a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.]

[(e)] *(f)* REPORT [TO CONGRESS].—By no later than the date that is 3 years after [October 29, 1992,] *the date of enactment of the Indian Health Care Improvement Act Amendments of 2007,* the Secretary shall submit to the Congress the current health status and resource deficiency report of the Service for each [Indian tribe or service unit] *Service Unit,* including newly recognized or acknowledged [tribes] *Indian Tribes.* Such report shall set out—

(1) the methodology then in use by the Service for determining [tribal] *Tribal* health status and resource deficiencies, as well as the most recent application of that methodology;

(2) the extent of the health status and resource deficiency of each Indian [tribe] *Tribe* served by the Service *or a Tribal Health Program*;

(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian [tribes] *Tribes* served by the Service *or a Tribal Health Program*; and

(4) an estimate of—

(A) the amount of health service funds appropriated under the authority of this [chapter] *Act*, or any other Act, including the amount of any funds transferred to the Service[,] for the preceding fiscal year which is allocated to each [service unit] *Service Unit*, Indian [tribe] *Tribe*, or [comparable entity] *Tribal Organization*;

(B) the number of Indians eligible for health services in each [service unit] *Service Unit* or Indian [tribe; and] *Tribe or Tribal Organization; and*

(C) the number of Indians using the Service resources made available to each [service unit or Indian tribe.] *Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.*

[(f) Appropriated funds included in base budget of Service]

(g) INCLUSION IN BASE BUDGET.—Funds appropriated under [authority of] this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

[(g) Continuation of Service responsibilities for backlogs and parity]

(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve [parity] *equity* among Indian [tribes.] *Tribes and Tribal Organizations.*

[(h) Authorization of appropriations]

(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the ["]'Indian Health Care Improvement Fund.["]'

[§ 1621a. Catastrophic Health Emergency Fund]

SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

(a) ESTABLISHMENT[; ADMINISTRATION; PURPOSE (1)].—There is [hereby] established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the ["Fund"] *"CHEF"*) consisting of—

[(A)] *(1)* the amounts deposited under subsection [(d) of this section,] *(f);* and

[(B)] *(2))* the amounts appropriated to [the Fund] *CHEF* under this section.

[(2) The Fund]*(b) ADMINISTRATION.—CHEF* shall be administered by the Secretary, acting through the [central office] *headquarters* of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

[(3) The Fund shall not] *(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds* be allocated, apportioned, or delegated on [a service unit, area office, or any other] *an Area Office, Service Unit, or other similar* basis.

[(4) No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].]

[(b) Regulations; procedures for payment]

(d) REGULATIONS.—The Secretary shall[, through the promulgation of] *promulgate* regulations consistent with the provisions of this section *to*—

(1) establish a definition of disasters and catastrophic illnesses for which the cost of the treatment provided under contract would qualify for payment from [the Fund] *CHEF*;

(2) provide that a [service unit] *Service Unit* shall not be eligible for reimbursement for the cost of treatment from [the Fund] *CHEF* until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

[(A) for 1993, not less than $15,000 or not more than $25,000; and]

(A) the 2000 level of $19,000; and

(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

(3) establish a procedure for the reimbursement of the portion of the costs *that exceeds such threshold cost* incurred by—

[(A) service units or facilities of the Service, or]

(A) Service Units; or

(B) whenever otherwise authorized by the Service, non-Service facilities or providers[, in rendering treatment that exceeds such threshold cost];

(4) establish a procedure for payment from [the Fund] *CHEF* in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

(5) establish a procedure that will ensure that no payment shall be made from [the Fund] *CHEF* to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

[(c) Effect on other appropriations]

(e) NO OFFSET OR LIMITATION.—Amounts appropriated to [the Fund] *CHEF* under this section shall not be used to offset or limit appropriations made to the Service under *the* authority of [section 13 of this title] *the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the "Snyder Act")*, or any other law.

[(d) Reimbursements to fund]

(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into [the Fund] *CHEF* all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from [the Fund] *CHEF*.

SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

(a) FINDINGS.—Congress finds that health promotion and disease prevention activities—

(1) improve the health and well-being of Indians; and

[§1621b. Health promotion and disease prevention services]

(2) reduce the expenses for health care of Indians.

[(a) Authorization]

(b) PROVISION OF SERVICES.—The Secretary, acting through the Service *and Tribal Health Programs*, shall provide health promotion and disease prevention services to Indians [so as] to achieve the health status objectives set forth in section [1602(b) of this title]*3(2)*.

[(b)](*c*) EVALUATION [statement for Presidential budget].—The Secretary*, after obtaining input from the affected Tribal Health Programs,* shall submit to the President for inclusion in [each statement] *the report* which is required to be submitted to [the] Congress under section [1671 of this title] *801* an evaluation of—

(1) the health promotion and disease prevention needs of Indians[,]*;*

(2) the health promotion and disease prevention activities which would best meet such needs[,]*;*

(3) the internal capacity of the Service *and Tribal Health Programs* to meet such needs[,]*;* and

(4) the resources which would be required to enable the Service *and Tribal Health Programs* to undertake the health promotion and disease prevention activities necessary to meet such needs.

[§ 1621c. Diabetes prevention, treatment, and control]

SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

[(a) Incidence and complications]

(a) DETERMINATIONS REGARDING DIABETES.—The Secretary, *acting through the Service, and* in consultation with [the tribes] *Indian Tribes and Tribal Organizations*, shall determine—

(1) by [tribe] *Indian Tribe* and by Service [unit of the Service] *Unit*, the incidence of, and the types of complications resulting from, diabetes among Indians; and

(2) based on *the determinations made pursuant to* paragraph (1), the measures (including patient education *and effective ongoing monitoring of disease indicators*) each Service [unit] *Unit* should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among [tribes] *Indian Tribes* within that Service [unit] *Unit*.

(b) *DIABETES SCREENING.*—[The]*To the extent medically indicated and with informed consent, the* Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic *and establish a cost-effective approach to ensure ongoing monitoring of disease indicators*. Such screening [may be done by a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].] *and monitoring may be conducted by a Tribal Health Program and may be conducted through appropriate Internet-based health care management programs*.

[(c) Model diabetes projects]

[(1)] (*c*) DIABETES PROJECTS.—The Secretary shall continue to maintain through [fiscal year 2000] each model diabetes project in existence on [October 29, 1992 and located—] *the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian Tribes. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 and for projects which are added and funded thereafter*.

[(A) at the Claremore Indian Hospital in Oklahoma;

[(B) at the Fort Totten Health Center in North Dakota;

[(C) at the Sacaton Indian Hospital in Arizona;

[(D) at the Winnebago Indian Hospital in Nebraska;

[(E) at the Albuquerque Indian Hospital in New Mexico;

[(F) at the Perry, Princeton, and Old Town Health Centers in Maine;

[(G) at the Bellingham Health Center in Washington;

[(H) at the Fort Berthold Reservation;

[(I) at the Navajo Reservation;

[(J) at the Papago Reservation;

[(K) at the Zuni Reservation; or

[(L) in the States of Alaska, California, Minnesota, Montana, Oregon, or Utah.

[(2) The Secretary may establish new model diabetes projects under this section taking into consideration applications received under this section from all service areas, except that the Secretary may not establish a greater number of such projects

in one service area than in any other service area until there is an equal number of such projects established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).

[(d) Control officer; registry of patients

[The Secretary shall—]

(d) DIALYSIS PROGRAMS.—The Secretary is authorized to provide, through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

(e) OTHER DUTIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

[(1) employ in each area office of the Service at least one diabetes control officer who shall coordinate and manage on a full-time basis activities within that area office] *(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs* for the prevention, treatment, and control of diabetes;

[(2) establish in each area office of the Service] *(B) establish in each Area Office* a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; *and*

[(3)](*C*) ensure that data collected in each [area office] *Area Office* regarding diabetes and related complications among Indians [is] *are* disseminated to all other [area offices; and (4) evaluate the effectiveness of services provided through model diabetes projects established under this section] *Area Offices, subject to applicable patient privacy laws.*

[(e) Authorization of appropriations

[Funds appropriated under this section in any fiscal year shall be in addition to base resources appropriated to the Service for that year.]

(2) DIABETES CONTROL OFFICERS.—

(A) IN GENERAL.—The Secretary may establish and maintain in each Area Office a position of diabetes control officer to coordinate and manage any activity of that Area Office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

SEC. 205. SHARED SERVICES FOR LONG-TERM CARE.

(a) LONG-TERM CARE.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations for, the delivery of long-term care (including health care services associated with long-

term care) provided in a facility to Indians. Such agreements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by such Indian Tribe or Tribal Organization.

(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

[§ 1621d. Hospice care feasibility study]

(1) may, at the request of the Indian Tribe or Tribal Organization, delegate to such Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

[(a) Duty of Secretary

[The Secretary, acting through the Service and in consultation with representatives of Indian tribes, tribal organizations, Indian Health Service personnel, and hospice providers, shall conduct a study—

[(1) to assess the feasibility and desirability of furnishing hospice care to terminally ill Indians; and

[(2) to determine the most efficient and effective means of furnishing such care.

[(b) Functions of study

[Such study shall—

[(1) assess the impact of Indian culture and beliefs concerning death and dying on the provision of hospice care to Indians;

[(2) estimate the number of Indians for whom hospice care may be appropriate and determine the geographic distribution of such individuals;

[(3) determine the most appropriate means to facilitate the participation of Indian tribes and tribal organizations in providing hospice care;

[(4) identify and evaluate various means for providing hospice care, including—

[(A) the provision of such care by the personnel of a Service hospital pursuant to a hospice program established by the Secretary at such hospital; and

[(B) the provision of such care by a community-based hospice program under contract to the Service; and

[(5) identify and assess any difficulties in furnishing such care and the actions needed to resolve such difficulties.

[(c) Report to Congress

[Not later than the date which is 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report containing—

[(1) a detailed description of the study conducted pursuant to this section; and

[(2) a discussion of the findings and conclusions of such study.

[(d) Definitions

[For the purposes of this section—

[(1) the term "terminally ill" means any Indian who has a medical prognosis (as certified by a physician) of a life expectancy of six months or less; and

[(2) the term "hospice program" means any program which satisfies the requirements of section 1395x(dd)(2) of Title 42; and

[(3) the term "hospice care" means the items and services specified in subparagraphs (A) through (H) of section 1395x(dd)(1) of Title 42.]

(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

[§ 1621e. Reimbursement from certain third parties of costs of health services]

(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

[(a) Right of recovery

[Except as provided in subsection (f) of this section, the United States, an Indian tribe, or a tribal organization shall have the right to recover the reasonable expenses incurred by the Secretary, an Indian tribe, or a tribal organization in providing health services, through the Service, an Indian tribe, or a tribal organization, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—

[(1) such services had been provided by a nongovernmental provider, and

[(2) such individual had been required to pay such expenses and did pay such expenses.

[(b) Recovery against State with workers' compensation laws or no-fault automobile accident insurance program

[Subsection (a) of this section shall provide a right of recovery against any State only if the injury, illness, or disability for which health services were provided is covered under—

[(1) workers' compensation laws, or

[(2) a no-fault automobile accident insurance plan or program.

[(c) Prohibition of State law or contract provision impeding right of recovery

[No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or a tribal organization under subsection (a) of this section.

[(d) Right to damages

[No action taken by the United States, an Indian tribe, or a tribal organization to enforce the right of recovery provided under subsection (a) of this section shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

[(e) Intervention or separate civil action

[The United States, an Indian tribe, or a tribal organization may enforce the right of recovery provided under subsection (a) of this section by—

[(1) intervening or joining in any civil action or proceeding brought—

[(A) by the individual for whom health services were provided by the Secretary, an Indian tribe, or a tribal organization, or

[(B) by any representative or heirs of such individual, or

[(2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, an Indian tribe, or a tribal organization to institute a separate civil action.

[(f) Right of recovery for services when self-insurance plan provides coverage

[The United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.]

(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

[§ 1621f. Crediting of reimbursements]

(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

[(a) Except as provided in section 1621a(d) of this title, subchapter III–A of this chapter, and section 1680c of this title, all reimbursements received or recovered, under authority of this chapter, Public Law 87–693 (42 U.S.C. 2651, et seq.), or any other provision of law, by reason of the provision of health services by the Service or by a tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

[(b) The Service may not offset or limit the amount of funds obligated to any service unit or any entity under contract with the Service because of the receipt of reimbursements under subsection (a) of this section.]

(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

[§ 1621g. Health services research]

SEC. 206. HEALTH SERVICES RESEARCH.

[Of the amounts appropriated for]

(a) IN GENERAL.—The Secretary, acting through the Service [in any fiscal year, other than amounts made available for the Indian Health Care Improvement Fund, not less than $200,000 shall be available only], *shall make funding available* for research to further the performance of the health service responsibilities of [the

Service. Indian tribes and tribal organizations contracting with the Service under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]] *Indian Health Programs.*

(b) COORDINATION OF RESOURCES AND ACTIVITIES.—The Secretary shall also, to the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs.

(c) AVAILABILITY.—Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section.

[§ 1621h. Mental health prevention and treatment services

[(a) National plan for Indian Mental Health Services

[(1) Not later than 120 days after November 28, 1990, the Secretary, acting through the Service, shall develop and publish in the Federal Register a final national plan for Indian Mental Health Services. The plan shall include—

[(A) an assessment of the scope of the problem of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians, including—

[(i) the number of Indians served by the Service who are directly or indirectly affected by such illness or behavior, and

[(ii) an estimate of the financial and human cost attributable to such illness or behavior;

[(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior; and

[(C) an estimate of the additional funding needed by the Service to meet its responsibilities under the plan.

[(2) The Secretary shall submit a copy of the national plan to the Congress.

[(b) Memorandum of agreement

[Not later than 180 days after November 28, 1990, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement under which the Secretaries shall, among other things—

[(1) determine and define the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

[(2) make an assessment of the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

[(3) make an initial determination of the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

[(4)(A) ensure that Indians, as citizens of the United States and of the States in which they reside, have access to mental health services to which all citizens have access;

[(B) determine the right of Indians to participate in, and receive the benefit of, such services; and

[(C) take actions necessary to protect the exercise of such right;

[(5) delineate the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

[(6) provide a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

[(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) [25 U.S.C.A. § 2401 et seq.] with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and

[(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

[(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to subsection (d) of this section; and

[(8) provide for an annual review of such agreement by the two Secretaries.

[(c) Community mental health plan

[(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a community mental health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members.

[(2) In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the tribe in the development of such plan. Upon the establishment of such a plan and at the request of the tribe, such officials, as directed by the memorandum of agreement developed pursuant to subsection (c), of this section, shall cooperate with the tribe in the implementation of such plan.

[(3) Two or more Indian tribes may form a coalition for the adoption of resolutions and the establishment and development of a joint community mental health plan under this subsection.

[(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community mental health plan and to provide administrative support in the implementation of such plan.

[(d) Mental health training and community education programs

[(1) The Secretary and the Secretary of the Interior, in consultation with representatives of Indian tribes, shall conduct a study and compile a list, of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness or dysfunctional and self-destructive behavior.

[(2) The positions referred to in paragraph (1) are—

[(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

[(i) elementary and secondary education;

[(ii) social services and family and child welfare;

[(iii) law enforcement and judicial services; and

[(iv) alcohol and substance abuse;

[(B) staff positions with the Service; and

[(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes, including positions established in contracts entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].

[(3)(A) The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraph (2)(A) and ensure that appropriate training has been, or will be, provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to an Indian tribe for the training of, such individual. In the case of positions funded under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], the appropriate Secretary shall ensure that such training costs are included in the contract, if necessary.

[(B) Funds authorized to be appropriated pursuant to this section may be used to provide training authorized by this paragraph for community education programs described in paragraph (5) if a plan adopted pursuant to subsection (d) of this section identifies individuals or employment categories, other than those identified pursuant to paragraph (1), for which such training or community education is deemed necessary or desirable.

[(4) Position-specific training criteria described in paragraph (3) shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional Indian healing and treatment practices is provided.

[(5) The Service shall develop and implement or, upon the request of an Indian tribe, assist such tribe to develop and implement, a program of community education on mental illness and dysfunctional and self-destructive behavior for individuals, as determined in a plan adopted pursuant to subsection (d) of this section. In carrying out this paragraph, the Service shall provide, upon the request of an Indian tribe, technical assistance to the Indian tribe to obtain or develop community education and training materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

[(e) Staffing

[(1) Within 90 days after November 28, 1990, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within five years after November 28, 1990, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level for services which shall include outpatient, emergency, aftercare and follow-up, and prevention and education services.

[(2) The plan developed under paragraph (1) shall be implemented section 13 of this title.

[(f) Staff recruitment and retention

[(1) The Secretary shall provide for the recruitment of the additional personnel required by subsection (f) of this section and the retention of all Service personnel providing mental health services. In carrying out this subsection, the Secretary shall give priority to practitioners providing mental health services to children and adolescents with mental health problems.

[(2) In carrying out paragraph (1), the Secretary shall develop a program providing for—

[(A) the payment of bonuses (which shall not be more favorable than those provided for under sections 1616i and 1616j of this title) for service in hardship posts;

[(B) the repayment of loans (for which the provisions of repayment contracts shall not be more favorable than the repayment contracts under section 1616a of this title) for health professions education as a recruitment incentive; and

[(C) a system of postgraduate rotations as a retention incentive.

[(3) This subsection shall be carried out in coordination with the recruitment and retention programs under subchapter I of this chapter.

[(g) Mental Health Technician program

[(1) Under the authority of section 13 of this title, the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

[(A) provides for the training of Indians as mental health technicians; and

[(B) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

[(2) In carrying out paragraph (1)(A), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

[(3) The Secretary shall supervise and evaluate the mental health technicians in the training program.

[(4) The Secretary shall ensure that the program established pursuant to this subsection involves the utilization and promotion of the traditional Indian health care and treatment practices of the Indian tribes to be served.

[(h) Mental health research

[The Secretary, acting through the Service and in consultation with the National Institute of Mental Health, shall enter into contracts with, or make grants to, appropriate institutions for the conduct of research on the incidence and prevalence of mental disorders among Indians on Indian reservations and in urban areas. Research priorities under this subsection shall include—

[(1) the inter-relationship and inter-dependence of mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence, and

[(2) the development of models of prevention techniques.

[The effect of the inter-relationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.

[(i) Facilities assessment

[Within one year after November 28, 1990, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

[(j) Annual report

[The Service shall develop methods for analyzing and evaluating the overall status of mental health programs and services for Indians and shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the mental health status of Indians which shall describe the progress being made to address mental health problems of Indian communities.

[(k) Mental health demonstration grant program

[(1) The Secretary, acting through the Service, is authorized to make grants to Indian tribes and inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs to deliver innovative community-based mental health services to Indians. The 25 percent tribal share of such cost may be provided in cash or through the provision of property or services.

[(2) The Secretary may award a grant for a project under paragraph (1) to an Indian tribe or inter-tribal consortium which meets the following criteria:

[(A) The project will address significant unmet mental health needs among Indians.

[(B) The project will serve a significant number of Indians.

[(C) The project has the potential to deliver services in an efficient and effective manner.

[(D) The tribe or consortium has the administrative and financial capability to administer the project.

[(E) The project will deliver services in a manner consistent with traditional Indian healing and treatment practices.

[(F) The project is coordinated with, and avoids duplication of, existing services.

[(3) For purposes of this subsection, the Secretary shall, in evaluating applications for grants for projects to be operated under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], use the same criteria that the Secretary uses in evaluating any other application for such a grant.

[(4) The Secretary may only award one grant under this subsection with respect to a service area until the Secretary has awarded grants for all service areas with respect to which the Secretary receives applications during the application period, as determined by the Secretary, which meet the criteria specified in paragraph (2).

[(5) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a report evaluating the effectiveness of the innovative community-based projects demonstrated pursuant to this subsection. Such report shall include findings and recommendations, if any, relating to the reorganization of the programs of the Service for delivery of mental health services to Indians.

[(6) Grants made pursuant to this section may be expended over a period of three years and no grant may exceed $1,000,000 for the fiscal years involved.

[(l) Licensing requirement for mental health care workers

[Any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this chapter or through a contract pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall—

[(1) in the case of a person employed as a psychologist, be licensed as a clinical psychologist or working under the direct supervision of a licensed clinical psychologist;

[(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

[(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

[(m) Intermediate adolescent mental health services

[(1) The Secretary, acting through the Service, may make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents, including—

[(A) inpatient and outpatient services;

[(B) emergency care;

[(C) suicide prevention and crisis intervention; and

[(D) prevention and treatment of mental illness, and dysfunctional and self-destructive behavior, including child abuse and family violence.

[(2) Funds provided under this subsection may be used—

[(A) to construct or renovate an existing health facility to provide intermediate mental health services;

[(B) to hire mental health professionals;

[(C) to staff, operate, and maintain an intermediate mental health facility, group home, or youth shelter where intermediate mental health services are being provided; and

[(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units.

[(3) Funds provided under this subsection may not be used for the purposes described in section 1625o(b)(1) of this title.

[(4) An Indian tribe or tribal organization receiving a grant under this subsection shall ensure that intermediate adolescent mental health services are coordinated with other tribal, Service, and Bureau of Indian Affairs mental health, alcohol and substance abuse, and social services programs on the reservation of such tribe or tribal organization.

[(5) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this subsection.

[(6) There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

(d) USE OF FUNDS.—This funding may be used for both clinical and nonclinical research.

[§ 1621i. Managed care feasibility study]

(e) EVALUATION AND DISSEMINATION.—The Secretary shall periodically—

[(a) The Secretary, acting through the Service, shall conduct a study to assess the feasibility of allowing an Indian tribe to purchase, directly or through the Service, managed care coverage for all members of the tribe from—

[(1) a tribally owned and operated managed care plan; or

[(2) a State licensed managed care plan.

[(b) Not later than the date which is 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report containing—

[(1) a detailed description of the study conducted pursuant to this section; and

[(2) a discussion of the findings and conclusions of such study.

(1) evaluate the impact of research conducted under this section; and

[§ 1621j. California contract health services demonstration program]

(2) disseminate to Tribal Health Programs information regarding that research as the Secretary determines to be appropriate.

[(a) Establishment

[The Secretary shall establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.

[(b) Agreement with California Rural Indian Health Board

[(1) In establishing such program, the Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred, during the period of the demonstration program, in providing medical treatment under contract to California Indians described in section 1679(b) of this title throughout the California contract health services delivery area described in section 1680 of this title with respect to high-cost contract care cases.

[(2) Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the Board during such fiscal year.

[(3) No payment may be made for treatment provided under the demonstration program to the extent payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 1621a of this title or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

[(c) Advisory board

[There is hereby established an advisory board which shall advise the California Rural Indian Health Board in carrying out the demonstration pursuant to this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under such demonstration, at least one half of whom are not affiliated with the California Rural Indian Health Board.

[(d) Commencement and termination dates

[The demonstration program described in this section shall begin on January 1, 1993, and shall terminate on September 30, 1997.

[(e) Report

[Not later than July 1, 1998, the California Rural Indian Health Board shall submit to the Secretary a report on the demonstration program carried out under this section, including a statement of its findings regarding the impact of using a contract care intermediary on—

[(1) access to needed health services;

[(2) waiting periods for receiving such services; and

[(3) the efficient management of high-cost contract care cases.

[(f) "High-cost contract care cases" defined

[For the purposes of this section, the term "high-cost contract care cases" means those cases in which the cost of the medical treatment provided to an individual—

[(1) would otherwise be eligible for reimbursement from the Catastrophic Health Emergency Fund established under section 1621a of this title, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 1621a(b)(2) of this title; and

[(2) exceeds $1,000.

[(g) Authorization of appropriations

[There are authorized to be appropriated for each of the fiscal years 1996 through 2000 such sums as may be necessary to carry out the purposes of this section.]

SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

[§ 1621k. Coverage of screening mammography]

The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:

[The Secretary, through the Service, shall provide for screening] *(1) Screening* mammography (as defined in section 1861(jj) of the Social Security Act [[42 U.S.C.A. § 1395x(jj)]]) for Indian [and urban Indian women 35 years of age or older at a frequency, determined by the Secretary (in consultation with the Director of the National Cancer Institute),] *women at a frequency* appropriate to such women *under accepted and appropriate national standards*, and under such terms and conditions as are consistent with standards established by the Secretary to [assure] *ensure* the safety and accuracy of screening mammography under part B of title XVIII of [the Social Security Act [42 U.S.C.A. § 1395j et seq.].] *such Act.*

(2) Other cancer screening that receives an A or B rating as recommended by the United States Preventive Services Task Force established under section 915(a)(1) of the Public Health Service Act (42 U.S.C. 299b–4(a)(1)). The Secretary shall ensure that screening provided for under this paragraph complies with the recommendations of the Task Force with respect to—

(A) frequency;

(B) the population to be served;

(C) the procedure or technology to be used;

(D) evidence of effectiveness; and

(E) other matters that the Secretary determines appropriate.

SEC. 208. PATIENT TRAVEL COSTS.

(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term 'qualified escort' means—

(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

[§ 1621l. Patient travel costs]

(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

[(a) The Secretary, acting through the Service, shall provide funds for the following patient travel costs] *(b) PROVISION OF FUNDS.—The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts*, associated with receiving health care services provided (either through direct or contract care or through [contracts entered into pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]) under this Act—] a *contract or compact under the Indian Self-Determination*

and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

(1) emergency air transportation[;] and [(2) nonemergency] *non-emergency* air transportation where ground transportation is infeasible[.]*;*

[(b) There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

[§ 1621m. Epidemiology centers]

SEC. 209. EPIDEMIOLOGY CENTERS.

(a)[(1)] ESTABLISHMENT OF CENTERS.—The Secretary shall establish an epidemiology center in each Service [area] *Area* to carry out the functions described in [paragraph (3).] *subsection (b). Any new center established after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.*

[(2) To assist such centers in carrying out such functions, the Secretary shall perform the following:

[(A) In consultation with the Centers for Disease Control and Indian tribes, develop sets of data (which to the extent practicable, shall be consistent with the uniform data sets used by the States with respect to the year 2000 health objectives) for uniformly defining health status for purposes of the objectives specified in section 1602(b) of this title. Such sets shall consist of one or more categories of information. The Secretary shall develop formats for the uniform collecting and reporting of information on such categories.

[(B) Establish and maintain a system for monitoring the progress made toward meeting each of the health status objectives described in section 1602(b) of this title.

[(3) In consultation with Indian tribes and urban Indian communities, each area epidemiology center established under this subsection shall, with respect to such area—

(b) FUNCTIONS OF CENTERS.—*In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each Service Area epidemiology center established under this section shall, with respect to such Service Area—*

[A] *(1)* collect data relating to, and monitor progress made toward meeting, each of the health status objectives [described in section 1602(b) of this title using the data sets and monitoring system developed by the Secretary pursuant to paragraph (2);] *of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the Service Area;*

[(B)]*(2)* evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

[(C)]*(3)* assist [tribes and urban Indian communities] *Indian Tribes, Tribal Organizations, and Urban Indian Organizations* in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

[(D)]*(4)* make recommendations for the targeting of services needed by [tribal, urban, and other Indian communities] *the populations served*;

[(E)]*(5)* make recommendations to improve health care delivery systems for Indians and [urban] *Urban* Indians;

[(F) work cooperatively with tribal providers of health and social services in order to avoid duplication of existing services; and]

[(G)] *(6)* provide *requested* technical assistance to Indian [tribes and urban Indian organizations] *Tribes, Tribal Organizations, and Urban Indian Organizations* in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community[.]*; and*

[(4) Epidemiology centers established under this subsection shall be subject to the provisions of the Indian Self-Determination Act (25 U.S.C. 450f et seq.).]

(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

[(5)] *(c) TECHNICAL ASSISTANCE.*—The [director] *Director* of the Centers for Disease Control *and Prevention* shall provide technical assistance to the centers in carrying out the requirements of this [subsection] *section.*

[(6) The Service shall assign one epidemiologist from each of its area offices to each area epidemiology center to provide such center with technical assistance necessary to carry out this subsection.]

(d) GRANTS FOR STUDIES.—

[(b)] (1) *IN GENERAL.*—The Secretary may make grants to Indian [tribes, tribal organizations] *Tribes, Tribal Organizations, Urban Indian Organizations*, and eligible intertribal consortia [or Indian organizations] to conduct epidemiological studies of Indian communities.

[(2)] *(2) ELIGIBLE INTERTRIBAL CONSORTIA.*—An intertribal [consortia or Indian organization] *consortium* is eligible to receive a grant under this subsection if—

[(A) it] *(A) the intertribal consortium* is incorporated for the primary purpose of improving Indian health; and

[(B) it] *(B) the intertribal consortium* is representative of the [tribes] *Indian Tribes* or urban Indian communities in which [it] *the intertribal consortium* is located.

(3) *APPLICATIONS.*—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

[(4) Applicants for grants] *(4) REQUIREMENTS.—An applicant for a grant* under this subsection shall—

(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

(C) demonstrate cooperation from Indian [tribes] *Tribes* or [urban] *Urban* Indian [organizations] *Organizations* in the area to be served.

(5) *USE OF FUNDS.*—A grant awarded under paragraph (1) may be used [to]—

(A) *to* carry out the functions described in subsection ([*a*]*b*);

[(3) of this section;] (B) *to* provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff[,] on health care and health [services]*service* management issues; and

(C) [provide,] in collaboration with [tribes] *Indian Tribes, Tribal Organizations,* and urban Indian communities, *to provide* the Service with information regarding ways to improve the health status of [Indian people] *Indians.*

[(6) There are authorized to be appropriated to carry out the purposes of this subsection not more than $12,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

(e) ACCESS TO INFORMATION.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such entities are defined in part 164.501 of title 45, Code of Federal Regulations (or a successor regulation). The Secretary shall grant such grantees access to and use of data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

[§ 1621n. Comprehensive school health education programs]

SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

[(a) Award of grants

[The] *(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—In addition to carrying out any other program for health promotion or disease prevention, the* Secretary, acting through the Service [and in consultation with the Secretary of the Interior, may]*, is authorized to* award grants to Indian [tribes] *Tribes, Tribal Organizations, and Urban Indian Organizations* to develop comprehensive school health education programs for children from [preschool] *pre-school* through grade 12 in schools [located on] *for the benefit of* Indian [reservations.] *and Urban Indian children.*

(b) USE OF [grantsGrants] *GRANT FUNDS.—A grant* awarded under this section may be used [to—] *for purposes which may include, but are not limited to, the following:*

[(1) develop health education curricula;]

(1) Developing health education materials both for regular school programs and afterschool programs.

(2) [train] *Training* teachers in comprehensive school health education [curricula;] *materials.*

(3) [integrate] *Integrating* school-based, community-based, and other public and private health promotion efforts[;].

(4) [encourage] *Encouraging* healthy, tobacco-free school environments[;].

(5) [coordinate] *Coordinating* school-based health programs with existing services and programs available in the community[;].

(6) [develop] *Developing* school programs on nutrition education, personal health, *oral health,* and fitness[;].

[(7) develop mental] *(7) Developing behavioral* health wellness programs[;].

(8) [develop] *Developing* chronic disease prevention programs[;].

(9) [develop] *Developing* substance abuse prevention programs[;].

(10) [develop accident] *Developing injury* prevention and safety education programs[;].

(11) [develop] *Developing* activities for the prevention and control of communicable diseases[; and].

(12) [develop] *Developing* community and environmental health education programs *that include traditional health care practitioners.*

(13) Violence prevention.

(14) Such other health issues as are appropriate.

(c) *TECHNICAL* ASSISTANCE [The].—*Upon request, the* Secretary, *acting through the Service,* shall provide technical assistance to Indian [tribes] *Tribes, Tribal Organizations, and Urban Indian Organizations* in the development of *comprehensive* health education plans[,] and the dissemination of *comprehensive* health education materials and information on existing health programs and resources.

(d) CRITERIA FOR [review and approval of applications. The Secretary] *REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations,* shall establish criteria for the review and approval of applications for grants [made pursuant to this section.] *awarded under this section.*

(e) [Report] *DEVELOPMENT* OF [recipient]

[Recipients of grants under this section shall submit to the Secretary an annual report on activities undertaken with funds provided under this section. Such reports shall include a statement of—

[(1) the number of preschools, elementary schools, and secondary schools served;

[(2) the number of students served;

[(3) any new curricula established with funds provided under this section;

[(4) the number of teachers trained in the health curricula; and

[(5) the involvement of parents, members of the community, and community health workers in programs established with funds provided under this section.]

[(f)] PROGRAM [DEVELOPMENT] *FOR BIA-FUNDED SCHOOLS.*—

(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, *acting through the Service, and affected Indian Tribes and Tribal Organizations,* shall develop a comprehensive school health education program for children from preschool through grade 12 in schools [operated] *for which support is provided* by the Bureau of Indian Affairs.

[(2) Such program shall include—]

(2) *REQUIREMENTS FOR PROGRAMS.—Such programs shall include—*

(A) school programs on nutrition education, personal health, *oral health,* and fitness;

(B) [mental] *behavioral* health wellness programs;

(C) chronic disease prevention programs;

(D) substance abuse prevention programs;

(E) [accident] *injury* prevention and safety education programs; and

(F) activities for the prevention and control of communicable diseases.

[(3) The Secretary of the Interior shall—]

(3) *DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—*

[(A) provide training to teachers in comprehensive school health education [curricula;] *materials;*

(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

(C) encourage healthy, tobacco-free school environments.

[(g) Authorization of appropriations

[There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

[§ 1621o. Indian youth grant program]

SEC. 211. INDIAN YOUTH PROGRAM.

[(a) Grants]

(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to [make] *establish and administer a program to provide* grants to Indian [tribes, tribal organizations, and urban Indian organizations] *Tribes, Tribal Organizations, and Urban Indian Organizations* for innovative mental and physical disease prevention and health promotion and treatment programs for *Indian and Urban* Indian preadolescent and adolescent youths.

(b) USE OF [FUNDS] *FUNDS.*—

(1) *Allowable Uses.*—Funds made available under this section may be used to—

(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional [healers] *health care practitioners;* and

(B) develop and provide community training and education.

(2) *PROHIBITED USE*.—Funds made available under this section may not be used to provide services described in section [1621h(m) of this title.] *707(c).*

[(c) Models for delivery of comprehensive health care services

[The]

(c) DUTIES OF THE SECRETARY[shall].—*The Secretary shall—*

(1) disseminate to Indian [tribes] *Tribes, Tribal Organizations, and Urban Indian Organizations* information regarding models for the delivery of comprehensive health care services to Indian and [urban] *Urban* Indian adolescents;

(2) encourage the implementation of such models; and

(3) at the request of an Indian [tribe] *Tribe, Tribal Organization, or Urban Indian Organization,* provide technical assistance in the implementation of such models.

(d) CRITERIA FOR [the review and approval of applications] *REVIEW AND APPROVAL OF APPLICATIONS*.—The Secretary*, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations,* shall establish criteria for the review and approval of applications *or proposals* under this section.

[(e) Authorization of appropriations

[There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

[§ 1621p. American Indians Into Psychology Program

[(a) Grants

[The Secretary may provide grants to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.

[(b) Quentin N. Burdick American Indians Into Psychology Program

[The Secretary shall provide one of the grants authorized under subsection (a) of this section to develop and maintain a program at the University of North Dakota to be known as the "Quentin N. Burdick American Indians Into Psychology Program". Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 1616g(b) of this title, the Quentin N. Burdick American Indians Into Nursing Program authorized under section 1616e(e) of this title, and existing university research and communications networks.

[(c) Issuance of regulations

[(1) The Secretary shall issue regulations for the competitive awarding of the grants provided under this section.

[(2) Applicants for grants under this section shall agree to provide a program which, at a minimum—

[(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community colleges located on Indian reservations that will be served by the program;

[(B) incorporates a program advisory board comprised of representatives from the tribes and communities that will be served by the program;

[(C) provides summer enrichment programs to expose Indian students to the varied fields of psychology through research, clinical, and experiential activities;

[(D) provides stipends to undergraduate and graduate students to pursue a career in psychology;

[(E) develops affiliation agreements with tribal community colleges, the Service, university affiliated programs, and other appropriate entities to enhance the education of Indian students;

[(F) to the maximum extent feasible, utilizes existing university tutoring, counseling and student support services; and

[(G) to the maximum extent feasible, employs qualified Indians in the program.

[(d) Active duty service obligation

[The active duty service obligation prescribed under section 254m of Title 42 shall be met by each graduate student who receives a stipend described in subsection (c)(2)(D) of this section that is funded by a grant provided under this section. Such obligation shall be met by service—

[(1) in the Indian Health Service;

[(2) in a program conducted under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.];

[(3) in a program assisted under subchapter IV of this chapter; or

[(4) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

[§1621q. Prevention, control, and elimination of tuberculosis

SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

[(a) Grants]

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service*, and* after consultation with the Centers for Disease Control *and Prevention*, may make grants [to Indian tribes and tribal organizations for—] *available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for the following:*

[(1) projects for the prevention, control, and elimination of tuberculosis;

[(2) public information and education programs for the prevention, control, and elimination of tuberculosis; and]

(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. Pylori.

(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

(3) [education] *Education*, training, and clinical skills improvement activities in the prevention, control, and elimination

of [tuberculosis] *communicable and infectious diseases* for health professionals, including allied health professionals.

(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

(b) APPLICATION [for grant] *REQUIRED.*—The Secretary may [make a grant] *provide funding* under subsection (a) [of this section] only if an application [for the grant] *or proposal for funding* is submitted to the Secretary [and the application is in such form, is made in such manner, and contains the assurances required by subsection (c) of this section and such other agreements, assurances, and information as the Secretary may require.].

[(c) Eligibility for grant

[To be eligible for a grant under subsection (a) of this section, an applicant must provide assurances satisfactory to the Secretary that—]

[(1) the applicant will coordinate its activities for the prevention, control, and elimination of tuberculosis with activities of] *(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving funding under this section are encouraged to coordinate their activities with* the Centers for Disease Control[,] *and Prevention* and State and local health agencies[; and].

[(2) the applicant will submit to the Secretary an annual report on its activities for the prevention, control, and elimination of tuberculosis.

[(d) Duty of Secretary]

(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

[(1) shall establish criteria for the review and approval of applications for grants under subsection (a) of this section, including requirement of public health qualifications of applicants;

[(2) shall, subject to available appropriations, make at least one grant under subsection (a) of this section within each area office;

[(3] *(1)* may, at the request of an Indian [tribe or tribal organization] *Tribe, Tribal Organization, or Urban Indian Organization*, provide technical assistance; and

[(4] *(2)* shall prepare and submit a report to [the Committee on Energy and Commerce and the Committee on Natural Resources of the House and the Committee on Indian Affairs of the Senate not later than February 1, 1994, and biennially thereafter,] *Congress biennially* on the use of funds under this section and on the progress made toward the prevention, control, and elimination of [tuberculosis among Indian tribes and tribal organizations.] *communicable and infectious diseases among Indians and Urban Indians.*

[(e) Reduction of amount of grant

[The Secretary may, at the request of a recipient of a grant under subsection (a) of this section, reduce the amount of such grant by—

[(1) the fair market value of any supplies or equipment furnished the grant recipient; and

[(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to

the grant recipient and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such grant recipient and for the purpose of carrying out a program with respect to which the grant under subsection (a) of this section is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, and such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.]

SEC. 213. OTHER AUTHORITY FOR PROVISION OF SERVICES.

(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide funding under this Act to meet the objectives set forth in section 3 of this Act through health care-related services and programs not otherwise described in this Act, including—

(1) hospice care;

(2) assisted living;

(3) long-term care; and

(4) home- and community-based services.

(b) TERMS AND CONDITIONS.—

(1) IN GENERAL.—Any service provided under this section shall be in accordance with such terms and conditions as are consistent with accepted and appropriate standards relating to the service, including any licensing term or condition under this Act.

(2) STANDARDS.—

(A) IN GENERAL.—The Secretary may establish, by regulation, the standards for a service provided under this section, provided that such standards shall not be more stringent than the standards required by the State in which the service is provided.

(B) USE OF STATE STANDARDS.—If the Secretary does not, by regulation, establish standards for a service provided under this section, the standards required by the State in which the service is or will be provided shall apply to such service.

(C) INDIAN TRIBES.—If a service under this section is provided by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the verification by the Secretary that the service meets any standards required by the State in which the service is or will be provided shall be considered to meet the terms and conditions required under this subsection.

(3) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care under this section:

(A) Individuals who are unable to perform a certain number of activities of daily living without assistance.

(B) Individuals with a mental impairment, such as dementia, Alzheimer's disease, or another disabling mental

illness, who may be able to perform activities of daily living under supervision.

(C) Such other individuals as an applicable Indian Health Program determines to be appropriate.

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

(1) The term "home- and community-based services" means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with the standards described in subsection (b).

(2) The term "hospice care" means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).

SEC. 214. INDIAN WOMEN'S HEALTH CARE.

The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

(a) STUDIES AND MONITORING.—The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum contamination, and contamination of water source and of the food chain. Such studies shall include—

(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

(2) an analysis of the potential effect of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and

nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and develop health care plans to address the health problems studied under subsection (a). The plans shall include—

(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

(d) INTERGOVERNMENTAL TASK FORCE.—

(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees):

(A) The Secretary of Energy.

(B) The Secretary of the Environmental Protection Agency.

(C) The Director of the Bureau of Mines.

(D) The Assistant Secretary for Occupational Safety and Health.

(E) The Secretary of the Interior.

(F) The Secretary of Health and Human Services.

(G) The Assistant Secretary.

(2) DUTIES.—The Task Force shall—

(A) identify existing and potential operations related to nuclear resource development or other environmental haz-

ards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work-related illness or condition;

(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program from the employer for providing medical care for such illness or condition.

SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2016, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

(b) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

SEC. 216A. NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

(a) IN GENERAL.—Beginning in fiscal year 2003, the States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of North Dakota and South Dakota.

(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if such curtailment is due to the provision of contract services in such States pursuant to the

designation of such States as a contract health service delivery area pursuant to subsection (a).

SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PROGRAM.

(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the "CRIHB") as a contract care intermediary to improve the accessibility of health services to California Indians.

(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

(d) LIMITATION ON PAYMENT.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

(e) ADVISORY BOARD.—There is established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least 1/2 of whom of whom are not affiliated with the CRIHB.

SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

(a) AUTHORIZATION FOR SERVICES.—The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided

by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

The Service shall provide funds for health care programs and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

SEC. 221. LICENSING.

Health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

[§ 1621r. Contract health services payment study]

SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.

[(a) Duties of Secretary

[The Secretary, acting through the Service and in consultation with representatives of Indian tribes and tribal organizations operating contract health care programs under the Indian Self-Determination Act (25 U.S.C. 450f et seq.) or under self-governance compacts, Service personnel, private contract health services providers, the Indian Health Service Fiscal Intermediary, and other appropriate experts, shall conduct a study—

[(1) to assess and identify administrative barriers that hinder the timely payment for services delivered by private contract health services providers to individual Indians by the Service and the Indian Health Service Fiscal Intermediary;

[(2) to assess and identify the impact of such delayed payments upon the personal credit histories of individual Indians who have been treated by such providers; and

[(3) to determine the most efficient and effective means of improving the Service's contract health services payment system and ensuring the development of appropriate consumer protection policies to protect individual Indians who receive authorized services from private contract health services providers from billing and collection practices, including the development of materials and programs explaining patients' rights and responsibilities.

[(b) Functions of study

[The study required by subsection (a) of this section shall—

[(1) assess the impact of the existing contract health services regulations and policies upon the ability of the Service and the Indian Health Service Fiscal Intermediary to process, on a timely and efficient basis, the payment of bills submitted by private contract health services providers;

[(2) assess the financial and any other burdens imposed upon individual Indians and private contract health services providers by delayed payments;

[(3) survey the policies and practices of collection agencies used by contract health services providers to collect payments for services rendered to individual Indians;

[(4) identify appropriate changes in Federal policies, administrative procedures, and regulations, to eliminate the problems experienced by private contract health services providers and individual Indians as a result of delayed payments; and

[(5) compare the Service's payment processing requirements with private insurance claims processing requirements to evaluate the systemic differences or similarities employed by the Service and private insurers.

[(c) Report to Congress

[Not later than 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report that includes—

[(1) a detailed description of the study conducted pursuant to this section; and

[(2) a discussion of the findings and conclusions of such study.]

With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

[§ 1621s. Prompt action on payment of claims]

SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

[(a) Time of response]

(a) DEADLINE FOR RESPONSE.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

[(b) Failure to timely respond]

(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a) [of this section], the Service shall accept as valid the claim submitted by the provider of a contract care service.

[(c) Time of payment]

(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a [completed] *valid* contract care service claim within 30 days after *the* completion of the claim.

[§ 1621t. Demonstration of electronic claims processing]

[(a) Not later than June 15, 1993, the Secretary shall develop and implement, directly or by contract, 2 projects to demonstrate in a pilot setting the use of claims processing technology to improve the accuracy and timeliness of the billing for, and payment of, contract health services.

[(b) The Secretary shall conduct one of the projects authorized in subsection (a) of this section in the Service area served by the area office located in Phoenix, Arizona.]

SEC. 224. LIABILITY FOR PAYMENT.

[§ 1621u.]

(a) NO PATIENT LIABILITY[for payment (a)].—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

(b) *NOTIFICATION.*—[The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services *not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.*

(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall have no further recourse against the patient who received the services.

SEC. 225. OFFICE OF INDIAN MEN'S HEALTH.

(a) ESTABLISHMENT.—The Secretary may establish within the Service an office to be known as the "Office of Indian Men's Health" (referred to in this section as the "Office").

(b) DIRECTOR.—

(1) IN GENERAL.—The Office shall be headed by a director, to be appointed by the Secretary.

(2) DUTIES.—The director shall coordinate and promote the status of the health of Indian men in the United States.

(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, acting through the director of the Office, shall submit to Congress a report describing—

[§ 1621v. Office of Indian Women's Health Care]

(1) any activity carried out by the director as of the date on which the report is prepared; and

[There is established within the Service an Office of Indian Women's Health Care to oversee efforts of the Service to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.]

(2) any finding of the director with respect to the health of Indian men.

[§ 1621w. Authorization of appropriations]

SEC. 226. AUTHORIZATION OF APPROPRIATIONS.

[Except as provided in sections 1621h(m), 1621j, 1621l, 1621m(b)(5), 1621n, and 1621o of this title, there] *There* are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year [2000 to carry out this subchapter] *2017 to carry out this title.*

[§ 1621x. Limitation on use of funds

[Amounts appropriated to carry out this subchapter may not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C.A. §14401 et seq.].]

TITLE III—FACILITIES

[§ 1631. Consultation; closure of facilities; reports]

SEC. 301. CONSULTATION; CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

[(a) Consultation; standards for accreditation]

(a) PREREQUISITES FOR EXPENDITURE OF FUNDS.—Prior to the expenditure of, or the making of any [firm] *binding* commitment *to* expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13)[,] [popularly] *(commonly* known as the "Snyder Act"*)*, the Secretary, acting through the Service, shall—

(1) consult with any Indian [tribe] *Tribe* that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made[,]*;* and

(2) ensure, whenever practicable *and applicable*, that such facility meets the *construction* standards of [the Joint Commission on Accreditation of Health Care Organizations] *any accrediting body recognized by the Secretary for the purposes of the Medicare, Medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act* by not later than 1 year after the date on which the construction or renovation of such facility is completed.

[(b) Closure; report on proposed closure]

(b) CLOSURES.—

(1) *EVALUATION REQUIRED.*—Notwithstanding any *other* provision of law [other than this subsection], no *facility operated by the* Service [hospital or outpatient health care facility of the Service], or any portion of such [a hospital or] facility, may be closed if the Secretary has not submitted to [the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed on evaluation of the impact of such proposed closure which] *Congress not less than 1 year, and not more than 2 years, before the date of the proposed closure an evaluation, completed not more than 2 years before the submission, of the impact of the proposed closure that* specifies, in addition to other considerations—

(A) the accessibility of alternative health care resources for the population served by such [hospital or] facility;

(B) the cost-effectiveness of such closure;

(C) the quality of health care to be provided to the population served by such [hospital or] facility after such closure;

(D) the availability of contract health care funds to maintain existing levels of service;

(E) the views of the Indian [tribes] *Tribes* served by such [hospital or] facility concerning such closure;

(F) the level of [utilization] *use* of such [hospital or] facility by all eligible Indians; and

(G) the distance between such [hospital or] facility and the nearest operating Service hospital.

(2) *EXCEPTION FOR CERTAIN TEMPORARY CLOSURES.*—Paragraph (1) shall not apply to any temporary closure of a facility or [of] any portion of a facility if such closure is necessary for medical, environmental, or *construction* safety reasons.

[(c) Annual report on health facility priority system

[(1) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report which sets forth—

[(A) the current health facility priority system of the Service,

[(B) the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters),

[(C) the justification for such order of priority,

[(D) the projected cost of such projects, and

[(E) the methodology adopted by the Service in establishing priorities under its health facility priority system.

[(2) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall—

[(A) consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], and

[(B) review the needs of such tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

[(3) For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.]

(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

(1) IN GENERAL.—

(A) PRIORITY SYSTEM.—The Secretary, acting through the Service, shall maintain a health care facility priority system, which—

(i) shall be developed in consultation with Indian Tribes and Tribal Organizations;

(ii) shall give Indian Tribes' needs the highest priority;

(iii)(I) may include the lists required in paragraph (2)(B)(ii); and

(II) shall include the methodology required in paragraph (2)(B)(v); and

(III) may include such other facilities, and such renovation or expansion needs of any health care facility, as the Service, Indian Tribes, and Tribal Organizations may identify; and

(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

[(4)] *(B) NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.*—The Secretary shall ensure that the planning, design, construction, [and] renovation, *and expansion* needs

of Service and non-Service facilities [which are the subject of a contract for health services entered into with the Service under] *operated under contracts or compacts in accordance with* the Indian Self-Determination *and Education Assistance* Act [[]*(*25 U.S.C.[A. § 450f] *450* et seq.[]]*)*are fully and equitably integrated into the [development of the] health *care* facility priority system.

[(d) Funds appropriated subject to section 450f of this title]

(C) CRITERIA FOR EVALUATING NEEDS.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 shall not be affected by any change in the construction priority system taking place after that date if the project—

(i) was identified in the fiscal year 2008 Service budget justification as—

(I) 1 of the 10 top-priority inpatient projects;

(II) 1 of the 10 top-priority outpatient projects;

(III) 1 of the 10 top-priority staff quarters developments; or

(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

(ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

(I) on the initiative of the Secretary; or

(II) pursuant to a request of an Indian Tribe or Tribal Organization.

(2) REPORT; CONTENTS.—

(A) INITIAL COMPREHENSIVE REPORT.—

(i) DEFINITIONS.—In this subparagraph:

(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term "Facilities Appropriation Advisory Board" means the advisory board, comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Assistant Secretary—

(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

(bb) to address other facilities issues.

(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term "Facilities Needs Assessment Workgroup" means the workgroup established at the discretion of the Assistant Secretary—

(aa) to review the health care facilities construction priority system; and

(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

(ii) INITIAL REPORT.—

(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian Tribes, and Tribal Organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, staff quarters and hostels associated with health care facilities, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian Tribes, and Tribal Organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

(II) INCLUSIONS.—The initial report shall include—

(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

(bb) such other information as the Secretary determines to be appropriate.

(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

(I) update the report under clause (ii) not less frequently than once every 5 years; and

(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

(B) ANNUAL REPORTS.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

(i) A description of the health care facility priority system of the Service established under paragraph (1).

(ii) Health care facilities lists, which may include—

(I) the 10 top-priority inpatient health care facilities;

(II) the 10 top-priority outpatient health care facilities;

(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment);

(IV) the 10 top-priority staff quarters developments associated with health care facilities; and

(V) the 10 top-priority hostels associated with health care facilities.

(iii) The justification for such order of priority.

(iv) The projected cost of such projects.

(v) The methodology adopted by the Service in establishing priorities under its health care facility priority system.

(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing the report required under paragraph (2), the Secretary shall—

(A) consult with and obtain information on all health care facilities needs from Indian Tribes, Tribal Organizations, and Urban Indian Organizations; and

(B) review the total unmet needs of all Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health care facilities (including hostels and staff quarters), including needs for renovation and expansion of existing facilities.

(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

(1) IN GENERAL.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i)); and

(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

(A) the Committees on Indian Affairs and Appropriations of the Senate;

(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

(C) the Secretary.

(e) FUNDING CONDITION.— All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) *(commonly known as the "Snyder Act")*, for the planning, design, construction, or renovation of health facilities for the benefit of ❚an❚ *1 or more* Indian ❚tribe or tribes❚ *Tribes* shall be subject to the provisions of ❚section 102 of❚ the Indian Self-Determination *and Education Assistance* Act [(25 U.S.C.❚A. § 450f].❚ *450 et seq.*).

(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construc-

tion of health facilities, including those provided for in other sections of this title and other approaches.

[§ 1632. Safe water and sanitary waste disposal facilities]

SEC. 302. SANITATION FACILITIES.

[(a) Congressional findings

[The] *(a) FINDINGS.*—Congress [hereby] finds [and declares that—] *the following:*

(1) [the]*The* provision of [safe water supply systems and sanitary sewage and solid waste disposal systems]*sanitation facilities* is primarily a health consideration and function[;].

(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of [such systems;]*sanitation facilities.*

(3) [the]*The* long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing [such systems]*sanitation facilities* and other preventive health measures[;].

(4) [many]*Many* Indian homes and *Indian* communities still lack [safe water supply systems and sanitary sewage and solid waste disposal systems; and]*sanitation facilities.*

(5) [it]*It* is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with [safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible]*sanitation facilities.*

[(b) Authority; assistance; transfer of funds]

[(1)]*(b) FACILITIES AND SERVICES.*—In furtherance of the findings [and declarations] made in subsection (a) [of this section] , Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section [2004a of Title 42. (2) The] *7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Under such authority, the* Secretary, acting through the Service, is authorized to provide [under section 2004a of Title 42—] *the following:*

[(A) financial]*(1) Financial* and technical assistance to Indian [tribes and]*Tribes, Tribal Organizations, and Indian* communities in the establishment, training, and equipping of utility organizations to operate and maintain [Indian sanitation facilities;]*sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.*

[(B)] *(2)* [ongoing]*Ongoing* technical assistance and training *to Indian Tribes, Tribal Organizations, and Indian communities* in the management of utility organizations which operate and maintain sanitation facilities[; and].

[(C)]*(3) Priority funding for* operation and maintenance assistance for, and emergency repairs to, [tribal] sanitation facilities *operated by an Indian Tribe, Tribal Organization or Indian community* when necessary to avoid [a] *an imminent* health [hazard] threat or to protect the [Federal] investment in sanitation facilities[.] *and the investment in the health benefits gained through the provision of sanitation facilities.*

[(3)]*(c) FUNDING.*—Notwithstanding any other provision of law—

[(A) the Secretary of Housing and Urban Affairs is authorized to transfer funds appropriated under the Housing and Community Development Act of 1974 (42 U.S.C. 5301, et seq.) to the Secretary of Health and Human Services; and]

(1) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.) to the Secretary of Health and Human Services;

[(B)]*(2) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section [2004a of Title 42.] 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);*

[(c) 10-year plan

[Beginning in fiscal year 1990, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes

[(d) Tribal capability]

(3) unless specifically authorized when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services and place these funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

(7) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned, or appropriated whereby the Department's applicable policies, rules, and regulations shall apply in the implementation of such projects;

(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act;

(9) the Secretary of Health and Human Services shall, by regulation, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act; and

(10) the Secretary of Health and Human Services is authorized to accept payments for goods and services furnished by the Service from appropriate public authorities, nonprofit organizations or agencies, or Indian Tribes, as contributions by that authority, organization, agency, or tribe to agreements made under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), and such payments shall be credited to the same or subsequent appropriation account as funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

(d) CERTAIN CAPABILITIES NOT PREREQUISITE.—The financial and technical capability of an Indian [tribe or] *Tribe, Tribal Organization, or Indian* community to safely operate, *manage,* and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

[(e) Amount of assistance]

[(1)] *(e) FINANCIAL ASSISTANCE.*—The Secretary is authorized to provide financial assistance to Indian [tribes and communities in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (c) of this section.] *Tribes, Tribal Organizations, and Indian communities for operation, management, and maintenance of their sanitation facilities.*

[(2) For the purposes of paragraph (1), the term "Federal share" means 80 percent of the costs described in paragraph (1).

[(3) With respect to Indian tribes with fewer than 1,000 enrolled members, the non-Federal portion of the costs of operating, managing, and maintaining such facilities may be provided, in part, through cash donations or in kind property, fairly evaluated.

[(f) Eligibility of programs administered by Indian tribes

[Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.] shall be eligible for—

[(1) any funds appropriated pursuant to this section, and

[(2) any funds appropriated for the purpose of providing water supply or sewage disposal services,

[on an equal basis with programs that are administered directly by the Service.

[(g) Annual]

(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving a community that is operated by an Indian Tribe or Tribal Organization is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordi-

nator or by providing operation, management, and maintenance service.

(g) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

(1) any funds appropriated pursuant to this section; and

(2) any funds appropriated for the purpose of providing sanitation facilities.

(h) REPORT.—

(1) REQUIRED; CONTENTS.—The Secretary, in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) shall submit to the President, for inclusion in the report[; sanitation deficiency levels]

[(1) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the [Congress under section 1671 of this title,] *Congress under section 801,* a report which sets forth—

[(A) the current Indian sanitation facility priority system of the Service;]

(A) the current Indian sanitation facility priority system of the Service;

(B) the methodology for determining sanitation deficiencies[;]

[(C) the level of sanitation deficiency for each sanitation facilities project of each Indian tribe or community;

[(D) the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency; and

[(E) the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.

[(2) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.]) to determine the sanitation needs of each tribe.] *and needs;*

(C) the criteria on which the deficiencies and needs will be evaluated;

(D) the level of initial and final sanitation deficiency for each type of sanitation facility for each project of each Indian Tribe or Indian community;

(E) the amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act (25 U.S.C. 4101 et seq.), and to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (3)(A); and

(F) a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

[(3)] *(2) UNIFORM METHODOLOGY.*—The methodology used by the Secretary in determining*, preparing cost estimates for, and reporting* sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian [tribes and] *Tribes and Indian* communities.

[(4)] *(3) SANITATION DEFICIENCY LEVELS.*—For purposes of this subsection, the sanitation deficiency levels for an [Indian tribe or community are] *individual, Indian Tribe, or Indian community sanitation facility to serve Indian homes are determined* as follows:

[(A) level I is an Indian tribe or community with a sanitation system—]

(A) A level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

(i) [which] complies with all applicable water supply [and,] pollution control, *and solid waste disposal* laws[,]*;* and

(ii) [in which the] deficiencies relate to routine replacement, repair, or maintenance needs[;].

(B) *A* level II [is an Indian tribe or community with a sanitation system—]

[(i) which complies] *deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or recently complied* with all applicable water supply [and]*,* pollution control [laws, and (ii) in which the]*, and solid waste laws and any* deficiencies relate to—

(i) small or minor capital improvements needed to bring the facility back into compliance;

(ii) capital improvements that are necessary to *enlarge or* improve the facilities in order to meet the *current* needs [of such tribe or community] for domestic sanitation facilities; *or*

(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

(C) *A* level III [is an Indian tribe or community with a sanitation system which—] *deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets 1 or more of the following conditions—*

[(i) has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or

[(ii) has no solid waste disposal facility;

[(D) level IV is an Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

[(E) level V is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.

[(5) For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to

enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.]

(i) water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;

(ii) major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or

(iii) there is no access to or no approved or permitted solid waste facility available.

(D) A level IV deficiency exists—

(i) if a sanitation facility for an individual home, an Indian Tribe, or an Indian community exists but—

(I) lacks—

(aa) a safe water supply system; or

(bb) a waste disposal system;

(II) contains no piped water or sewer facilities; or

(III) has become inoperable due to a major component failure; or

(ii) if only a washeteria or central facility exists in the community.

(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

(i) DEFINITIONS.—For purposes of this section, the following terms apply:

(1) INDIAN COMMUNITY.—The term "Indian community" means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

(2) SANITATION FACILITIES.—The terms "sanitation facility" and "sanitation facilities" mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

[§1633. Preference to Indians and Indian firms]

SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

[(a) Discretionary authority; covered activities]

(a) BUY INDIAN ACT.—The Secretary, acting through the Service, may [utilize] *use* the negotiating authority of section [47 of this title] *23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the "Buy Indian Act")*, to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian [tribes] *Tribes* in the State of New York (hereinafter referred to as an "Indian firm") in the construction and renovation of Service facilities pursuant to section [1631 of this title and in the construction of safe water and sanitary waste disposal] *301 and in the construction of sanitation* facilities pursuant to section [1632 of this title.] *302.* Such preference may be accorded by the Secretary unless [he] *the Secretary* finds, pursuant to [rules and] regulations [promul-

gated by him**]**, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at **[**his**]** *such a* finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

(1) ownership and control by Indians**[**,**]***;*

(2) equipment**[**,**]***;*

(3) bookkeeping and accounting procedures**[**,**]***;*

(4) substantive knowledge of the project or function to be contracted for**[**,**]***;*

(5) adequately trained personnel**[**,**]***;* or

(6) other necessary components of contract performance.

[(b) Pay rates**]**

(b) LABOR STANDARDS.—

(1) *IN GENERAL.*—For the **[**purpose**]** *purposes* of implementing the provisions of this **[**subchapter, the Secretary shall assure that the rates of pay for personnel engaged in**]** *title, contracts for* the construction or renovation of **[**facilities constructed or renovated**]** *health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded* in whole or in part **[**by**]** *with* funds made available pursuant to this title **[**[25 U.S.C.A. §§ 1631 et seq.] are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a to 276a–5, known as the Davis-Bacon Act).**]***, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the "Davis-Bacon Act"), unless such construction or renovation—*

(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract or compact authorized by the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other statutory authority; and

(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal Organizations to be served by the construction or renovation.

(2) EXCEPTION.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

[§ 1634. Expenditure of non-Service funds for renovation]

SEC. 304. EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION.

[(a) Authority of Secretary**]**

[(1)**]** *(a) IN GENERAL.*—Notwithstanding any other provision of law, **[**the Secretary**]***if the requirements of subsection (c) are met, the Secretary, acting through the Service,* is authorized to accept any major **[**renovation**]** *expansion, renovation,* or modernization by any Indian **[**tribe of any Service facility,**]** *Tribe or Tribal Organization of any Service facility* or of any other Indian health facility operated pursuant to a contract **[**entered into**]** *or compact* under the Indian Self-Determination **[**Act[**]** *and Education Assistance Act* (25 U.S.C.**[**A. §**]** **[**450**]**(f) et seq.**[**]**]***)*, including—

[(A)**]** *(1)* any plans or designs for such *expansion,* renovation*,* or modernization; and

[(B)] *(2)* any *expansion,* renovation, or modernization for which funds appropriated under any Federal law were lawfully expended[, but only if the requirements of subsection (b) of this section are met].

(b) PRIORITY LIST.—

[(2)] *(1) IN GENERAL.*—The Secretary shall maintain a separate priority list to address the needs [of such facilities] for *increased operating expenses,* personnel, or equipment[.] *for such facilities. The methodology for establishing priorities shall be developed through regulations. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.*

[(3)]*(2) REPORT.*—The Secretary shall submit to the President, for inclusion in [each] *the* report required to be transmitted to [the] Congress under section [1671 of this title,] *801,* the priority list maintained pursuant to paragraph ([2]*1*).

([b]*c*) REQUIREMENTS.—The requirements of this subsection are met with respect to any *expansion,* renovation, or modernization if—

(1) the [tribe or tribal organization] *Indian Tribe or Tribal Organization—*

(A) provides notice to the Secretary of its intent to *expand,* renovate, or modernize; and

(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for *increased operating expenses,* personnel [or equipment; and]*, or equipment; and*

(2) the [renovation] *expansion, renovation,* or modernization—

(A) is approved by the appropriate area director of the Service[; and] *for Federal facilities; and*

(B) is administered by the [tribe] *Indian Tribe or Tribal Organization* in accordance with [the rules and] *any applicable* regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

[(c) Recovery for non-use as Service facility]

(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—In addition to the requirements under subsection (c), for any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information pursuant to regulations, including additional staffing, equipment, and other costs associated with the expansion.

(*e*) *CLOSURE OR CONVERSION OF FACILITIES.*—If any Service facility which has been *expanded,* renovated, or modernized by an Indian [tribe] *Tribe or Tribal Organization* under this section ceases to be used as a Service facility during the 20-year period beginning on the date such *expansion,* renovation, or modernization is completed, such Indian [tribe] *Tribe or Tribal Organization* shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such *expansion*, renovation, or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such *expansion,* renovation, or modernization) bore to the value of such facility at the time of the completion of such *expansion,* renovation, or modernization.

SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

[§ 1636. Grant program for the construction, expansion, and modernization of small ambulatory care facilities]

(a) GRANTS.—

[(a) Authorization]

(1) *IN GENERAL.*—The Secretary, acting through the Service, shall make grants to [tribes and tribal organizations] *Indian Tribes and Tribal Organizations* for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons [as provided in subsection] *pursuant to subsections (b)(2) and* (c)(1)(C)[of this section]). A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term "construction" includes the replacement of an existing facility.

(2) *GRANT AGREEMENT REQUIRED.*—A grant under paragraph (1) may only be made [to a tribe or tribal organization] *available to a Tribal Health Program* operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to [a tribe or tribal organization) pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].] *an Indian Tribe or Tribal Organization).*

[(b) Use of grant

(1) A grant provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—]

(b) USE OF GRANT FUNDS.—

(1) ALLOWABLE USES.—A grant awarded under this section may be used for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

(A) located apart from a hospital;

(B) not funded under section [1631] *301* or section [1637 of this title] *306*; and

(C) which, upon completion of such construction[, expansion,] or modernization will—

(i) have a total capacity appropriate to its projected service population;

[(ii) serve no less than 500]*(ii) provide annually no fewer than 150 patient visits by* eligible Indians [annually;] and *other users who are eligible for services in such facility in accordance with section 807(c)(2); and*

(iii) provide ambulatory care in a [service area] *Service Area* (specified in the contract [entered into] *or compact* under the Indian Self-Determination *and Education Assistance* Act [[]*(*25 U.S.C.[A. §]450[f et seq.]] *et seq.*)) with a population of [not less than 2,000] *no fewer than 1,500* eligible Indians[.] *and*

other users who are eligible for services in such facility in accordance with section 807(c)(2).

(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the construction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

[(2)] *(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—A grant provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C) (ii) and (iii).* The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to [a tribe or tribal organization] *an Indian Tribe or Tribal Organization* applying for a grant under this section [whose tribal government offices are located on an island] *for a health care facility located or to be constructed on an island or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.*

[(c) Application of grant]

(C) GRANTS.—

(1) *APPLICATION.*—No grant may be made under this section unless an application *or proposal* for [such a] *the* grant has been[submitted to and] approved by the Secretary[. An application for a grant under this section shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall] *in accordance with applicable regulations and has* set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out [pursuant to] *using* a grant received under this section—

(A) adequate financial support will be available for the provision of services at such facility;

(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

(2) *PRIORITY.*—In awarding grants under this section, the Secretary shall give priority to [tribes and tribal organizations]*Indian Tribes and Tribal Organizations* that demonstrate—

(A) a need for increased ambulatory care services; and

(B) insufficient capacity to deliver such services.

(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed pursuant to subsection (a)(1).

(d) [Transfer of interest to United States upon cessation of facility]*REVERSION OF FACILITIES.*—If any facility (or portion thereof)

with respect to which funds have been paid under this section, ceases, at any time after completion of the construction, expansion, or modernization carried out with such funds, to be [utilized] *used* for the purposes of providing [ambulatory] *health* care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States *unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.*

(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or for reallocation or redesign thereunder.

[§1637. Indian health care delivery demonstration project]

SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

[(a) Health care delivery demonstration projects]

(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to *carry out, or to* enter into contracts [with, or make grants to, Indian tribes or tribal organizations for the purpose of carrying out]*under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations to carry out,* a health care delivery demonstration project to test alternative means of delivering health care and services *to Indians* through [health] facilities [to Indians].

(b) USE OF [FUNDS]*FUNDS.*—The Secretary, in approving projects pursuant to this section, may authorize [funding] *such contracts* for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

(1) waive any leasing prohibition;

(2) permit carryover of funds appropriated for the provision of health care services;

(3) permit the use of [non-Service Federal funds and non-Federal]*other available* funds;

(4) permit the use of funds or property donated from any source for project purposes; [and]

(5) provide for the reversion of donated real or personal property to the donor[.]; *and*

[(c) Criteria]

(6) permit the use of Service funds to match other funds, including Federal funds.

(c) HEALTH CARE DEMONSTRATION PROJECTS.—

(1) GENERAL PROJECTS.—

[(1) Within 180 days after November 28, 1990, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and publish in the Federal Register criteria for the review and approval of applications submitted under this section. The Secretary may enter into a contract or award a grant under this section for projects which]

(A) CRITERIA.—The Secretary may approve under this section demonstration projects that meet the following criteria:

[(A)] *(i)*There is a need for a new facility or program*, such as a program for convenient care services,* or the reorientation of an existing facility or program.

[(B)] *(ii)* A significant number of Indians, including [those] *Indians* with low health status, will be served by the project.

[(C) The project has the potential to address the health needs of Indians in an innovative manner.]

[(D)] *(iii)* The project has the potential to deliver services in an efficient and effective manner.

[(E)] *(iv)* The project is economically viable.

[(F)] *(v)* [The Indian tribe or tribal organization] *For projects carried out by an Indian Tribe or Tribal Organization, the Indian Tribe or Tribal Organization* has the administrative and financial capability to administer the project.

[(G)] *(vi)* The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services *in order to expand the availability of services.*

[(2) The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such applications using the criteria developed pursuant to paragraph (1).

[(3)(A) On or before September 30, 1995, the Secretary shall enter into contracts or award grants under this section for a demonstration project in each of the following service units which meets the criteria specified in paragraph (1) and for which a completed application has been received by the Secretary:]

(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service Units:

(i) Cass Lake, Minnesota.

(ii[) Clinton, Oklahoma.

[(iii) Harlem, Montana.

(iv]) Mescalero, New Mexico.

([v]*iii*) Owyhee, Nevada.

[(vi) Parker, Arizona.]

([vii]*iv*) Schurz, Nevada.

[(viii) Winnebago, Nebraska.]

([ix]*v*) Ft. Yuma, California.

[(B) The Secretary may also enter into contracts or award grants under this section taking into consideration applications received under this section from all service areas. The Secretary may not award a greater number of such contracts or grants in one service area than in any other service area until there is an equal number of such contracts or grants awarded with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria specified in paragraph (1).]

(2) CONVENIENT CARE SERVICE PROJECTS.—

(A) DEFINITION OF CONVENIENT CARE SERVICE.—In this paragraph, the term "convenient care service" means any primary health care service, such as urgent care services, nonemergent care services, prevention services and screenings, and any service authorized by sections 203 or 213(d), that is—

(i) provided outside the regular hours of operation of a health care facility; or

(ii) offered at an alternative setting.

(B) APPROVAL.—In addition to projects described in paragraph (1), in any fiscal year, the Secretary is authorized to approve not more than 10 applications for health care delivery demonstration projects that—

(i) include a convenient care services program as an alternative means of delivering health care services to Indians; and

(ii) meet the criteria described in subparagraph (C).

(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

(i) The criteria set forth in paragraph (1)(A).

(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at those facilities or other factors.

(iii) The project—

(I) expands the availability of services; or

(II) reduces—

(aa) the burden on Contract Health Services; or

(bb) the need for emergency room visits.

(d) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria described in paragraphs (1)(A) and (2)(C) of subsection (c).

(**[**d**]***e*) TECHNICAL **[**assistance**]** *ASSISTANCE.*—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with **[**the provisions of**]** this section.

(**[**e**]***f*) SERVICE TO **[**ineligible persons The**]***INELIGIBLE PERSONS.— Subject to section 807, the* authority to provide services to persons otherwise ineligible for the health care benefits of the Service, and the authority to extend hospital privileges in **[**service**]***Service* facilities to non-Service health **[**care**]** practitioners as provided in section **[**1680c of this title**]** *807,* may be included, subject to the terms of **[**such**]** *that* section, in any demonstration project approved pursuant to this section.

(**[**f**]***g*) EQUITABLE **[**TREATMENT**]** *TREATMENT.*—For purposes of subsection (c)**[**(1)(A) of this section,**]** the Secretary **[**shall**]**, in evaluating facilities operated under any contract **[**entered into with the Service**]** *or compact* under the Indian Self-Determination *and Education Assistance* Act**[** **[**)*(*25 U.S.C.**[**A. §**]**450**[**f**]** et seq.**]**,*)*, *shall* use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

(**[**g**]***h* EQUITABLE **[**integration of facilities**]** *INTEGRATION OF FACILITIES.*—The Secretary shall ensure that the planning, design,

construction, [and] renovation*, and expansion* needs of Service and non-Service facilities [which] *that* are the subject of a contract [for health services entered into with the Service]*or compact* under the Indian Self-Determination *and Education Assistance* Act [[]*(*25 U.S.C.[A. §]450[f] et seq.],*) for health services* are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

[(h) Reports to Congress

[(1) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 1671 of this title for fiscal year 1997, an interim report on the findings and conclusions derived from the demonstration projects established under this section.

[(2) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 1671 of this title for fiscal year 1999, a final report on the findings and conclusions derived from the demonstration projects established under this section, together with legislative recommendations.

SEC. 307. LAND TRANSFER.

Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.

The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450j(l)) and regulations thereunder.

SEC. 309. STUDY ON LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

(1) inpatient facilities;

(2) outpatient facilities;

(3) staff quarters;

(4) hostels; and

(5) specialized care facilities, such as behavioral health and elder care facilities.

(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any one time;

(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

(6) whether acceptance by the Secretary of an assignment of the revenue of an Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate;

(7) whether, in the planning and design of health facilities under this section, users eligible under section 807(c) may be included in any projection of patient population;

(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

(c) REPORT.—Not later than September 30, 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

(1) the manner of consultation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.

SEC. 310. TRIBAL LEASING.

A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in ex-

change for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project; or

(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project.

(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

(2) the Indian Tribe or Tribal Organization meets the need criteria determined using the criteria developed under the health care facility priority system under section 301, unless the Secretary determines, pursuant to regulations, that other criteria will result in a more cost-effective and efficient method of facilitating and completing construction of health care facilities.

(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

(f) DEFINITION.—For the purposes of this section, the term "health facility" or "health facilities" includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

SEC. 312. LOCATION OF FACILITIES.

(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the

Service shall give priority to locating such facilities and projects on Indian lands, or lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), or any land allotted to any Alaska Native, if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

(b) DEFINITION.—For purposes of this section, the term "Indian lands" means—

(1) all lands within the exterior boundaries of any reservation; and

(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation.

SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the health care facility priority system under section 301(c).

(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY-OWNED QUARTERS.

(a) RENTAL RATES.—

(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally-owned quarters associated therewith pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

(B) generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally-owned quarters used to house personnel in Services-supported programs.

(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

(b) DIRECT COLLECTION OF RENT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally-owned quarters, such retrocession shall become effective on the earlier of—

[§ 1638. Land transfer]

(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

[The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem,

Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.]

(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

[§1638a. Authorization of appropriations]

(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally-owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

[There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this subchapter.]

SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.

[§ 1638b.]

(a) APPLICABILITY [of Buy American requirement (a) Duty of Secretary].—The Secretary shall ensure that the requirements of the Buy American Act [[41 U.S.C.A. § 10a et seq.]] apply to all procurements made with funds provided pursuant to [the authorization contained in section 1638a of this title.] *section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.*

[(b) Report to Congress

[The Secretary shall submit to the Congress a report on the amount of procurements from foreign entities made in fiscal years 1993 and 1994 with funds provided pursuant to the authorization contained in section 1638a of this title. Such report shall separately indicate the dollar value of items procured with such funds for which the Buy American Act [41 U.S.C.A. § 10a et seq.] was waived pursuant to the Trade Agreement Act of 1979 [19 U.S.C.A. § 250 et seq.] or any international agreement to which the United States is a party.

[(c) Fraudulent use of Made-in-America label]

(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a "Made in America" inscription[,] or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to [the authorization contained in] section [1638a of this title,] *317,* pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

[(d) "Buy American Act" defined] *(c) DEFINITIONS.*—For purposes of this section, the term ["Buy American Act"] *"Buy American Act"* means title III of the Act entitled "An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes", approved March 3, 1933 (41 U.S.C. 10a et seq.).

[§ 1638c. Contracts for provision of personal services in Indian Health Service facilities

[In fiscal year 1995 and thereafter—]

SEC. 316. OTHER FUNDING FOR FACILITIES.

[(a) In general

[The Secretary may enter into personal services contracts with entities, either individuals or organizations, for the provision of services in facilities owned, operated or constructed under the jurisdiction of the Indian Health Service.]

(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

[(b) Exemption from competitive contracting requirements

[The Secretary may exempt such a contract from competitive contracting requirements upon adequate notice of contracting opportunities to individuals and organizations residing in the geographic vicinity of the health facility.]

(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

[(c) Consideration of individuals and organizations

[Consideration of individuals and organizations shall be based solely on the qualifications established for the contract and the proposed contract price.]

(c) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation for the planning, design, and construction of health care facilities serving Indians under this Act.

[(d) Liability

[Individuals providing health care services pursuant to these contracts are covered by the Federal Tort Claims Act.]

SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

[§ 1638d. Crediting of money collected for meals served at Indian Health Service facilities]

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

[Money heretofore and hereafter collected for meals served at Indian Health Service facilities will be credited to the appropriations from which the services were furnished and shall be credited to the appropriation when received.]

TITLE IV—ACCESS TO HEALTH SERVICES

[§ 1641. Treatment of payments under medicare program]

SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

[(a) Determination of appropriations

[Any payments received by a hospital or skilled nursing facility of the Service (whether operated by the Service or by an Indian tribe or tribal organization pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.])]

(a) DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian Health Program or by an Urban Indian Organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under [title XVIII of the Social Security Act [42 U.S.C.A. §1395 et seq.]] *such respective titles* shall not be considered in determining appropriations for [health care and services to Indians.] *the provision of health care and services to Indians.*

[(b) Preferences]

(b) NONPREFERENTIAL TREATMENT.—Nothing in this [chapter] *Act* authorizes the Secretary to provide services to an Indian [beneficiary] with coverage under title XVIII*, XIX, or XXI* of the Social Security [Act [42 U.S.C.A. § 1395 et seq.], as amended,] *Act* in preference to an Indian [beneficiary] without such coverage.

(c) USE OF FUNDS.—

[§ 1642. Treatment of payments under medicaid program]

(1) SPECIAL FUND.—

[(a) Payments to special fund]

(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, [payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.]) is entitled under a State plan by reason of section 1911 of such Act [42 U.S.C.A. § 1396j]]*but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of the Social Security Act* shall be placed in a special fund to be held by the Secretary [and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title]. In making payments from such fund, the Secretary shall ensure that each [service unit] *Service Unit* of the Service receives [at least 80] *100* percent of the [amounts] *amount* to which the facilities of the Service, for which such [service unit] *Service Unit* makes collections, are entitled by reason of [section 1911 of the Social Security Act [42 U.S.C.A. § 1396j].] *a provision of the Social Security Act.*

[(b) Determination of appropriation

[Any payments received by such facility for services provided to Indians eligible for benefits under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] shall not be considered in determining appropriations for the provision of health care and services to Indians.

[§ 1643. Amount and use of funds reimbursed through medicare and medicaid available to Indian Health Service]

[The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 1671 of this title, an accounting on the amount and use of funds made available to the Service pursuant to this subchapter as a result of reimbursements through titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq., 1396 et seq.], as amended.]

[§1644. Grants to and contracts with tribal organizations]

(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian Tribes being served by the Service Unit, be used for reducing the health resource deficiencies (as determined under section 201(d)) of such Indian Tribes.

[(a) Access to health services

[The Secretary, acting through the Service, shall make grants to or enter into contracts with tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

[(1) enroll under section 1818 of part A and sections 1836 and 1837 of part B of title XVIII of the Social Security Act [42 U.S.C.A. §§ 1395i–2, 1395o, and 1395p];

[(2) pay monthly premiums for coverage due to financial need of such individual; and

[(3) apply for medical assistance provided pursuant to title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.].

[(b) Terms and conditions

[The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any contract or grant which the Secretary makes with any tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

[(1) determine the population of Indians to be served that are or could be recipients of benefits under titles XVIII and

XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq., 1396 et seq.];

[(2) assist individual Indians in becoming familiar with and utilizing such benefits;

[(3) provide transportation to such individual Indians to the appropriate offices for enrollment or application for medical assistance;

[(4) develop and implement—

[(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for coverage of needy individuals; and

[(B) methods of improving the participation of Indians in receiving the benefits provided under titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq., 1396 et seq.].

[(c) Application for medical assistance

[The Secretary, acting through the Service, may enter into an agreement with an Indian tribe, tribal organization, or urban Indian organization which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act [42 U.S.C.A. §§ 1396 et seq.] and benefits under title XVIII of the Social Security Act [42 U.S.C.A. §§ 1395 et seq.] at a Service facility or a health care facility administered by such tribe or organization pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].

(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a Tribal Health Program upon the election of such Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such Program during the period of such election.

[§ 1645. Direct billing of Medicare, Medicaid, and other third party payors]

(d) DIRECT BILLING.—

[(a) Establishment of direct billing program

[(1) In general

[The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Service under the Indian Self-Determination and Education Assistance Act]

(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a Tribal Health Program may elect to directly bill for, and receive payment for, health care *items and* services provided by such [hospital or clinic] *Program* for which payment is made under title XVIII *or XIX* of the Social Security Act [(42 U.S.C. 1395 et seq.) (in this section referred to as the "medicare program"), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (in this section referred to as the "medicaid program"),] or from any other third party payor.

[(2) Application of 100 percent FMAP

[The third sentence of section 1396d(b) of Title 42 shall apply for purposes of reimbursement under the medicaid pro-

gram for health care services directly billed under the program established under this section.

[(b) Direct reimbursement

[(1) Use of funds]

(2) DIRECT REIMBURSEMENT.—

[Each hospital or clinic participating in the program described in subsection (a) of this section]

(A) USE OF FUNDS.—Each Tribal Health Program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly [under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1395qq(c) of Title 42 and sections 602(a) and 1013(b)(2)(A) of Title 42, but all funds] *by that program for items and services furnished without regard to subsection (c)(1), but all amounts* so reimbursed shall [first] be used by [the hospital or clinic] *Tribal Health Program* for the purpose of making any improvements in the [hospital or clinic] *facilities of the Tribal Health Program* that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to [facilities of such type under the medicare or medicaid programs. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—] *such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and Tribal Health Programs, any health care related purpose, or otherwise to achieve the objectives provided in section 3 of this Act.*

[(A) solely for improving the health resources deficiency level of the Indian tribe; and

[(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

[(2) Audits

[The amounts paid to the hospitals and clinics participating in the program established under this section]

(B) AUDITS.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be subject to all auditing requirements applicable to [programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

[(3) Secretarial oversight

[The Secretary shall monitor the performance of hospitals and clinics participating in the program established under this section, and shall require such hospitals and clinics to submit reports on the program to the Secretary on an annual basis.

[(4) No payments from special funds

[Notwithstanding section 1395qq(c) of Title 42 or section 602(a) of Title 42, no payment may be made out of the special funds described in such sections for the benefit of any hospital

or clinic during the period that the hospital or clinic participates in the program established under this section.

[(c) Requirements for participation

[(1) Application

[Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the [Secretary that—

[(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;

[(B) the facility is eligible to participate in the medicare or medicaid programs under section 1395qq or 1396j of Title 42;

[(C) the facility meets the requirements that apply to programs operated directly by the Service; and

[(D) the facility—

[(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or

[(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.

[(2) Approval

[(A) In general

[The Secretary shall review and approve a qualified application not later than 90 days after the date the application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.

[(B) Grandfather of demonstration program participants

[Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999 shall be deemed approved for participation in the program established under this section and shall not be required to submit an application in order to participate in the program.

[(C) Duration

[An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved applicant or the deemed approved demonstration program meets the requirements of this section.

[(d) Examination and implementation of changes

[(1) In general] *the program under such title, as well as all auditing requirements applicable to programs administered by an Indian Health Program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.*

(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any Tribal Health Program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, shall provide to the Service a list of each provider en-

rollment number (or other identifier) under which such Program receives such reimbursements or payments.

(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

(A) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the [Health Care Financing Administration] *Centers for Medicare & Medicaid Services*, shall examine on an ongoing basis and implement[— (A)] any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this [section] *subsection*, including any agreements with States that may be necessary to provide for direct billing under the [medicaid] *a* program[; and] *under a title of the Social Security Act.*

[(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.

[(2) Accounting information

[The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

[(e) Withdrawal from program]

(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services with copies of the lists submitted to the Service under paragraph (2)(C), enrollment data regarding patients served by the Service (and by Tribal Health Programs, to the extent such data is available to the Service), and such other information as the Administrator may require for purposes of administering title XVIII, XIX, or XXI of the Social Security Act.

[A participant in]

(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this [section] *subsection* may withdraw from participation in the same manner and under the same conditions that [a tribe or tribal organization] *an Indian Tribe or Tribal Organization* may retrocede a contracted program to the Secretary under *the* authority of the Indian Self-Determination *and Education Assistance* Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this [section] *subsection* shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

(5) TERMINATION FOR FAILURE TO COMPLY WITH REQUIREMENTS.—The Secretary may terminate the participation of a Tribal Health Program or in the direct billing program estab-

lished under this subsection if the Secretary determines that the Program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a Tribal Health Program with notice of a determination that the Program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the Program's participation in the direct billing program established under this subsection.

(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.

SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—From funds appropriated to carry out this title in accordance with section 416, the Secretary, acting through the Service, shall make grants to or enter into contracts with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and administering programs on or near reservations and trust lands to assist individual Indians—

(1) to enroll for benefits under a program established under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes or Tribal Organizations being served based on a schedule of income levels developed or implemented by such Tribe, Tribes, or Tribal Organizations).

(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section. Such conditions shall include requirements that the Indian Tribe or Tribal Organization successfully undertake—

(1) to determine the population of Indians eligible for the benefits described in subsection (a);

(2) to educate Indians with respect to the benefits available under the respective programs;

(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to Urban Indian Organizations with respect to populations served by such organizations in the same manner they apply to grants and contracts with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

(A) consistent with the requirements imposed by the Secretary under subsection (b);

(B) appropriate to Urban Indian Organizations and Urban Indians; and

(C) necessary to effect the purposes of this section.

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

(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements between the Secretary, acting through the Service, and Indian Tribes, Tribal Organizations, and Urban Indian Organizations for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and State children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

(f) DEFINITION OF PREMIUMS AND COST SHARING.—In this section:

(1) PREMIUM.—The term "premium" includes any enrollment fee or similar charge.

(2) COST SHARING.—The term "cost sharing" includes any deduction, deductible, copayment, coinsurance, or similar charge.

SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian Tribe, or Tribal Organization in providing health services through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

(1) such services had been provided by a nongovernmental provider; and

(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

(1) workers' compensation laws; or

(2) a no-fault automobile accident insurance plan or program.

(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

(e) ENFORCEMENT.—

(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

(A) intervening or joining in any civil action or proceeding brought—

(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

(ii) by any representative or heirs of such individual, or

(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

(3) RECOVERY FROM TORTFEASORS.—

(A) IN GENERAL.—In any case in which an Indian Tribe or Tribal Organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian Tribe or Tribal Organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

(B) TREATMENT.—The right of an Indian Tribe or Tribal Organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian Tribe or Tribal Organization.

(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

(h) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to Urban Indian Organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with respect to populations served by such Indian Tribes and Tribal Organizations.

(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws.

SEC. 404. CREDITING OF REIMBURSEMENTS.

(a) USE OF AMOUNTS.—

(1) RETENTION BY PROGRAM.—Except as provided in section 202(f) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an Urban Indian Organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

(A) Titles XVIII, XIX, and XXI of the Social Security Act.
(B) This Act, including section 807.
(C) Public Law 87–693.
(D) Any other provision of law.

(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

SEC. 405. PURCHASING HEALTH CARE COVERAGE.

(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health benefits for Service beneficiaries, Indian Tribes, Tribal Organizations, and Urban Indian Organizations may use such amounts to purchase health benefits coverage for such beneficiaries in any manner, including through—

(1) a tribally owned and operated health care plan;
(2) a State or locally authorized or licensed health care plan;
(3) a health insurance provider or managed care organization; or
(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

(2) the quality of health care services provided to any Indian through the Service;

(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

SEC. 407. PAYOR OF LAST RESORT.

Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

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

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

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

(b) APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—

(1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organi-

zation that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

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

(3) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).

SEC. 409. CONSULTATION.

For provisions related to consultation with representatives of Indian Health Programs and Urban Indian Organizations with respect to the health care programs established under titles XVIII, XIX, and XXI of the Social Security Act, see section 1139(d) of the Social Security Act (42 U.S.C. 1320b–9(d)).

SEC. 410. STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

For provisions relating to—

(1) outreach to families of Indian children likely to be eligible for child health assistance under the State children's health insurance program established under title XXI of the Social Security Act, see sections 2105(c)(2)(C) and 1139(a) of such Act (42 U.S.C. 1397ee(c)(2), 1320b–9); and

(2) ensuring that child health assistance is provided under such program to targeted low-income children who are Indians and that payments are made under such program to Indian Health Programs and Urban Indian Organizations operating in the State that provide such assistance, see sections 2102(b)(3)(D) and 2105(c)(6)(B) of such Act (42 U.S.C. 1397bb(b)(3)(D), 1397ee(c)(6)(B)).

SEC. 411. EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS AND SAFE HARBOR TRANSACTIONS UNDER THE SOCIAL SECURITY ACT.

For provisions relating to—

(1) exclusion waiver authority for affected Indian Health Programs under the Social Security Act, see section 1128(k) of the Social Security Act (42 U.S.C. 1320a–7(k)); and

(2) certain transactions involving Indian Health Programs deemed to be in safe harbors under that Act, see section 1128B(b)(4) of the Social Security Act (42 U.S.C. 1320a–7b(b)(4)).

SEC. 412. PREMIUM AND COST SHARING PROTECTIONS AND ELIGIBILITY DETERMINATIONS UNDER MEDICAID AND SCHIP AND PROTECTION OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.

For provisions relating to—

(1) premiums or cost sharing protections for Indians furnished items or services directly by Indian Health Programs or through referral under the contract health service under the Medicaid program established under title XIX of the Social Security Act, see sections 1916(j) and 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o(j), 1396o–1(a)(1));

(2) rules regarding the treatment of certain property for purposes of determining eligibility under such programs, see sections 1902(e)(13) and 2107(e)(1)(B) of such Act (42 U.S.C. 1396a(e)(13), 1397gg(e)(1)(B)); and

(3) the protection of certain property from estate recovery provisions under the Medicaid program, see section 1917(b)(3)(B) of such Act (42 U.S.C. 1396p(b)(3)(B)).

SEC. 413. TREATMENT UNDER MEDICAID AND SCHIP MANAGED CARE.

For provisions relating to the treatment of Indians enrolled in a managed care entity under the Medicaid program under title XIX of the Social Security Act and Indian Health Programs and Urban Indian Organizations that are providers of items or services to such Indian enrollees, see sections 1932(h) and 2107(e)(1)(H) of the Social Security Act (42 U.S.C. 1396u–2(h), 1397gg(e)(1)(H)).

SEC. 414. NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

(c) REPORT.—Not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

(1) the results of the study under this section;

(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

[§ 1646. Authorization for emergency contract health services]

SEC. 415. GENERAL EXCEPTIONS.

[With respect to an elderly or disabled Indian receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.]

The requirements of this title shall not apply to any excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91).

[§ 1647. Authorization of appropriations]

SEC. 416. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year [2000] *2017* to carry out this [subchapter] *title.*

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

[§ 1651. Purpose]

SEC. 501. PURPOSE.

The purpose of this [subchapter] *title* is to establish *and maintain* programs in [urban centers] *Urban Centers* to make health services more accessible *and available* to [urban] *Urban* Indians.

[§ 1652. Contracts with, and grants to, urban Indian organizations]

SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

Under authority of the Act of November 2, 1921 (25 U.S.C. 13), [popularly] *(commonly* known as the "Snyder Act"), the Secretary, *acting* through the Service, shall enter into contracts with, or make grants to, [urban] *Urban* Indian [organizations] *Organizations* to assist such organizations in the establishment and administration,

within [the urban centers in which such organizations are situated] *Urban Centers*, of programs which meet the requirements set forth in this [subchapter. The] *title. Subject to section 506, the* Secretary, *acting* through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this [subchapter] *title* in any contract *into* which the Secretary enters [into] with, or in any grant the Secretary makes to, any [urban] *Urban* Indian [organization] *Organization* pursuant to this [subchapter] *title*.

[§ 1653. Contracts and grants for the provision of health care and referral services]

SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

(a) REQUIREMENTS FOR GRANTS AND CONTRACTS.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] *(commonly* known as the "Snyder Act"*),* the Secretary, *acting* through the Service, shall enter into contracts with, [or] *and* make grants to, [urban] *Urban* Indian [organizations] *Organizations* for the provision of health care and referral services for [urban Indians residing in the urban centers in which such organizations are situated] *Urban Indians*. Any such contract or grant shall include requirements that the [urban] *Urban* Indian [organization] *Organization* successfully undertake to—

(1) estimate the population of [urban] *Urban* Indians residing in the [urban center in which such] *Urban Center or centers that the* organization [is situated] *proposes to serve* who are or could be recipients of health care or referral services;

(2) estimate the current health status of [urban] *Urban* Indians residing in such [urban center] *Urban Center or centers*;

(3) estimate the current health care needs of [urban] *Urban* Indians residing in such [urban center] *Urban Center or centers*;

[(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

[(5) determine the use of public and private health services resources by the urban Indians residing in such urban center;

[(6) assist such health services resources in providing services to urban Indians;

[(7) assist urban Indians in becoming familiar with and utilizing such health services resources;]

[(8)] (4) provide basic health education, including health promotion and disease prevention education, to [urban] *Urban* Indians;

[(9) establish and implement training programs to accomplish the referral and education tasks set forth in paragraphs (6) through (8) of this subsection;

[(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;]

[(11)] *(5)* make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of [urban] *Urban* Indians; and

[(12)] *(6)* where necessary, provide, or enter into contracts for the provision of, health care services for [urban] *Urban* Indians.

(b) CRITERIA FOR SELECTION OF ORGANIZATIONS TO ENTER INTO CONTRACTS OR RECEIVE GRANTS.—THE SECRETARY, *acting* through the Service, shall, by regulation, prescribe the criteria for selecting [urban] *Urban* Indian [organizations] *Organizations* to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

(1) the extent of unmet health care needs of [urban] *Urban* Indians in the [urban center] *Urban Center or centers* involved;

(2) the size of the [urban] *Urban* Indian population in the [urban center] *Urban Center or centers* involved;

[(3) the accessibility to, and utilization of, health care services (other than services provided under this subchapter) by urban Indians in the urban center involved;]

[(4)] (3) the extent, if any, to which the activities set forth in subsection (a) [of this section] would duplicate[— (A) any previous or] *any project funded under this title, or under any* current public [or private health services project in an urban center that was or is] *health service project* funded in a manner other than pursuant to this [subchapter; or] *title;*

[(B) any project funded under this subchapter;]

[(5)] *(4)* the capability of an [urban] *Urban* Indian [organization] *Organization* to perform the activities set forth in subsection [(a) of this section] and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

[(6)] *(5)* the satisfactory performance and successful completion by an [urban] *Urban* Indian [organization] *Organization* of other contracts with the Secretary under this [subchapter;] *title*;

[(7)] *(6)* the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) [of this section in an urban center; and] *in an Urban Center or centers; and*

[(8)] *(7)* the extent of existing or likely future participation in the activities set forth in subsection (a) [of this section] by appropriate health and health-related Federal, State, local, and other agencies.

[(c) Grants for health promotion and disease prevention services]

(c) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for [urban] *Urban* Indians through grants made to [urban] Urban Indian [organizations] *Organizations* administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section].

[(d) Grants for immunization services]

(d) IMMUNIZATION SERVICES.—

[(1)] *(1) ACCESS OR SERVICES PROVIDED.*—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for [urban] *Urban* Indians through grants made to [urban] *Urban* Indian [organizations] *Organi-*

zations administering contracts entered into [pursuant to this section] or receiving grants under [subsection (a) of] this section.

[(2) In making any grant to carry out this subsection, the Secretary shall take into consideration—

[(A) the size of the urban Indian population to be served;

[(B) the immunization levels of the urban Indian population, particularly the immunization levels of infants, children, and the elderly;

[(C) the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population; and

[(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.]

[(3)] *(2) DEFINITION.*—For purposes of this subsection, the term "immunization services" means services to provide without charge immunizations against vaccine-preventable diseases.

[(e) Grants for mental health services]

(e) BEHAVIORAL HEALTH SERVICES.—

[(1)] *(1) ACCESS OR SERVICES PROVIDED.*—The Secretary, acting through the Service, shall facilitate access to, or provide, [mental] *behavioral* health services for [urban] *Urban* Indians through grants made to [urban] *Urban* Indian [organizations] *Organizations* administering contracts entered into [pursuant to this section] or receiving grants under subsection [(a) of this section].

[(2)A] *(2) ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a* grant may not be made under this subsection to an [urban] *Urban* Indian [organization] *Organization* until that organization has prepared, and the Service has approved, an assessment of the [mental] *following:*

(A) The behavioral health needs of the [urban] *Urban* Indian population concerned*,* [the mental].

(B) The behavioral health services and other related resources available to that population[, the] .

(C) The barriers to obtaining those services and resources, [and the] .

(D) The needs that are unmet by such services and resources.

(3) *PURPOSES OF GRANTS.*—Grants may be made under this subsection[—]*for the following*:

(A) [to] *To* prepare assessments required under paragraph (2)[;] .

(B) [to] *To* provide outreach, educational, and referral services to [urban] *Urban* Indians regarding the availability of direct [mental] *behavioral* health services, to educate [urban] *Urban* Indians about [mental] *behavioral* health issues and services, and effect coordination with existing [mental] *behavioral* health providers in order to improve services to [urban] *Urban* Indians[;] .

(C) [to] *To* provide outpatient [mental] *behavioral* health services to [urban] *Urban* Indians, including the

identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment[; and] .

(D) [to] *To* develop innovative [mental] *behavioral* health service delivery models which incorporate Indian cultural support systems and resources.

[(f) Grants for prevention and treatment of child abuse]

(f) PREVENTION OF CHILD ABUSE.—

[(1)] *(1) ACCESS OR SERVICES PROVIDED.*—The Secretary, acting through the Service, shall facilitate access to[,] or provide[,] services for [urban] *Urban* Indians through grants to [urban] *Urban* Indian [organizations] *Organizations* administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section] to prevent and treat child abuse (including sexual abuse) among [urban] *Urban* Indians.

[(2) A] *(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a* grant may not be made under this subsection to an [urban] *Urban* Indian [organization] *Organization* until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the [urban] *Urban* Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

(3) PURPOSES OF GRANTS.—Grants may be made under this subsection[—] *for the following:*

(A) [to] *To* prepare assessments required under paragraph (2)[;] .

(B) [for] *For* the development of prevention, training, and education programs for [urban Indian populations] *Urban Indians*, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection[; and] .

(C) [to] *To* provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to [urban] *Urban* Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to [urban] *Urban* Indian perpetrators of child abuse (including sexual abuse).

[(4)] *(4) CONSIDERATIONS WHEN MAKING GRANTS.*—In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the support for the [urban] *Urban* Indian [organization] *Organization* demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

(B) the capability and expertise demonstrated by the [urban] *Urban* Indian [organization] *Organization* to address the complex problem of child sexual abuse in the community; and

(C) the assessment required under paragraph (2).

(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an Urban Indian Organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

[(C) the assessment required under paragraph (2).]

[§ 1654. Contracts and grants for determination of unmet health care needs]

[(a) Authority] *(a) GRANTS AND CONTRACTS AUTHORIZED.*—Under authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] *(commonly* known as the "Snyder Act"), the Secretary, *acting* through the Service, may enter into contracts with[,] or make grants to[, urban] *Urban* Indian [organizations] *Organizations* situated in [urban centers] *Urban Centers* for which contracts have not been entered into[,] or grants have not been made[,] under section [1653 of this title.] *503.*

(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection [(b)] *(c)*(1) in order to assist the Secretary in assessing the health status and health care needs of [urban] *Urban* Indians in the [urban center] *Urban Center* involved and determining whether the Secretary should enter into a contract or make a grant under section [1653 of this title] *503* with respect to the [urban] *Urban* Indian [organization] *Organization* which the Secretary has entered into a contract with, or made a grant to, under this section.

[(b)] *(c) GRANT AND CONTRACT REQUIREMENTS.*—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

(1) the [urban] *Urban* Indian [organization] *Organization* successfully [undertake] *undertakes* to—

(A) document the health care status and unmet health care needs of [urban] *Urban* Indians in the [urban center] *Urban Center* involved; and

(B) with respect to [urban] *Urban* Indians in the [urban center] *Urban Center* involved, determine the matters described in [clauses] *paragraphs* (2), (3), (4), and [(8)] *(7)* of section [1653] *503*(b) [of this title]; and

(2) the [urban] *Urban* Indian [organization] *Organization* complete performance of the contract, or carry out the requirements of the grant, within [one] *1* year after the date on which the Secretary and such organization enter into such contract, or within [one] *1* year after such organization receives such grant, whichever is applicable.

[(c) Renewal] *(d) NO RENEWALS.*—The Secretary may not renew any contract entered into[,] or grant made[,] under this section.

SEC. 505. EVALUATIONS; RENEWALS.

[§ 1655.] *(a) PROCEDURES FOR EVALUATIONS*[; renewals]

[(a) Contract compliance and performance].—The Secretary, *acting* through the Service, shall develop procedures to evaluate compliance with grant requirements [under this subchapter] and com-

pliance with[,] and performance of contracts entered into by [urban] *Urban* Indian [organizations] *Organizations* under this [subchapter] *title.* Such procedures shall include provisions for carrying out the requirements of this section.

[(b) Annual onsite evaluation]

(b) EVALUATIONS.—The Secretary, *acting* through the Service, shall [conduct an annual onsite evaluation of each urban Indian organization] *evaluate the compliance of each Urban Indian Organization* which has entered into a contract or received a grant under section [1653 of this title for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract or the terms of such] *503 with the terms of such contract or* grant. *For purposes of this evaluation, the Secretary shall—*

(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

(c) NONCOMPLIANCE [or unsatisfactory performance]*; UNSATISFACTORY PERFORMANCE.*—If, as a result of the evaluations conducted under this section, the Secretary determines that an [urban] *Urban* Indian [organization] *Organization* has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section [1653 of this title,] *503,* the Secretary shall, prior to renewing such contract or grant, attempt to resolve with [such] *the* organization the areas of noncompliance or unsatisfactory performance and modify [such] *the* contract *or grant* to prevent future occurrences of [such] noncompliance or unsatisfactory performance. If the Secretary determines that [such] *the* noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew [such] *the* contract *or grant* with [such] *the* organization and is authorized to enter into a contract or make a grant under section [1653 of this title] *503* with another [urban] *Urban* Indian [organization] *Organization* which is situated in the same [urban center] *Urban Center* as the [urban] *Urban* Indian [organization] *Organization* whose contract or grant is not renewed under this section.

[(d) Contract and grant renewals]

(d) CONSIDERATIONS FOR RENEWALS.—In determining whether to renew a contract or grant with an [urban] *Urban* Indian [organization] *Organization* under section [1653 of this title] *503* which has completed performance of a contract or grant under section [1654 of this title,] *504,* the Secretary shall review the records of the [urban] *Urban* Indian [organization] *Organization*, the reports submitted under section [1657 of this title, and, in the case of a renewal of a contract or grant under section 1653 of this title,] *507, and* shall consider the results of the onsite evaluations [conducted] *or accreditations* under subsection (b) [of this section].

[§ 1656. Other contract and grant requirements]

SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

[(a) Federal regulations; exceptions]

(a) PROCUREMENT.—Contracts with [urban Indian organizations] *Urban Indian Organizations* entered into pursuant to this [subchapter] *title* shall be in accordance with all Federal contracting laws and regulations *relating to procurement* except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of [the Act of August 24, 1935 (40 U.S.C 270a, et seq.).] *sections 1304 and 3131 through 3133 of title 40, United States Code.*

[(b) Payment]

(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—

(1) IN GENERAL.—Payments under any contracts or grants pursuant to this [subchapter may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this subchapter.] *title, notwithstanding any term or condition of such contract or grant—*

(A) may be made in a single advance payment by the Secretary to the Urban Indian Organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such a single advance payment; and

(B) if any portion thereof is unexpended by the Urban Indian Organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the availability for expenditure of such funds.

(2) SEMIANNUAL AND QUARTERLY PAYMENTS AND REIMBURSEMENTS.—If the Secretary determines under paragraph (1)(A) that an Urban Indian organization is not capable of administering an entire single advance payment, on request of the Urban Indian Organization, the payments may be made—

(A) in semiannual or quarterly payments by not later than 30 days after the date on which the funding period with respect to which the payments apply begins; or

(B) by way of reimbursement.

(c) REVISION OR [amendment] *AMENDMENT OF CONTRACTS.*—Notwithstanding any provision of law to the contrary, the Secretary may, at the request [or] *and* consent of an [urban] *Urban* Indian [organization] *Organization,* revise or amend any contract entered into by the Secretary with such organization under this [subchapter] *title* as necessary to carry out the purposes of this [subchapter] *title.*

[(d) Existing Government facilities]

[In connection with any contract or grant entered into pursuant to this subchapter, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract or grant, exist-

ing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.]

[(e)] *(d) FAIR AND UNIFORM* [provision of services and assistance] *SERVICES AND ASSISTANCE.*—Contracts with, or grants to[, urban] *Urban* Indian [organizations] *Organizations* and regulations adopted pursuant to this [subchapter] *title* shall include provisions to assure the fair and uniform provision to [urban] *Urban* Indians of services and assistance under such contracts or grants by such organizations.

[(f) Eligibility for health care or referral services

[Urban Indians, as defined in section 1603(f) of this title, shall be eligible for health care or referral services provided pursuant to this subchapter.]

SEC. 507. REPORTS AND RECORDS.

[§ 1657.] *(a)* REPORTS [and records].—

[(a) Quarterly reports]

(1) IN GENERAL.—For each fiscal year during which an [urban] *Urban* Indian [organization] *Organization* receives or expends funds pursuant to a contract entered into[,] or a grant received[,] pursuant to this [subchapter] *title*, such [organization] *Urban Indian Organization* shall submit to the Secretary [a quarterly report including—] *not more frequently than every 6 months, a report that includes the following:*

[(1)] *(A)* [in] *In* the case of a contract or grant under section [1653 of this title, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;] *503, recommendations pursuant to section 503(a)(5).*

[(2) information] *(B) Information* on activities conducted by the organization pursuant to the contract or grant[;].

[(3)] *(C)* [an] *An* accounting of the amounts and [purposes] *purpose* for which Federal funds were expended[; and].

[(4) such other information as the Secretary may request.]

(D) A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with Urban Indian Organizations.

(2) HEALTH STATUS AND SERVICES.—

(A) IN GENERAL.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, acting through the Service, shall submit to Congress a report evaluating—

(i) the health status of Urban Indians;

(ii) the services provided to Indians pursuant to this title; and

(iii) areas of unmet needs in the delivery of health services to Urban Indians.

(B) CONSULTATION AND CONTRACTS.—In preparing the report under paragraph (1), the Secretary—

(i) shall consult with Urban Indian Organizations; and

(ii) may enter into a contract with a national organization representing Urban Indian Organizations to conduct any aspect of the report.

(b) AUDIT [by Secretary and Comptroller General].—The reports and records of the [urban] *Urban* Indian [organization] *Organization* with respect to a contract or grant under this [subchapter] *title* shall be subject to audit by the Secretary and the Comptroller General of the United States.

(c) [Cost] *COSTS OF* [annual private audit] *AUDITS*.—The Secretary shall allow as a cost of any contract or grant entered into *or awarded* under section [1653 of this title] *502 or 503* the cost of an annual [private] *independent financial* audit conducted by—

(1) a certified public accountant[.] *; or*

[(d) Health status, services, and areas of unmet needs; child welfare

[(1) The Secretary, acting through the Service, shall submit a report to the Congress not later than March 31, 1992, evaluating—

[(A) the health status of urban Indians;

[(B) the services provided to Indians through this subchapter;

[(C) areas of unmet needs in urban areas served under this subchapter; and

[(D) areas of unmet needs in urban areas not served under this subchapter.

[(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

[(3) The Secretary and the Secretary of the Interior, shall]

(2) a certified public accounting firm qualified to conduct Federal compliance audits.

SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

[(A) assess the status of the welfare of urban Indian children, including the volume of child protection cases, the prevalence of child sexual abuse, and the extent of urban Indian coordination with tribal authorities with respect to child sexual abuse; and

[(B) submit a report on the assessment required under subparagraph (A), together with recommended legislation to improve Indian child protection in urban Indian populations, to the Congress no later than March 31, 1992.]

[§ 1658. Limitation on contract authority]

The authority of the Secretary to enter into contracts *or to award grants* under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

[§ 1659. Facilities renovation]

SEC. 509. FACILITIES.

(a) GRANTS.—The Secretary, *acting through the Service,* may make [funds available] *grants* to contractors or grant recipients under this [subchapter for minor renovations to] *title for the lease, purchase, renovation, construction, or expansion of* facilities, including leased facilities, *in order* to assist such contractors or grant recipients in [meeting or maintaining the Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards] *complying with applicable licensure or certification requirements.*

(b) LOAN FUND STUDY.—The Secretary, acting through the Service, may carry out a study to determine the feasibility of establishing a loan fund to provide to Urban Indian Organizations direct loans or guarantees for loans for the construction of health care facilities in a manner consistent with section 309, including by submitting a report in accordance with subsection (c) of that section.

[§ 1660. Urban Health Programs Branch]

SEC. 510. DIVISION OF URBAN INDIAN HEALTH.

[(a) Establishment

There is [hereby] established within the Service a [Branch] *Division* of Urban *Indian* Health[Programs], which shall be responsible for—

(1) carrying out the provisions of this [subchapter and for] *title;*

(2) providing central oversight of the programs and services authorized under this [subchapter.] *title; and*

[(b) Staff, services, and equipment

[The Secretary shall appoint such employees to work in the branch, including a program director, and shall provide such services and equipment, as may be necessary for it to carry out its responsibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request.]

(3) providing technical assistance to Urban Indian Organizations.

[§ 1660a. Grants for alcohol and substance abuse related services

SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

[(a) Grants]

[The Secretary] *(a)* GRANTS AUTHORIZED.—*The Secretary, acting through the Service,* may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education [in] *regarding*, alcohol and substance abuse in [urban centers] *Urban Centers* to those [urban] *Urban* Indian [organizations] *Organizations* with [whom] *which* the Secretary has entered into a contract under this [subchapter] *title* or under section [1621 of this title.] *201.*

(b) GOALS [of grant].—Each grant made pursuant to subsection (a) [of this section] shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) of this section, including criteria relating to the[—] *following:*

(1) *The* size of the [urban] *Urban* Indian population[;].

[(2) accessibility to, and utilization of, other health resources available to such population;

[(3) duplication of existing Service or other Federal grants or contracts;

[(4) capability of the organization to adequately perform the activities required under the grant;]

(2) Capability of the organization to adequately perform the activities required under the grant.

[(5) satisfactory] *(3) Satisfactory* performance standards for the organization in meeting the goals set forth in such grant[, which]. *The* standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis[; and].

[(6) identification of] *(4) Identification of the* need for services.

(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on [such] *the* criteria *established pursuant to subsection (c).*

[(d) Treatment of funds received by urban Indian organizationsAny funds]

(e) GRANTS SUBJECT TO CRITERIA.—Any grant received by an [urban] *Urban* Indian [organization] *Organization* under this [chapter] *Act* for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c)[of this section].

[§1660b. Treatment of certain demonstration projects]

SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

[(a)] Notwithstanding any other provision of law, the *Tulsa Clinic and* Oklahoma City Clinic demonstration [project and the Tulsa Clinic demonstration project shall be treated as service units] *projects shall—*

(1) be permanent programs within the Service's direct care program;

(2) continue to be treated as Service Units and Operating Units in the allocation of resources and coordination of care*; and*

(3) continue to meet the requirements and definitions of an Urban Indian Organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination *and Education Assistance* Act [[](25 U.S.C.[A. § 450f et seq.] for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.] *450 et seq.).*

[(b) The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects specified in subsection (a) of this section.

[(c) In addition to the amounts made available under section 1660d of this title to carry out this section through fiscal year 2000, there are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2001 and 2002.]

[§ 1660c. Urban NIAAA transferred programs]

SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

[(a) Duty of Secretary

[The Secretary shall, within]

(a) GRANTS AND CONTRACTS.—The Secretary, through the [Branch] *Division* of Urban [Health Programs of the Service,] *Indian Health, shall* make grants or enter into contracts *with Urban Indian Organizations, to take effect not later than September 30, 2010,* for the administration of [urban] *Urban* Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as "NIAAA") and transferred to the Service.

(b) USE OF [grants] *FUNDS.*—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for [urban] *Urban* Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

(c) ELIGIBILITY [for grants].—Urban Indian [organizations] *Organizations* that operate Indian alcohol programs originally funded under *the* NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

[(d) Combination of funds

[For the purpose of carrying out this section, the Secretary may combine NIAAA alcohol funds with other substance abuse funds currently administered through the Branch of Urban Health Programs of the Service.

[(e) Evaluation and report to Congress]

(d) REPORT.—The Secretary shall evaluate and report to [the] Congress on the activities of programs funded under this section [at least] *not less than* every 5 years.

SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—The Secretary shall ensure that the Service consults, to the greatest extent practicable, with Urban Indian Organizations.

(b) DEFINITION OF CONSULTATION.—For purposes of subsection (a), consultation is the open and free exchange of information and opinions which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

SEC. 515. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, through grant or contract, is authorized to fund the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

(b) DEFINITION OF STATE.—A State described in this subsection is a State in which—

(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and

(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

SEC. 516. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

(a) GRANTS AUTHORIZED.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract

or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

(1) the size and location of the Urban Indian population to be served;

(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served;

(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

(4) the capability of the organization to adequately perform the activities required under the grant; and

(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

SEC. 517. COMMUNITY HEALTH REPRESENTATIVES.

The Secretary, acting through the Service, may enter into contracts with, and make grants to, Urban Indian Organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to Urban Indians.

SEC. 518. EFFECTIVE DATE.

The amendments made by the Indian Health Care Improvement Act Amendments of 2007 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

SEC. 519. ELIGIBILITY FOR SERVICES.

Urban Indians shall be eligible for, and the ultimate beneficiaries of, health care or referral services provided pursuant to this title.

[§ 1660d. Authorization of appropriations]

SEC. 520. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year [2000] *2017* to carry out this [subchapter] *title.*

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

[§ 1661. Establishment of the Indian Health Service as an agency of Public Health Service]

SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian [tribes] *Tribes,* as are or may be [on and after November 23, 1988,] *hereafter* provided by Federal statute or treaties, there is established within the Public Health Service of the Department [of Health and Human Services] the Indian Health Service.

(2) ASSISTANT SECRETARY FOR INDIAN HEALTH.—The [Indian Health] Service shall be administered by [a Director] *an Assistant Secretary for Indian Health,* who shall be appointed by the President, by and with the advice and consent of the Senate. The [Director of the Indian Health Service] *Assistant Secretary* shall report to the Secretary [through the Assistant Secretary for Health of the Department of Health and Human Services]. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, [1993,] *2007,* the term of service of the [Director] *Assistant Secretary* shall be 4 years. [A Director] *An Assistant Secretary* may serve more than 1 term.

(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 shall serve as Assistant Secretary.

(4) ADVOCACY AND CONSULTATION.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

(A) facilitate advocacy for the development of appropriate Indian health policy; and

(B) promote consultation on matters relating to Indian health.

(b) AGENCY.—[status] The [Indian Health]Service shall be an agency within the Public Health Service of the Department [of Health and Human Services], and shall not be an office, component, or unit of any other agency of the Department.

(c) DUTIES.—The *Assistant* Secretary shall [carry out through the Director of the Indian Health Service]—

(1) *perform* all functions [which] *that* were, on the day before [November 23, 1988,] *the date of enactment of the Indian Health Care Improvement Act Amendments of 2007,* carried out by or under the direction of the individual serving as Director of the [Indian Health]Service on[such] *that* day;

(2) *perform* all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

(3) *administer* all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including[(but not limited to)]programs under—

(A) this[chapter] *Act;*

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1954 (42 U.S.C. [2001,] *2001* et seq.);

(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

(E) the Indian Self-Determination *and Education Assistance* Act (25 U.S.C. 450[f] et seq.); [and]

(4) *administer* all scholarship and loan functions carried out under [subchapter I of this chapter.] *title I;*

(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

(9) coordinate the activities of the Department concerning matters of Indian health; and

(10) perform such other functions as the Secretary may designate.

(d) AUTHORITY [of Secretary].—

(1) *IN GENERAL.*—The Secretary, acting through the [Director of the Indian Health Service] *Assistant Secretary*, shall have the authority—

(A) except to the extent provided *for* in paragraph (2), to appoint and compensate employees for the Service in accordance with [Title 5] *title 5, United States Code*;

(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) *PERSONNEL ACTIONS.*—Notwithstanding any other *provision of* law, the provisions of section [472 of this title] *12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472)*, shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a)[of this section].

(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

[§ 1662. Automated management information system]

SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

(a) *ESTABLISHMENT.*—

(1) *IN GENERAL.*—The Secretary shall establish an automated management information system for the Service.

(2) *REQUIREMENTS OF SYSTEM.*—The information system established under paragraph (1) shall include—

(A) a financial management system**[**,**]***;*

(B) a patient care information system for each area served by the Service**[**,**]***;*

(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service**[**, and**]***;*

(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each **[**area**]** *Area* office of the Service*;*

(E) an interface mechanism for patient billing and accounts receivable system; and

(F) a training component.

(b) *PROVISION* **[**to Indian tribes and organizations; reimbursement (1) The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.**]** *OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Tribal Health Program* automated management information systems which—

[(A)**]** *(1)* meet the management information needs of such **[**Indian tribe or tribal organization**]***Tribal Health Program* with respect to the treatment by the **[**Indian tribe or tribal organization**]** *Tribal Health Program* of patients of the Service**[**,**]***;* and

[(B)**]** *(2)* meet the management information needs of the Service.

[(2) The Secretary shall reimburse each Indian tribe or tribal organization for the part of the cost of the operation of a system provided under paragraph (1) which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Service.

[(3) The Secretary shall provide systems under paragraph (1) to Indian tribes and tribal organizations providing health services in California by no later than September 30, 1990.**]**

(c) *ACCESS TO* **[**records**]** *RECORDS.*—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

[§ 1663. Authorization of appropriations]

SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

There **[**are**]** *is* authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year **[**2000**]** *2017* to carry out this **[**subchapter**]** *title*.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

(a) PURPOSES.—The purposes of this section are as follows:

(1) To authorize and direct the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

(b) PLANS.—

(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

(ii) an estimate of the financial and human cost attributable to such illness or behavior.

(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and Urban

Indian Organizations to meet their responsibilities under the plans.

(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, Urban Indian Organization, or the Service.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

(c) PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, to the extent feasible and if funding is available, programs including the following:

(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

(B) detoxification (social and medical);

(C) acute hospitalization;

(D) intensive outpatient/day treatment;

(E) residential treatment;

(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

(G) emergency shelter;

(H) intensive case management; and

(I) diagnostic services.

(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

(C) identification and treatment of co-occurring disorders and comorbidity;

(D) prevention of alcohol, drug, inhalant, and tobacco use;

(E) early intervention, treatment, and aftercare;

(F) promotion of healthy approaches to risk and safety issues; and

(G) identification and treatment of neglect and physical, mental, and sexual abuse.

(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of healthy approaches for risk-related behavior;

(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

(F) sex specific treatment for sexual assault and domestic violence.

(4) FAMILY CARE.—Behavioral health services for families, including—

(A) early intervention, treatment, and aftercare for affected families;

(B) treatment for sexual assault and domestic violence; and

(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of healthy approaches to managing conditions related to aging;

(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

(F) identification and treatment of dementias regardless of cause.

(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization in the development and implementation of such plan.

(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

SEC. 702. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

(a) CONTENTS.—Not later than 12 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

(B) The right of Indians to participate in, and receive the benefit of, such services.

(C) The actions necessary to protect the exercise of such right.

(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral

health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

[§ 1665. Indian Health Service responsibilities]

(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

[The Memorandum of Agreement]

(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to [section 2411 of this title] *subsection (a)* shall include specific provisions pursuant to which the Service shall assume responsibility for—

(1) the determination of the scope of the problem of alcohol and substance abuse among [Indian people] *Indians*, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and Urban Indian Organization.

SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

[§ 1665a. Indian Health Service program]

(a) ESTABLISHMENT.—

[(a) Comprehensive prevention and treatment program]

(1) *IN GENERAL.*—The Secretary, acting through the Service, *Indian Tribes, and Tribal Organizations,* shall provide a program of comprehensive [alcohol and substance abuse preven-

tion and treatment] *behavioral health, prevention, treatment, and aftercare,* which shall include—

(A) prevention, through educational intervention, in Indian communities;

(B) acute detoxification [and treatment;], *psychiatric hospitalization, residential, and intensive outpatient treatment;*

(C) community-based rehabilitation[;] *and aftercare;*

(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; [and]

(E) *specialized* residential treatment programs for *high-risk populations, including* pregnant and [post partum] *postpartum* women and their children*; and*

(F) diagnostic services.

(2) *TARGET POPULATIONS.*—The target population of such [program] *programs* shall be members of Indian [tribes] *Tribes.* Efforts to train and educate key members of the Indian community shall *also* target employees of health, education, judicial, law enforcement, legal, and social service programs.

(b) CONTRACT [health services] *HEALTH SERVICES.*—

(1) *IN GENERAL.*—The Secretary, acting through the Service*, Indian Tribes, and Tribal Organizations*, may enter into contracts with public or private providers of [alcohol and substance abuse] *behavioral health* treatment services for the purpose of [assisting the Service in] carrying out the program required under subsection (a) [of this section].

(2) *PROVISION OF ASSISTANCE.*—In carrying out this subsection, the Secretary shall provide assistance to Indian [tribes] *Tribes and Tribal Organizations* to develop criteria for the certification of [alcohol and substance abuse] *behavioral health* service providers and accreditation of service facilities which meet minimum standards for such services and facilities [as may be determined pursuant to section 2411(a)(3) of this title].

[(c) Grants for model program

[(1) The Secretary, acting through the Service shall make a grant to the Standing Rock Sioux Tribe to develop a community-based demonstration project to reduce drug and alcohol abuse on the Standing Rock Sioux Reservation and to rehabilitate Indian families afflicted by such abuse.

[(2) Funds shall be used by the Tribe to—

[(A) develop and coordinate community-based alcohol and substance abuse prevention and treatment services for Indian families;

[(B) develop prevention and intervention models for Indian families;

[(C) conduct community education on alcohol and substance abuse; and

[(D) coordinate with existing Federal, State, and tribal services on the reservation to develop a comprehensive alcohol and substance abuse program that assists in the rehabilitation of Indian families that have been or are afflicted by alcoholism.

[(3) The Secretary shall submit to the President for inclusion in the report to be transmitted to the Congress under section 1671 of this title for fiscal year 1995 an evaluation of the demonstration project established under paragraph (1).]

SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the "Snyder Act"), the Secretary shall establish and maintain a mental health technician program within the Service which—

(1) provides for the training of Indians as mental health technicians; and

(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall supervise and evaluate the mental health technicians in the training program.

(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the traditional health care practices of the Indian Tribes to be served.

SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

(a) IN GENERAL.—Subject to the provisions of section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

[§ 1665b. Indian women treatment programs]

SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

[(a) Grants

[The Secretary]

(a) GRANTS.—The Secretary, consistent with section 701, may make grants to Indian [tribes and tribal organizations] *Tribes, Tribal Organizations, and Urban Indian Organizations* to develop and implement a comprehensive [alcohol and substance abuse] behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.

(b) USE OF [grantsGrants] *GRANT FUNDS.*—A grant made pursuant to this section may be used to—

(1) develop and provide community training, education, and prevention programs for Indian women relating to [alcohol and substance abuse] *behavioral health* issues, including fetal alcohol [syndrome and fetal alcohol effect] *disorders*;

(2) identify and provide [appropriate] *psychological services,* counseling, advocacy, support, and relapse prevention to Indian women and their families; and

(3) develop prevention and intervention models for Indian women which incorporate traditional [healers] *health care practices*, cultural values, and community and family involvement.

(c) CRITERIA [for the review and approval of grant applications].—The Secretary*, in consultation with Indian Tribes and Tribal Organizations,* shall establish criteria for the review and approval of applications *and proposals* for [grants] *funding* under this section.

[(d) Authorization of appropriations

[There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1993 and such sums as are necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

[(2)] *(d) EARMARK OF CERTAIN FUNDS.*—Twenty percent of the funds appropriated pursuant to this [subsection] *section* shall be used to make grants to [urban] *Urban* Indian [organizations funded under subchapter IV of this chapter] *Organizations*.

[§ 1665c. Indian Health Service youth program]

SEC. 707. INDIAN YOUTH PROGRAM.

(a) DETOXIFICATION AND [REHABILITATION] *REHABILITATION.*—The Secretary*, acting through the Service, consistent with section 701,* shall develop and implement a program for acute detoxification and treatment for Indian [youth who are alcohol and substance abusers] *youths, including behavioral health services*. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis. [These regional] *and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional* centers shall be integrated with the

intake and rehabilitation programs based in the referring Indian community.

(b) *ALCOHOL AND SUBSTANCE ABUSE* TREATMENT [centers or facilities] *CENTERS OR FACILITIES.—*

(1) ESTABLISHMENT.—

(A) *IN GENERAL.*—The Secretary*, acting through the Service, Indian Tribes, and Tribal Organizations,* shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, [a] *at least 1* youth regional treatment center *or treatment network* in each area under the jurisdiction of an [area office] *Area Office*.

(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the [area offices of the Service in Tucson and Phoenix, Arizona, shall be considered one area office and the area office] *Area Office* in California shall be considered to be [two area offices, one] *2 Area Offices, 1* office whose jurisdiction shall be considered to encompass the northern area of the State of California, and [one] *1* office whose jurisdiction shall be considered to encompass the remainder of the State of California *for the purpose of implementing California treatment networks.*

(2) *FUNDING.*—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

(3) *LOCATION.*—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the [tribes] *Indian Tribes* to be served by such center.

(4) SPECIFIC PROVISION OF FUNDS.—

(4A) [*(A)*] *IN GENERAL.*—Notwithstanding any other provision of this [subchapter] *title*, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating[,] and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section [450b(l) of this title] *4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).*

(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

[(B) Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youth residing in such State.]

(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services to Indian children and adolescents, including—

(A) pretreatment assistance;

(B) inpatient, outpatient, and aftercare services;

(C) emergency care;

(D) suicide prevention and crisis intervention; and

(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) USE OF FUNDS.—Funds provided under this subsection may be used—

(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

(B) to hire behavioral health professionals;

(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

(E) for intensive home- and community-based services.

(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

[(c)] *(d)* FEDERALLY[owned structures]-*OWNED STRUCTURES.*—

(1) *IN GENERAL.*—The Secretary, [acting through the Service, shall,] in consultation with Indian [tribes] *Tribes and Tribal Organizations, shall—*

(A) identify and use, where appropriate, federally-owned structures suitable [as] *for* local residential or regional [alcohol and substance abuse] *behavioral health* treatment [centers] for Indian [youth] *youths*; and

(B) establish guidelines for determining the suitability of any such federally-owned structure to be used [as a] *for* local residential or regional [alcohol and substance abuse] *behavioral health* treatment [center] for Indian [youth] *youths.*

[(2)] *(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.*—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure *and any Indian Tribe or Tribal Organization operating the program.*

[(d)] *(e)* REHABILITATION AND [aftercare services] *AFTERCARE SERVICES.*—

(1) *IN GENERAL.*—The Secretary, *Indian Tribes, or Tribal Organizations,* in cooperation with the Secretary of the Interior, shall develop and implement within each Service [service unit] *Unit,* community-based rehabilitation and follow-up services for Indian [youth who are alcohol or substance abusers which are designed to integrate] *youths who are having signifi-*

cant behavioral health problems, and require long-term treatment*, community reintegration,* and *monitoring* to [monitor and] support the Indian [youth] *youths* after their return to their home community.

(2) *ADMINISTRATION.*—Services under paragraph (1) shall be [administered within each service unit] *provided by* trained staff within the community who can assist the Indian [youth] *youths* in *their* continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff [shall] *may* include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

[(e)] *(f)* INCLUSION OF [FAMILY IN YOUTH TREATMENT PROGRAM] FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian [youth] *youths* authorized by this section, the Secretary, *acting through the Service, Indian Tribes, and Tribal Organizations,* shall provide for the inclusion of family members of such [youth] *youths* in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection [(d) of this section] *(e)* shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

[(f) Multidrug abuse study (1) The Secretary shall conduct a study to determine the incidence and prevalence of] *(g)* MULTIDRUG ABUSE PROGRAM.—*The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall provide, consistent with section 701, programs and services to prevent and treat* the abuse of multiple forms of [drugs] *substances,* including alcohol, *drugs, inhalants, and tobacco,* among Indian [youth] *youths* residing [on Indian] *in Indian communities, on or near* reservations, and in urban areas and [the interrelationship of such abuse with] *provide appropriate mental health services to address* the incidence of mental illness among such [youth] *youths.*

[(2) The Secretary shall submit a report detailing the findings of such study, together with recommendations based on such findings, to the Congress no later than two years after October 29, 1992.]

(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

(1) the number of Indian youth who are being provided mental health services through the Service and Tribal Health Programs;

(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and Tribal Health Programs;

(3) the number of youth referred to the Service or Tribal Health Programs for mental health services;

(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and Tribal Health Programs, reported separately for on- and off-reservation facilities; and

(5) the costs of the services described in paragraph (4).

SEC. 708. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

(a) PURPOSE.—The purpose of this section is to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention and treatment of Indian youth, including through—

(1) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

(2) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

(3) training and related support for community leaders, family members and health and education workers who work with Indian youth;

(4) the development of culturally-relevant educational materials on suicide; and

(5) data collection and reporting.

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

(1) DEMONSTRATION PROJECT.—The term "demonstration project" means the Indian youth telemental health demonstration project authorized under subsection (c).

(2) TELEMENTAL HEALTH.—The term "telemental health" means the use of electronic information and telecommunications technologies to support long distance mental health care, patient and professional-related education, public health, and health administration.

(c) AUTHORIZATION.—

(1) IN GENERAL.—The Secretary is authorized to award grants under the demonstration project for the provision of telemental health services to Indian youth who—

(A) have expressed suicidal ideas;

(B) have attempted suicide; or

(C) have mental health conditions that increase or could increase the risk of suicide.

(2) ELIGIBILITY FOR GRANTS.—Such grants shall be awarded to Indian Tribes and Tribal Organizations that operate 1 or more facilities—

(A) located in Alaska and part of the Alaska Federal Health Care Access Network;

(B) reporting active clinical telehealth capabilities; or

(C) offering school-based telemental health services relating to psychiatry to Indian youth.

(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

(4) AWARDING OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian Tribes and Tribal Organizations that—

(A) serve a particular community or geographic area where there is a demonstrated need to address Indian youth suicide;

(B) enter into collaborative partnerships with Indian Health Service or Tribal Health Programs or facilities to provide services under this demonstration project;

(C) serve an isolated community or geographic area which has limited or no access to behavioral health services; or

(D) operate a detention facility at which Indian youth are detained.

(d) USE OF FUNDS.—

(1) IN GENERAL.—An Indian Tribe or Tribal Organization shall use a grant received under subsection (c) for the following purposes:

(A) To provide telemental health services to Indian youth, including the provision of—

(i) psychotherapy;

(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

(iii) alcohol and substance abuse treatment.

(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service, tribal, or urban clinicians and health services providers working with youth being served under this demonstration project.

(C) To assist, educate and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals and with State and local health services providers.

(D) To develop and distribute culturally appropriate community educational materials on—

(i) suicide prevention;

(ii) suicide education;

(iii) suicide screening;

(iv) suicide intervention; and

(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

(E) For data collection and reporting related to Indian youth suicide prevention efforts.

(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian Tribe or Tribal Organization may use and promote the traditional health care practices of the Indian Tribes of the youth to be served.

(e) APPLICATIONS.—To be eligible to receive a grant under subsection (c), an Indian Tribe or Tribal Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of the project that the Indian Tribe or Tribal Organization will carry out using the funds provided under the grant;

(2) a description of the manner in which the project funded under the grant would—

(A) meet the telemental health care needs of the Indian youth population to be served by the project; or

(B) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

(3) evidence of support for the project from the local community to be served by the project;

(4) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

(5) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

(6) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

(f) COLLABORATION; REPORTING TO NATIONAL CLEARINGHOUSE—

(1) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations receiving grants under this section to collaborate to enable comparisons about best practices across projects.

(2) REPORTING TO NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall also encourage Indian Tribes and Tribal Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse authorized under section 701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

(g) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

(1) describes the number of telemental health services provided; and

(2) includes any other information that the Secretary may require.

(h) REPORT TO CONGRESS.—Not later than 270 days after the termination of the demonstration project, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a final report, based on the annual reports provided by grant recipients under subsection (h), that—

(1) describes the results of the projects funded by grants awarded under this section, including any data available which indicates the number of attempted suicides;

(2) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

(3) evaluates whether the demonstration project should be—

(A) expanded to provide more than 5 grants; and

(B) designated a permanent program; and

(4) evaluates the benefits of expanding the demonstration project to include Urban Indian Organizations.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2008 through 2011.

SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 Area Offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

[§ 1665d. Training and community education]

SEC. 710. TRAINING AND COMMUNITY EDUCATION.

[(a) Community education]

(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement *or assist Indian Tribes and Tribal Organizations to develop and implement,* within each [service unit] *Service Unit or tribal program,* a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education [in alcohol and substance abuse] *about behavioral health issues* to political leaders, [tribal] *Tribal* judges, law enforcement personnel, members of tribal health and education boards, *health care providers including traditional practitioners,* and other critical members of each tribal community. *Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.*

(b) [Training] *INSTRUCTION.*—The Secretary*, acting through the Service,* shall, either directly or [by contract] *through Indian Tribes and Tribal Organizations*, provide instruction in the area of [alcohol and substance abuse] *behavioral health issues*, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, *child sexual abuse*, youth alcohol and substance abuse, and the causes and effects of fetal alcohol [syndrome] *disorders* to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section [2433 of this title] *4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).*

[(c) Community-based training models] *(c) TRAINING MODELS.*—In carrying out the education and training programs required by this section, the Secretary, [acting through the Service and] in consultation with [tribes] *Indian Tribes, Tribal Organizations, Indian behavioral health experts*, and Indian alcohol and substance

abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

[(1) the elevated risk of alcohol and [substance abuse] *behavioral health problems* faced by children of alcoholics;

[(2) the cultural, *spiritual*, and multigenerational aspects of [alcohol and substance abuse] *behavioral health problem* prevention and recovery; and

[(3) community-based and multidisciplinary strategies for preventing and treating [alcohol and substance abuse] *behavioral health problems*.

SEC. 711. BEHAVIORAL HEALTH PROGRAM.

(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

(b) AWARDS; CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

(1) The project will address significant unmet behavioral health needs among Indians.

(2) The project will serve a significant number of Indians.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

[§ 1665e. Gallup alcohol and substance abuse treatment center]

(5) The project may deliver services in a manner consistent with traditional health care practices.

[(a) Grants for residential treatment

[The Secretary shall make grants to the Navajo Nation for the purpose of providing residential treatment for alcohol and substance abuse for adult and adolescent members of the Navajo Nation and neighboring tribes.

[(b) Purposes of grants

[Grants made pursuant to this section shall (to the extent appropriations are made available) be used to—

[(1) provide at least 15 residential beds each year for adult long-term treatment, including beds for specialized services such as polydrug abusers, dual diagnosis, and specialized services for women with fetal alcohol syndrome children;

[(2) establish clinical assessment teams consisting of a clinical psychologist, a part-time addictionologist, a master's level assessment counselor, and a certified medical records technician which shall be responsible for conducting individual assessments and matching Indian clients with the appropriate available treatment;

[(3) provide at least 12 beds for an adolescent shelterbed program in the city of Gallup, New Mexico, which shall serve as a satellite facility to the Acoma/Canoncito/Laguna Hospital and the adolescent center located in Shiprock, New Mexico, for emergency crisis services, assessment, and family intervention;

[(4) develop a relapse program for the purposes of identifying sources of job training and job opportunity in the Gallup area and providing vocational training, job placement, and job retention services to recovering substance abusers; and

[(5) provide continuing education and training of treatment staff in the areas of intensive outpatient services, development of family support systems, and case management in cooperation with regional colleges, community colleges, and universities.

[(c) Contract for residential treatment

[The Navajo Nation, in carrying out the purposes of this section, shall enter into a contract with an institution in the Gallup, New Mexico, area which is accredited by the Joint Commission of the Accreditation of Health Care Organizations to provide comprehensive alcohol and drug treatment as authorized in subsection (b) of this section.

[(d) Authorization of appropriations

[There are authorized to be appropriated, for each of fiscal years 1996 through 2000, such sums as may be necessary to carry out subsection (b) of this section.]

(6) The project is coordinated with, and avoids duplication of, existing services.

[§ 1665f. Reports]

(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

[(a) Compilation of data

[The Secretary, with respect to the administration of any health program by a service unit, directly or through contract, including a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], shall require the compilation of data relating to the number of cases or incidents in which any Service personnel or services were involved and which were related, either directly or indirectly, to alcohol or substance abuse. Such report shall include the type of assistance provided and the disposition of these cases.

[(b) Referral of data

[The data compiled under subsection (a) of this section shall be provided annually to the affected Indian tribe and Tribal Coordinating Committee to assist them in developing or modifying a Tribal Action Plan under section 2412 of this title.

[(c) Comprehensive report

[Each service unit director shall be responsible for assembling the data compiled under this section and section 2434 of this title into an annual tribal comprehensive report. Such report shall be provided to the affected tribe and to the Director of the Service who shall develop and publish a biennial national report based on such tribal comprehensive reports.]

SEC. 712. FETAL ALCOHOL DISORDER PROGRAMS.

[§ 1665g. Fetal alcohol syndrome and fetal alcohol effect grants]

(a) PROGRAMS.—

[(a) Award; use; review; criteria]

[(1) The Secretary may make grants to Indian tribes and tribal organizations to establish fetal alcohol syndrome and fetal alcohol effect] *(1) ESTABLISHMENT.—The Secretary, consistent with section 701, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol disorder* programs as provided in this section for the purposes of meeting the health status objectives specified in section [1602(b) of this title.] *3.*

[(2) Grants made pursuant to this section shall be used to—]

(2) USE OF FUNDS.—

(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

[(A) develop and provide] *(i) To develop and provide for Indians* community and in-school training, education, and prevention programs relating to [FAS and FAE;] *fetal alcohol disorders*.

[(B) identify and provide alcohol and substance abuse] *(ii) To identify and provide behavioral health* treatment to high-risk [women;] *Indian women and high-risk women pregnant with an Indian's child.*

[(C)] *(iii) To* identify and provide appropriate *psychological services,* educational and vocational support, counseling, advocacy, and information to [FAS and FAE] *fetal alcohol disorder* affected [persons] *Indians* and their families or caretakers[;].

[(D)] *(iv) To* develop and implement counseling and support programs in schools for [FAS and FAE] *fetal alcohol disorder* affected *Indian* children[;].

[(E)] *(v) To* develop prevention and intervention models which incorporate *practitioners of* traditional [healers] *health care practices*, cultural values, and community involvement[;].

[(F)] *(vi) To* develop, print, and disseminate education and prevention materials on [FAS and FAE; and] *fetal alcohol disorder*.

[(G)] *(vii) To* develop and implement, [through the tribal]*in* consultation [process] *with Indian Tribes, Tribal Organizations, and Urban Indian Organizations*, culturally sensitive assessment and diagnostic tools [for use in tribal and urban Indian communities]*including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.*

(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

(ii) Community-based support services for Indians and women pregnant with Indian children.

(iii) Community-based housing for adult Indians with fetal alcohol disorder.

(3) *CRITERIA FOR APPLICATIONS*.—The Secretary shall establish criteria for the review and approval of applications for [grants under this section.]*funding under this section.*

[(b) Plan; study; national clearinghouse]

(b) SERVICES.—The Secretary, acting through the Service[, shall—] *and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall—*

[(1) develop an annual plan] *(1) develop and provide services* for the prevention, intervention, treatment, and aftercare for those affected by [FAS and FAE in Indian communities;] *fetal alcohol disorder in Indian communities; and*

[(2) conduct a study, directly or by contract with any organization, entity, or institution of higher education with significant knowledge of FAS and FAE and Indian communities, of] *(2) provide supportive services, including services to meet* the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians [and Alaska Natives with FAS or FAE; and (3) establish a national clearinghouse for prevention and educational materials and other information on FAS and FAE effect in Indian and Alaska Native communities and ensure access to clearinghouse materials by any Indian tribe or urban Indian organization] *with fetal alcohol disorder*.

(c) TASK [force]*FORCE*.—The Secretary shall establish a task force to be known as the [FAS/FAE] *Fetal Alcohol Disorder* Task Force to advise the Secretary in carrying out subsection (b) [of this section]. Such task force shall be composed of representatives from the *following:*

(1) The National Institute on Drug Abuse [, the].

(2) The National Institute on Alcohol and Alcoholism[, the].

(3) The Office of Substance Abuse Prevention[, the].

(4) The National Institute of Mental Health[, the].

(5) The Service[, the].

(6) The Office of Minority Health of the Department of Health and Human Services[, the].

(7) The Administration for Native Americans[, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian FAS/FAE].

(8) The National Institute of Child Health and Human Development (NICHD).

(9) The Centers for Disease Control and Prevention.

(10) The Bureau of Indian Affairs.

(11) Indian Tribes.

(12) Tribal Organizations.

(13) Urban Indian Organizations.

(14) Indian fetal alcohol disorder experts.

[(d) Cooperative projects; research projects]

(d) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian [tribes, tribal organizations, universities working with Indian tribes on cooperative projects, and urban Indian organizations] *Tribes, Tribal Organizations, and Urban Indian Organizations* for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide *rehabilitation and behavioral health*

aftercare for Indians and [urban] *Urban* Indians affected by [FAS or FAE] *fetal alcohol disorder.*

[(e) Report

[(1) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the status of FAS and FAE in the Indian population. Such report shall include, in addition to the information required under section 1602(d) of this title with respect to the health status objective specified in section 1602(b)(27) of this title, the following:

[(A) The progress of implementing a uniform assessment and diagnostic methodology in Service and tribally based service delivery systems.

[(B) The incidence of FAS and FAE babies born for all births by reservation and urban-based sites.

[(C) The prevalence of FAS and FAE affected Indian persons in Indian communities, their primary means of support, and recommendations to improve the support system for these individuals and their families or caretakers.

[(D) The level of support received from the entities specified in subsection (c) in the area of FAS and FAE.

[(E) The number of inpatient and outpatient substance abuse treatment resources which are specifically designed to meet the unique needs of Indian women, and the volume of care provided to Indian women through these means.

[(F) Recommendations regarding the prevention, intervention, and appropriate vocational, educational and other support services for FAS and FAE affected individuals in Indian communities.

[(2) The Secretary may contract the production of this report to a national organization specifically addressing FAS and FAE in Indian communities.

[(f) Authorization of appropriations

[(1) There are authorized to be appropriated to carry out this section $22,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

[(2)] *(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.*—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to [urban Indian organizations] *Urban Indian Organizations* funded under [subchapter IV of this chapter] *title V.*

[§ 1665h. Pueblo substance abuse treatment project for San Juan Pueblo, New Mexico]

SEC. 713. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

(a) ESTABLISHMENT.—The Secretary, acting through the Service, [shall continue to make grants, through fiscal year 1995, to the 8 Northern Indian Pueblos Council, San Juan Pueblo, New Mexico, for the purpose of providing substance abuse treatment services to Indians in need of such services.] *and the Secretary of the Interior, Indian Tribes, and Tribal Organizations, shall establish, consistent*

with section 701, in every Service Area, programs involving treatment for—

(1) victims of sexual abuse who are Indian children or children in an Indian household; and

(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

(3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.

(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

SEC. 714. BEHAVIORAL HEALTH RESEARCH.

The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian Tribes, Tribal Organizations, and Urban Indian Organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

(1) the multifactorial causes of Indian youth suicide, including—

(A) protective and risk factors and scientific data that identifies those factors; and

(B) the effects of loss of cultural identity and the development of scientific data on those effects;

(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

[§ 1665i. Thunder Child Treatment Center]

(3) the development of models of prevention techniques.

[(a) The Secretary, acting through the Service, shall make a grant to the Intertribal Addictions Recovery Organization, Inc. (commonly known as the Thunder Child Treatment Center) at Sheridan, Wyoming, for the completion of construction of a multiple approach substance abuse treatment center which specializes in the treatment of alcohol and drug abuse of Indians.

[(b) For the purposes of carrying out subsection (a) of this section, there are authorized to be appropriated $2,000,000 for fiscal years 1993 and 1994. No funding shall be available for staffing or operation of this facility. None of the funding appropriated to carry out subsection (a) of this section shall be used for administrative purposes.]

The effect of the interrelationships and interdependencies referred to in paragraph (2) on children, and the development of prevention techniques under paragraph (3) applicable to children, shall be emphasized.

[§ 1665j. Substance abuse counselor education demonstration project]

SEC. 715. DEFINITIONS.

[(a) Contracts and grants

[The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible community colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

[(b) Use of funds

[Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

[(c) Effective period of contract or grant; renewal

[A contract entered into or a grant provided under this section shall be for a period of one year. Such contract or grant may be renewed for an additional one year period upon the approval of the Secretary.

[(d) Criteria for review and approval of applications

[Not later than 180 days after October 29, 1992, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

[(e) Assistance to recipients

[The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

[(f) Report

[The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.

[(g) Definitions]

For the [purposes] *purpose* of this [section] *title*, the following definitions *shall* apply:

[(1) The term "educational curriculum" means one or more of the following:

[(A) Classroom education.

[(B) Clinical work experience.

[(C) Continuing education workshops.

[(2) The term "eligible community college" means an accredited community college that—

[(i) is located on or near an Indian reservation;

[(ii) has entered into a cooperative agreement with the governing body of such Indian reservation to carry out a demonstration project under this section; and

[(iii) has a student enrollment of not less than 10 percent Indian.

[(3) The term "tribally controlled community college" has the meaning given such term in section 1801(a)(4) of this title.

[(4) The term "tribally controlled postsecondary vocational institution" has the meaning given such term in section 2397h(2) of Title 20.

[(h) Authorization of appropriations

[There are authorized to be appropriated for each of fiscal years 1996 through 2000, such sums as may be necessary to carry out the purposes of this section. Such sums shall remain available until expended.]

(1) ASSESSMENT.—The term "assessment" means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

(2) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term "alcohol-related neurodevelopmental disorders" or "ARND" means, with a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

(3) BEHAVIORAL HEALTH AFTERCARE.—The term "behavioral health aftercare" includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

(4) DUAL DIAGNOSIS.—The term "dual diagnosis" means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

(5) FETAL ALCOHOL DISORDERS.—The term "fetal alcohol disorders" means fetal alcohol syndrome, partial fetal alcohol syndrome and alcohol related neurodevelopmental disorder (ARND).

(6) FETAL ALCOHOL SYNDROME OR FAS.—The term "fetal alcohol syndrome" or "FAS" means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

(C) Prenatal or postnatal growth delay.

[§ 1665k. Gila River alcohol and substance abuse treatment facility]

(7) PARTIAL FAS.—The term "partial FAS" means, with a history of maternal alcohol consumption during pregnancy, having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

[(a) Regional center

[The Secretary, acting through the Service, shall establish a regional youth alcohol and substance abuse prevention and treatment center in Sacaton, Arizona, on the Gila River Indian Reservation. The center shall be established within facilities leased, with the consent of the Gila River Indian Community, by the Service from such Community.

[(b) Name of regional center

[The center established pursuant to this section shall be known as the "Regional Youth Alcohol and Substance Abuse Prevention and Treatment Center".

[(c) Unit of regional center

[The Secretary, acting through the Service, shall establish, as a unit of the regional center, a youth alcohol and substance abuse prevention and treatment facility in Fallon, Nevada.]

(8) REHABILITATION.—The term "rehabilitation" means to restore the ability or capacity to engage in usual and customary life activities through education and therapy.

[§ 1665l. Alaska Native drug and alcohol abuse demonstration project]

(9) SUBSTANCE ABUSE.—The term "substance abuse" includes inhalant abuse.

[(a) The Secretary, acting through the Service, shall make grants to the Alaska Native Health Board for the conduct of a two-part community-based demonstration project to reduce drug and alcohol

abuse in Alaska Native villages and to rehabilitate families afflicted by such abuse. Sixty percent of such grant funds shall be used by the Health Board to stimulate coordinated community development programs in villages seeking to organize to combat alcohol and drug use. Forty percent of such grant funds shall be transferred to a qualified nonprofit corporation providing alcohol recovery services in the village of St. Mary's, Alaska, to enlarge and strengthen a family life demonstration program of rehabilitation for families that have been or are afflicted by alcoholism.

[(b) The Secretary shall submit to the President for inclusion in the report required to be submitted to the Congress under section 1671 of this title for fiscal year 1995 an evaluation of the demonstration project established under subsection (a) of this section.**]**

SEC. 716. AUTHORIZATION OF APPROPRIATIONS.

[§ 1665m. Authorization of appropriations]

There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out the provisions of this title.

[Except as provided in sections 1665b, 1665e, 1665g, 1665i, and 1665j of this title, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out the provisions of this subchapter.**]**

TITLE VIII—MISCELLANEOUS

[§ 1671. Reports]

SEC. 801. REPORTS.

[The President shall, at the time the budget is submitted under section 1105 of Title 31, United States Code, for each fiscal year transmit to the**]** *For each fiscal year following the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary shall transmit to* Congress a report containing—*the following:*

(1) **[**a**]** *A* report on the progress made in meeting the objectives of this **[**chapter**]** *Act*, including a review of programs established or assisted pursuant to this **[**chapter**]** *Act* and **[**an assessment**]** *assessments* and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians**[**,**]** and ensure a health status for Indians, which are at a parity with the health services available to and the health status of**[**,**]** the general population**[**;**]**.

(2) **[**a**]** *A* report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this **[**chapter**]** *Act* and any steps that the Secretary may have taken to consult with Indian **[**tribes**]** *Tribes, Tribal Organizations, and Urban Indian Organizations* to address such impact**[**; (3)**]** *, including* a report on *proposed changes in allocation of funding pursuant to section 808.*

(3) A report on the use of health services by Indians—

(A) on a national and area or other relevant geographical basis;

(B) by gender and age;

(C) by source of payment and type of service; [and]

(D) comparing such rates of use with rates of use among comparable non-Indian populations[.] *; and*

(E) provided under contracts.

(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(n).

(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 125(f).

[(4)] *(7)* [a] *A* separate statement which specifies the amount of funds requested to carry out the provisions of section [1621 of this title;] *201.*

[(5) a separate statement of the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in section 1680d of this title, relating to infant and maternal mortality and fetal alcohol syndrome;

[(6) the reports required by sections 1602(d), 1616a(n), 1621b(b), 1621h(j), 1631(c), 1632(g), 1634(a)(3), 1643, 1665g(e), 1680g(a), and 1680l(f) of this title;

[(7) for fiscal year 1995, the report required by sections 1665a(c)(3) and 1665l(b) of this title;

[(8) for fiscal year 1997, the interim report required by section 1637(h)(1) of this title; and

[(9) for fiscal year 1999, the reports required by sections 1637(h)(2), 1660b(b), and 1680k(g) of this title.]

(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

(9) A biennial report to Congress on infectious diseases as required by section 212.

(10) A report on environmental and nuclear health hazards as required by section 215.

(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2)(B) and 301(d).

(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

(13) An annual report on the expenditure of non-Service funds for renovation as required by sections 304(b)(2).

(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

(16) A report on any arrangements for the sharing of medical facilities or services, as authorized by section 406.

(17) A report on evaluation and renewal of Urban Indian programs under section 505.

(18) A report on the evaluation of programs as required by section 513(d).

(19) A report on alcohol and substance abuse as required by section 701(f).

(20) A report on Indian youth mental health services as required by section 707(h).

(21) A report on the reallocation of base resources if required by section 808.

SEC. 802. REGULATIONS.

(a) DEADLINES.—

(1) PROCEDURES.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out titles II (except section 202) and VII, the sections of title III for which negotiated rulemaking is specifically required, and section 807. Unless otherwise required, the Secretary may promulgate regulations to carry out titles I, III, IV, and V, and section 202, using the procedures required by chapter V of title 5, United States Code (commonly known as the "Administrative Procedure Act").

(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 and shall have no less than a 120-day comment period.

(3) FINAL REGULATIONS.—The Secretary shall publish in the Federal Register final regulations to implement this Act by not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007.

(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes, and Tribal Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes and Tribal Organizations from each Service Area.

(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

[§ 1672.]

(d) LACK OF REGULATIONS.*—The lack of promulgated regulations shall not limit the effect of this Act.*

[Prior to any revision of or amendment to rules or regulations promulgated pursuant to this chapter, the Secretary shall consult with Indian tribes and appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.**]**

(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law in effect on the day before the date of enactment of the Indian Health Care Improvement

Act Amendments of 2007, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

[§ 1674. Leases with Indian tribes]

SEC. 803. PLAN OF IMPLEMENTATION.

[(a) Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this chapter, to enter into leases with Indian tribes for periods not in excess of twenty years. Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.

[(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

[(1) title to;

[(2) a leasehold interest in; or

[(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);]

[facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable.]

Not later than 9 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule, by title and section, by which the Secretary will implement the provisions of this Act. This consultation may be conducted jointly with the annual budget consultation pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

[§ 1675. Availability of funds]

SEC. 804. AVAILABILITY OF FUNDS.

The funds appropriated pursuant to this [chapter] *Act* shall remain available until expended.

[§ 1676. Limitation on use of funds appropriated to the Indian Health Service]

SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO INDIAN HEALTH SERVICE.

Any limitation on the use of funds contained in an Act providing appropriations for the Department [of Health and Human Services] for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the [Indian Health] Service.

[§ 1677. Nuclear resource development health hazards]

[(a) Study

[The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, a study of the health hazards to Indian miners and Indians on or near Indian reservations and in Indian communities as a result of nuclear resource development. Such study shall include—

[(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

[(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

[(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal;

[(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the five years prior to December 17, 1980, that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

[(5) the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such nuclear resource development.

[(b) Health care plan; development

[Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studied under subsection (a) of this section. The plan shall include—

[(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

[(2) preventive care for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

[(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear development activities, may experience health problems.

[(c) Reports to Congress

[The Secretary and the Service shall submit to Congress the study prepared under subsection (a) of this section no later than the date eighteen months after December 17, 1980. The health care plan prepared under subsection (b) of this section shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) of this section is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

[(d) Intergovernmental Task Force; establishment and functions

[(1) There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees): the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the United States Bureau of Mines, the Assistant Secretary for Occupational Safety and Health, and the Secretary of the Interior.

[(2) The Task Force shall identify existing and potential operations related to nuclear resource development that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community and enter into activities to correct existing health hazards and insure that current and future health problems resulting from nuclear resource development activities are minimized or reduced.

[(3) The Secretary shall be Chairman of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

[(e) Medical care

[In the case of any Indian who—

[(1) as a result of employment in or near a uranium mine or mill, suffers from a work related illness or condition;

[(2) is eligible to receive diagnosis and treatment services from a Service facility; and

[(3) by reason of such Indian's employment is entitled to medical care at the expense of such mine or mill operator;

[the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator from such operation. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

[1678. Arizona as a contract health service delivery area

[(a) Designation

[For the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, 2000, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of Arizona.

[(b) Curtailment of health services prohibited

[The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a) of this section.]

SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

[§1679. Eligibility of]

(a) IN GENERAL.—The following California Indians *shall be eligible for health services provided by the Service:*

[(a) Report to Congress

[(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth—

[(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,

[(B) the geographic location of such Indians,

[(C) the Indian tribes of which such Indians are members,

[(D) an assessment of the current health status, and health care needs, of such Indians, and

[(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

[(2) The report required under paragraph (1) shall be prepared by the Secretary—

[(A) in consultation with the Secretary of the Interior, and

[(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.

[(b) Eligible Indians

[Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:]

(1) Any member of a federally recognized Indian [tribe.] *Tribe.*

(2) Any descendant of an Indian who was residing in California on June 1, 1852, [but only] if such descendant—

(A) is [living in California, (B) is] a member of the Indian community served by a local program of the Service[,]*;* and

[(C)] *(B)* is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or [Indian] reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of [California] rancherias and reservations *located within the State of California* under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

[(c) Scope of eligibility

[Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§1680. California as a contract health service delivery area

[The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.

[§1680a. Contract health facilities

[The Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Service entered into under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.]—

[(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

[(2) for employee training,

[(3) for cost-of-living increases for employees, and

[(4) for any other expenses relating to the provision of health services,

[on the same basis as such funds are provided to programs and facilities operated directly by the Service.

[§ 1680b. National Health Service Corps

[The Secretary of Health and Human Services shall not—

[(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], or

[(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

[§ 1680c. Health services for ineligible persons

[(a) Individuals not otherwise eligible

[(1) Any individual who—]

[(A] *(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.*

SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

(a) CHILDREN.—Any individual who—

(1) has not attained 19 years of age[,]*;*

[(B] *(2)* is the natural or adopted child, [stepchild]*stepchild*, foster-child, legal ward, or orphan of an eligible Indian[,]*;* and

[(C] *(3)* is not otherwise eligible for [the] health services provided by the Service, shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration

by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until [one] *1* year after the date [such disability has been removed] *of a determination of competency*.

[(2)] *(b) SPOUSES.*—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but *is* not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all [of] such spouses *or spouses who are married to members of each Indian Tribe being served* are made eligible, as a class, by an appropriate resolution of the governing body of the Indian [tribe of the eligible Indian] *Tribe or Tribal Organization providing such services*. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

[(b) Health facilities providing health services

[(1)(A) The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other subsection of this section or under any other provision of law if—

[(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals, and

[(ii) the Secretary and the Indian tribe or tribes have jointly determined that—]

(c) PROVISION OF SERVICES TO OTHER INDIVIDUALS.—

[(I)] *(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service Unit and who are not otherwise eligible for such health services if—*

(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

(B) the Secretary and the served Indian Tribes have jointly determined that—

(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians[,]*;* and

[(II)] *(ii)* there is no reasonable alternative health [facility]*facilities* or services, within or without the [service area of such service unit]*Service Unit*, available to meet the health needs of such individuals.

[(B)] *(2) ISDEAA PROGRAMS.*—In the case of health *programs and* facilities operated under a contract *or compact* entered into under the Indian Self-Determination *and Education Assistance* Act [[]*(*25 U.S.C.[A. §]450[f] et seq.[]]*)*, the governing body of the Indian [tribe or tribal organization] *Tribe or Tribal Organization* providing health services under such contract *or compact* is authorized to determine whether health services should be provided under such contract to individuals

who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian [tribe or tribal organization] *Tribe or Tribal Organization* shall take into account the considerations described in [subparagraph (A)(ii)] *paragraph (1)(B)*.

(3) PAYMENT FOR SERVICES.—

[(2)](A) *IN GENERAL.*—Persons receiving health services provided by the Service [by reason of] *under* this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section [1880(c) of the Social Security Act [42 U.S.C.A. § 1395qq(c)], section 1642(a) of this title,] *404 of this Act* or any other provision of law, amounts collected under this subsection, including [medicare or medicaid] *Medicare, Medicaid, or SCHIP* reimbursements under titles XVIII[and], XIX, *and XXI* of the Social Security Act [42 U.S.C.A. §§ 1395 et seq. and 1396 et seq.], shall be credited to the account of the [facility] *program* providing the service and shall be used [solely for the provision of health services within that facility. Amounts] *for the purposes listed in section 401(d)(2) and amounts* collected under this subsection shall be available for expenditure within such [facility for not to exceed one fiscal year after the fiscal year in which collected] *program*.

(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent [person] *individual* who would not be *otherwise* eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent [person] *individual*.

(4) REVOCATION OF CONSENT FOR SERVICES.—

[(3)(A)] *(A) SINGLE TRIBE SERVICE AREA.*—In the case of a [service area] *Service Area* which serves only [one] *1* Indian [tribe] *Tribe*, the authority of the Secretary to provide health services under paragraph (1)[(A)] shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian [tribe] *Tribe* revokes its concurrence to the provision of such health services.

(B) MULTITRIBAL SERVICE AREA.—In the case of a [multitribal service area] *multitribal Service Area*, the authority of the Secretary to provide health services under paragraph (1)[(A)] shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian [tribes] *Tribes* in the [service area] *Service Area* revoke their concurrence to the [provision] *provisions* of such health services.

[(c) Purposes served in providing health services to otherwise ineligible individuals] *(d) OTHER SERVICES.*—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other [subsection of this section or under any other] provision of law in order to—

(1) achieve stability in a medical emergency[,]*;*

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard[,]*;*

(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through [post partum,] *postpartum;* or

(4) provide care to immediate family members of an eligible [person]*individual* if such care is directly related to the treatment of the eligible [person] *individual*.

[(d) Extension of hospital privileges to non-Service health care practitioners] *(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.*—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract [entered into under] *or compact pursuant to* the Indian Self-Determination *and Education Assistance* Act [[](25 U.S.C.[A. §] 450[f] et seq.[]]) may be extended to non-Service health care practitioners who provide services to [persons] *individuals* described in subsection (a) [or], (b) [of this section]*, (c), or (d)*. Such non-Service health care practitioners may [be regarded]*, as part of the privileging process, be designated* as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of [Title] *title* 28, *United States Code* (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible [persons] *individuals* as a part of the conditions under which such hospital privileges are extended.

[(e)] *(f)* ["]ELIGIBLE INDIAN[" defined].—For purposes of this section, the term "eligible Indian" means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

[§ 1680d. Infant and maternal mortality; fetal alcohol syndrome]

SEC. 808. REALLOCATION OF BASE RESOURCES.

[By no later than January 1, 1990, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1994:

[(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—

[(A) twelve deaths per one thousand live births, or

[(B) the rate of infant mortality applicable to the United States population as a whole;

[(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—

[(A) five deaths per one hundred thousand live births, or

[(B) the rate of maternal mortality applicable to the United States population as a whole; and

[(3) reduction of the rate of fetal alcohol syndrome among Indians served by, or on behalf of, the Service to one per one thousand live births.

[§ 1680e. Contract health services for the Trenton service area

[(a) Service to Turtle Mountain Band

[The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

[(b) Band member eligibility not expanded

[Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§ 1680f. Indian Health Service and Department of Veterans Affairs health facilities and services sharing

[(a) Feasibility study and report

[The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Department of Veterans Affairs and shall, in accordance with subsection (b) of this section, prepare a report on the feasibility of such an arrangement and submit such report to the Congress by no later than September 30, 1990.

[(b) Non-impairment of service quality, eligibility, or priority of access

[The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of Title 38 which would impair—

[(1) the priority access of any Indian to health care services provided through the Indian Health Service;

[(2) the quality of health care services provided to any Indian through the Indian Health Service;

[(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

[(4) the quality of health care services provided to any veteran by the Department of Veterans Affairs;

[(5) the eligibility of any Indian to receive health services through the Indian Health Service; or

[(6) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

[(c) Cross utilization of services

[(1) Not later than December 23, 1988, the Director of the Indian Health Service and the Secretary of Veterans Affairs shall implement an agreement under which—

[(A) individuals in the vicinity of Roosevelt, Utah, who are eligible for health care from the Department of Veterans Affairs could obtain health care services at the facilities of the Indian Health Service located at Fort Duchesne, Utah; and

[(B) individuals eligible for health care from the Indian Health Service at Fort Duchesne, Utah, could obtain health care services at the Department of Veterans Affairs medical center located in Salt Lake City, Utah.

[(2) Not later than November 23, 1990, the Secretary and the Secretary of Veterans Affairs shall jointly submit a report to the Congress on the health care services provided as a result of paragraph (1).

[(d) Right to health services

[Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Indian Health Service except as provided in an agreement under subsection (c) of this section.

[§ 1680g. Reallocation of base resources

[(a) Report to Congress] *(a) REPORT REQUIRED.*—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a [service unit] *Service Unit* may be implemented only after the Secretary has submitted to [the President, for inclusion in the report required to be transmitted to the] Congress*,* under section [1671 of this title,] *801,* a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

(b) [Appropriated amounts] *EXCEPTION.*—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is *at least 5 percent* less than the amount appropriated to the Service for *the* previous fiscal year.

SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

The Secretary shall provide for the dissemination to Indian Tribes, Tribal Organizations, and Urban Indian Organizations of the findings and results of demonstration projects conducted under this Act.

SEC. 810. PROVISION OF SERVICES IN MONTANA.

(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

SEC. 811. MORATORIUM.

During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807, until the Service has submitted to the Committees on Appropriations of the Senate and the House of Representatives a budget request reflecting the increased costs associated with the proposed final rule, and the request has been included in an appropriations Act and enacted into law.

SEC. 812. TRIBAL EMPLOYMENT.

For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall not be considered an "employer".

SEC. 813. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

SEC. 814. ESTABLISHMENT OF NATIONAL BIPARTISAN COMMISSION ON INDIAN HEALTH CARE.

(a) ESTABLISHMENT.—There is established the National Bipartisan Indian Health Care Commission (the "Commission").

(b) DUTIES OF COMMISSION.—The duties of the Commission are the following:

(1) To establish a study committee composed of those members of the Commission appointed by the Director of the Service and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:

(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

(B) To make legislative recommendations to the Commission regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

(C) To determine the effect of the enactment of such recommendations on (i) the existing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study

committee in the course of carrying out its duties under this section.

(2) To review and analyze the recommendations of the report of the study committee.

(3) To make legislative recommendations to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

(4) Not later than 18 months following the date of appointment of all members of the Commission, submit a written report to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

(c) MEMBERS.—

(1) APPOINTMENT.—The Commission shall be composed of 25 members, appointed as follows:

(A) Ten members of Congress, including 3 from the House of Representatives and 2 from the Senate, appointed by their respective majority leaders, and 3 from the House of Representatives and 2 from the Senate, appointed by their respective minority leaders, and who shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

(B) Twelve persons chosen by the congressional members of the Commission, 1 from each Service Area as currently designated by the Director of the Service to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

(D) All those persons chosen by the congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the congressional members of the Commission.

(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, and the remaining members of

the Commission shall be appointed not later than 60 days following the appointment of the congressional members.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(d) COMPENSATION.—

(1) CONGRESSIONAL MEMBERS.—Each congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(2) OTHER MEMBERS.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(e) MEETINGS.—The Commission shall meet at the call of the Chair.

(f) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—

(1) APPOINTMENT; PAY.—The Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF APPOINTMENT.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

(3) STAFF PAY.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) TEMPORARY SERVICES.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) FACILITIES.—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(h) HEARINGS.—

(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as

the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count toward the number of regional hearings required by this subsection.

(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of that Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this sec-

tion, which sum shall not be deducted from or affect any other appropriation for health care for Indian persons.

(j) NONAPPLICABILITY OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

SEC. 815. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

(a) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

(b) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).

(2) TESTIMONY.—A person who reviews or creates medical quality assurance records for any Indian Health Program or Urban Indian Organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform monitoring, required by law, of such program or organization.

(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization.

(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care

provider who is or was an employee of any Indian Health Program or Urban Indian Organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

(E) To an officer, employee, or contractor of the Indian Health Program or Urban Indian Organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization. Such requirement does not apply to the release of information pursuant to section 552a of title 5.

(d) DISCLOSURE FOR CERTAIN PURPOSES.—

(1) IN GENERAL.—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organizations's medical quality assurance programs.

(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

(e) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—A person or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

(f) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (a) may not be made available to any person under section 552 of title 5.

(g) LIMITATION ON CIVIL LIABILITY.—A person who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (a) shall not be civilly liable for such participation or for providing such in-

formation if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

(h) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

(i) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

(j) DEFINITIONS.—In this section:

(1) The term "health care provider" means any health care professional, including community health aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

(2) The term "medical quality assurance program" means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

(3) The term "medical quality assurance record" means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (2) and are produced or compiled by or for an Indian Health Program or Urban Indian Organization as part of a medical quality assurance program.

SEC. 816. APPROPRIATIONS; AVAILABILITY.

Any new spending authority (described in subparagraph (A) or (B) of section 401(c)(2) of the Congressional Budget Act of 1974 (Public Law 93–344; 88 Stat. 317)) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

SEC. 817. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title."

(b) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking "Assistant Secretaries of Health and Human Services (6)." and inserting "Assistant Secretaries of Health and Human Services (7)".

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking "Director, Indian Health Service, Department of Health and Human Services".

(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(1) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(A) in section 3 (25 U.S.C. 3902)—

(i) by striking paragraph (2);

(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(iii) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.";

(B) in section 5 (25 U.S.C. 3904), by striking the section designation and heading and inserting the following:

"SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.";

(C) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking "Director" and inserting "Assistant Secretary";

(D) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking "Director" and inserting "Assistant Secretary"; and

(E) by striking "Director" each place it appears and inserting "Assistant Secretary".

(3) Section 5504(d)(2) of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

(4) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

(5) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by striking "Director of the Indian Health Service" each place it appears and inserting "Assistant Secretary for Indian Health".

(6) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(A) by striking "Director of the Indian Health Service" each place it appears and inserting "Assistant Secretary for Indian Health"; and

(B) in paragraph (2)(A), by striking "the Directors referred to in such paragraph" and inserting "the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health".

(7) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

(8) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking "Director of the Indian Health Service" each place it appears and inserting "Assistant Secretary for Indian Health".

(9) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

(10) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

SEC. 102. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following:

"SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).".

SEC. 103. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) IN GENERAL.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

"TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

"SEC. 801. DEFINITIONS.

"In this title:

"(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

"(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802(f).

"(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

"(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

"SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with this title, the Native American Health and Wellness Foundation.

"(2) FUNDING DETERMINATIONS.—No funds, gift, property, or other item of value (including any interest accrued on such an item) acquired by the Foundation shall—

"(A) be taken into consideration for purposes of determining Federal appropriations relating to the provision of health care and services to Indians; or

"(B) otherwise limit, diminish, or affect the Federal responsibility for the provision of health care and services to Indians.

"(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

"(c) NATURE OF CORPORATION.—The Foundation—

"(1) shall be a charitable and nonprofit federally chartered corporation; and

"(2) shall not be an agency or instrumentality of the United States.

"(d) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

"(e) DUTIES.—The Foundation shall—

"(1) encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, the mission of the Service;

"(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

"(3) participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

"(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—

"(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

"(2) DUTIES.—Not later than 180 days after the date of enactment of this section, the Committee shall—

"(A) carry out such activities as are necessary to incorporate the Foundation under the laws of the District of Columbia, including acting as incorporators of the Foundation;

"(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

"(C) establish the constitution and initial bylaws of the Foundation;

"(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

"(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

"(g) BOARD OF DIRECTORS.—

"(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

"(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

"(3) SELECTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the terms of office of the members shall be as provided in the constitution and bylaws of the Foundation.

"(B) REQUIREMENTS.—

"(i) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

"(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board—

"(I) shall be appointed by the Committee not later than 180 days after the date on which the Foundation is established; and

"(II) shall have staggered terms.

"(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

"(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

"(h) OFFICERS.—

"(1) IN GENERAL.—The officers of the Foundation shall be—

"(A) a secretary, elected from among the members of the Board; and

"(B) any other officers provided for in the constitution and bylaws of the Foundation.

"(2) CHIEF OPERATING OFFICER.—The secretary of the Foundation may serve, at the direction of the Board, as the chief operating officer of the Foundation, or the Board may appoint a chief operating officer, who shall serve at the direction of the Board.

"(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

"(i) POWERS.—The Foundation—

"(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

"(2) may adopt and alter a corporate seal;

"(3) may enter into contracts;

"(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

"(5) may sue and be sued; and

"(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

"(j) PRINCIPAL OFFICE.—

"(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

"(2) ACTIVITIES; OFFICES.—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

"(k) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

"(l) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

"(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

"(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

"(m) RESTRICTIONS.—

"(1) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed the percentage described in paragraph (2) of the sum of—

"(A) the amounts transferred to the Foundation under subsection (o) during the preceding fiscal year; and

"(B) donations received from private sources during the preceding fiscal year.

"(2) PERCENTAGES.—The percentages referred to in paragraph (1) are—

"(A) for the first fiscal year described in that paragraph, 20 percent;

"(B) for the following fiscal year, 15 percent; and

"(C) for each fiscal year thereafter, 10 percent.

"(3) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

"(4) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with the Foundation be considered to be an officer, employee, or agent of the United States.

"(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

"(o) FUNDING.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (e)(1) $500,000 for each fiscal year, as adjusted to reflect changes in the Consumer Price Index for all-urban consumers published by the Department of Labor.

"(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

"SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

"(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

"(1) may provide personnel, facilities, and other administrative support services to the Foundation;

"(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board; and

"(3) shall require and accept reimbursements from the Foundation for—

"(A) services provided under paragraph (1); and

"(B) funds provided under paragraph (2).

"(b) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

"(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

"(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

"(c) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

"(1) are available; and

"(2) are provided on reimbursable cost basis."

(b) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

(1) by redesignating title V (25 U.S.C. 458bbb et seq.) as title VII;

(2) by redesignating sections 501, 502, and 503 (25 U.S.C. 458bbb, 458bbb–1, 458bbb–2) as sections 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking "section 501" and inserting "section 701".

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

SEC. 201. EXPANSION OF PAYMENTS UNDER MEDICARE, MEDICAID, AND SCHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.

(a) MEDICAID.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

"SEC. 1911. INDIAN HEALTH PROGRAMS.";

and

(B) by amending subsection (a) to read as follows:

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

tions and requirements which are applicable generally to the furnishing of items and services under this title and under such plan or waiver authority."

(2) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—Subsection (b) of such section is amended to read as follows:

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

(3) REVISION OF AUTHORITY TO ENTER INTO AGREEMENTS.—Subsection (c) of such section is amended to read as follows:

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

(4) CROSS-REFERENCES TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—Such section is further amended by striking subsection (d) and adding at the end the following new subsections:

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

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

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

(b) MEDICARE.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1880 of such Act (42 U.S.C. 1395qq) is amended—

(A) by amending the heading to read as follows:

"SEC. 1880. INDIAN HEALTH PROGRAMS.";

and

(B) by amending subsection (a) to read as follows:

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

(2) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—Subsection (b) of such section is amended to read as follows:

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

(3) CROSS-REFERENCES TO SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES; DIRECT BILLING OPTION; DEFINITIONS.—

(A) IN GENERAL.—Such section is further amended by striking subsections (c) and (d) and inserting the following new subsections:

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

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

(B) CONFORMING AMENDMENT.—Paragraph (3) of section 1880(e) of such Act (42 U.S.C. 1395qq(e)) is amended by inserting "and section 401(c)(1) of the Indian Health Care Improvement Act" after "Subsection (c)".

(4) DEFINITIONS.—Such section is further amended by amending subsection (f) to read as follows:

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

(c) APPLICATION TO SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C), the following new subparagraph:

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

SEC. 202. 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.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9) is amended to read as follows:

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

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

(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children's health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

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

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

(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms "Indian", "Indian Tribe", "Indian Health Program", "Tribal Organization", and "Urban Indian Organization"

have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.

SEC. 203. ADDITIONAL PROVISIONS TO INCREASE OUTREACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID.

(a) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following new subparagraph:

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

(b) ASSURANCE OF PAYMENTS TO INDIAN HEALTH CARE PROVIDERS FOR CHILD HEALTH ASSISTANCE.—Section 2102(b)(3)(D) of such Act (42 U.S.C. 1397bb(b)(3)(D)) is amended by striking '(as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c))' and inserting ', including how the State will ensure that payments are made to Indian Health Programs and Urban Indian Organizations operating in the State for the provision of such assistance'.

(c) INCLUSION OF OTHER INDIAN FINANCED HEALTH CARE PROGRAMS IN EXEMPTION FROM PROHIBITION ON CERTAIN PAYMENTS.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by striking 'insurance program, other than an insurance program operated or financed by the Indian Health Service' and inserting 'program, other than a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization'.

(d) SATISFACTION OF MEDICAID DOCUMENTATION REQUIREMENTS.—

> *(1) IN GENERAL.—Section 1903(x)(3)(B) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)) is amended—*
>
> > *(A) by redesignating clause (v) as clause (vi); and*
> >
> > *(B) by inserting after clause (iv), the following new clause:*
> >
> > > *"(v)(I) Except as provided in subclause (II), a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe.*
> > >
> > > *"(II) With respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if*

appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.".

(2) TRANSITION RULE.—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.—Section 2110(c) of such Act (42 U.S.C. 1397jj(c)) is amended by adding at the end the following new paragraph:

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

SEC. 204. 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.—

(1) IN GENERAL.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking "and (i)" and inserting ", (i), and (j)"; and

(B) by adding at the end the following new subsection:

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

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

"(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under the contract health service for which payment may be made under this title.

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

charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

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

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

(2) CONFORMING AMENDMENT.—Section 1916A (a)(1) of such Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking "section 1916(g)" and inserting "subsections (g), (i), or (j) of section 1916".

(b) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID AND SCHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new paragraph:

"(13) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property for purposes of determining the eligibility of an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act) for medical assistance under this title:

"(A) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

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

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

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

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B) through (E), as subparagraphs (C) through (F), respectively; and

(B) by inserting after subparagraph (A), the following new subparagraph:

"(B) Section 1902(e)(13) (relating to disregard of certain property for purposes of making eligibility determinations).".

(c) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—

(1) by inserting "(A)" after "(3)"; and

(2) by adding at the end the following new subparagraph:

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

SEC. 205. NONDISCRIMINATION IN QUALIFICATIONS FOR PAYMENT FOR SERVICES UNDER FEDERAL HEALTH CARE PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by section 202, is amended by redesignating subsection (c) as subsection (d), and inserting after subsection (b) the following new subsection:

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

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

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

"(B) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accord-

ance with section 221 of the Indian Health Care Improvement Act, the absence of the licensure of a health care professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

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

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

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

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

SEC. 206. CONSULTATION ON MEDICAID, SCHIP, AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by sections 202 and 205, is amended by redesignating subsection (d) as subsection (e), and inserting after subsection (c) the following new subsection:

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

(b) SOLICITATION OF ADVICE UNDER MEDICAID AND SCHIP.—

(1) MEDICAID STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (69), by striking 'and' at the end;

(B) in paragraph (70)(B)(iv), by striking the period at the end and inserting '; and'; and

(C) by inserting after paragraph (70)(B)(iv), the following new paragraph:

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

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

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

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by section 204(b)(2), is amended—

(A) by redesignating subparagraphs (B) through (F) as subparagraphs (C) through (G), respectively; and

(B) by inserting after subparagraph (A), the following new subparagraph:

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

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

SEC. 207. EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS AND SAFE HARBOR TRANSACTIONS UNDER THE SOCIAL SECURITY ACT.

(a) EXCLUSION WAIVER AUTHORITY.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

"(k) ADDITIONAL EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS.—In addition to the authority granted the Secretary under subsections (c)(3)(B) and (d)(3)(B) to waive an exclusion under subsection (a)(1), (a)(3), (a)(4), or (b), the Secretary may, in the case of an Indian Health Program, waive such an exclusion upon the request of the administrator of an affected Indian Health Program (as defined in section 4 of the Indian Health Care Improvement Act) who determines that the exclusion would impose

a hardship on individuals entitled to benefits under or enrolled in a Federal health care program.".

(b) CERTAIN TRANSACTIONS INVOLVING INDIAN HEALTH CARE PROGRAMS DEEMED TO BE IN SAFE HARBORS.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

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

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

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

"(ii) inventory or supplies;

"(iii) staff; or

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

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

"(i) consist of expenditures related to providing transportation for the patient for the provision of necessary health care items or services, provided that the provision of such transportation is not advertised, nor an incentive of which the value is disproportionately large in relationship to the value of the health care item or service (with respect to the value of the item or service itself or, for preventative items or services, the future health care costs reasonably expected to be avoided);

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

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

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

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

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

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

SEC. 208. 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.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

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

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

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

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

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such

Indian health care provider as the Indian's primary care provider under the entity.

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

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

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

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

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

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

"(D) COMPLIANCE WITH GENERALLY APPLICABLE REQUIREMENTS.—

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

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

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

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

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

"(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

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

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

"(ii) CONTINUED APPLICATION OF ENCOUNTER RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a Federally-qualified health center and that has elected to receive payment under this title as an Indian Health Service provider under the July 11, 1996, Memorandum of Agreement between the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) and the Indian Health Service for services provided by such provider to an Indian

enrollee with the managed care entity is less than the encounter rate that applies to the provision of such services under such memorandum, the State plan shall provide for payment to the Indian health care provider of the difference between the applicable encounter rate under such memorandum and the amount paid by the managed care entity to the provider for such services.

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

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

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

"(B) an Indian health care provider that is funded in whole or in part by the Indian Health Service, or a consortium composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Indian Health Service, has established an Indian Medicaid managed care entity in the State that meets generally applicable standards required of such an entity under such Medicaid managed care program, the State shall offer to enter into an agreement with the entity to serve as a Medicaid managed care entity with respect to eligible Indians served by such entity under such program.

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

"(A) ENROLLMENT.—

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

"(ii) NO LESS CHOICE OF PLANS.—Under such program the State may not limit the choice of an Indian among Medicaid managed care entities only to Indian Medicaid managed care entities or to be more restrictive than the choice of managed care entities offered to individuals who are not Indians.

"(iii) DEFAULT ENROLLMENT.—

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

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

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

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

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

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

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

"(D) FLEXIBILITY IN INFORMATION AND MARKETING.—

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

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

[§ 1680h. Demonstration projects for tribal management of health care services]

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

[(a) Establishment; grants

[(1) The Secretary, acting through the Service, shall make grants to Indian tribes to establish demonstration projects under which the Indian tribe will develop and test a phased approach to assumption by the Indian tribe of the health care delivery system of the Service for members of the Indian tribe living on or near the reservations of the Indian tribe through the use of Service, tribal, and private sector resources.

[(2) A grant may be awarded to an Indian tribe under paragraph (1) only if the Secretary determines that the Indian tribe has the administrative and financial capabilities necessary to conduct a demonstration project described in paragraph (1).

[(b) Health care contracts

[During the period in which a demonstration project established under subsection (a) of this section is being conducted by an Indian tribe, the Secretary shall award all health care contracts, including community, behavioral, and preventive health care contracts, to the Indian tribe in the form of a single grant to which the regulations prescribed under part A of title XIX of the Public Health Service Act [42 U.S.C.A. § 300w et seq.] (as modified as necessary by any agreement entered into between the Secretary and the Indian tribe to achieve the purposes of the demonstration project established under subsection (a) of this section) shall apply.

[(c) Waiver of procurement laws

[The Secretary may waive such provisions of Federal procurement law as are necessary to enable any Indian tribe to develop and test administrative systems under the demonstration project established under subsection (a) of this section, but only if such waiver does not diminish or endanger the delivery of health care services to Indians.

[(d) Termination; evaluation and report

[(1) The demonstration project established under subsection (a) of this section shall terminate on September 30, 1993, or, in the case of a demonstration project for which a grant is made after September 30, 1990, three years after the date on which such grant is made.

[(2) By no later than September 30, 1996, the Secretary shall evaluate the performance of each Indian tribe that has participated in a demonstration project established under subsection (a) of this section and shall submit to the Congress a report on such evaluations and demonstration projects.

[(e) Joint venture demonstration projects

[(1) The Secretary, acting through the Service, shall make arrangements with Indian tribes to establish joint venture demonstration projects under which an Indian tribe shall expend tribal, private, or other available nontribal funds, for the acquisition or construction of a health facility for a minimum of 20 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. A tribe may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

[(2) The Secretary shall make such an arrangement with an Indian tribe only if the Secretary first determines that the Indian tribe has the administrative and financial capabilities

necessary to complete the timely acquisition or construction of the health facility described in paragraph (1).

[(3) An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this subsection, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe, or paid to a third party on the tribe's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, or for personnel or staffing, shall be recoverable.]

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

[§ 1680i. Child sexual abuse treatment programs]

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

[(a) Continuation of existing demonstration programs

[The Secretary and the Secretary of the Interior shall, for each fiscal year through fiscal year 1995, continue the demonstration programs involving treatment for child sexual abuse provided through the Hopi Tribe and the Assiniboine and Sioux Tribes of the Fort Peck Reservation.

[(b) Establishment of new demonstration programs

[Beginning October 1, 1995, the Secretary and the Secretary of the Interior may establish, in any service area, demonstration programs involving treatment for child sexual abuse, except that the Secretaries may not establish a greater number of such programs in one service area than in any other service area until there is an equal number of such programs established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).]

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

[§ 1680j. Tribal leasing]

are deemed to satisfy such requirement.

[Indian tribes providing health care services pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.]

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

[§ 1680k. Home- and community-based care demonstration project]

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

[(a) Authority of Secretary

[The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations providing health care services pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], to establish demonstration projects for the delivery of home- and community-based services to functionally disabled Indians.

[(b) Use of funds

[(1) Funds provided for a demonstration project under this section shall be used only for the delivery of home- and community-based services (including transportation services) to functionally disabled Indians.

[(2) Such funds may not be used—

[(A) to make cash payments to functionally disabled Indians;

[(B) to provide room and board for functionally disabled Indians;

[(C) for the construction or renovation of facilities or the purchase of medical equipment; or

[(D) for the provision of nursing facility services.

[(c) Criteria for approval of applications

[Not later than 180 days after October 29, 1992, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and issue criteria for the approval of applications submitted under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of tribes and tribal organizations to deliver, or arrange for the delivery of, high quality, culturally appropriate home- and community-based services to functionally disabled Indians;

[(d) Assistance to applicants

[The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

[(e) Services to ineligible persons

[At the discretion of the tribe or tribal organization, services provided under a demonstration project established under this section may be provided (on a cost basis) to persons otherwise ineligible for the health care benefits of the Service.

[(f) Maximum number of demonstration projects

[The Secretary shall establish not more than 24 demonstration projects under this section. The Secretary may not establish a greater number of demonstration projects under this section in one service area than in any other service area until there is an equal number of such demonstration projects established with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria issued pursuant to subsection (c) of this section.

[(g) Report

[The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section, together with legislative recommendations.

[(h) Definitions

[For the purposes of this section, the following definitions shall apply:

[(1) The term "home- and community-based services" means one or more of the following:

[(A) Homemaker/home health aide services.

[(B) Chore services.

[(C) Personal care services.

[(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

[(E) Respite care.

[(F) Training for family members in managing a functionally disabled individual.

[(G) Adult day care.

[(H) Such other home- and community-based services as the Secretary may approve.

[(2) The term "functionally disabled" means an individual who is determined to require home- and community-based services based on an assessment that uses criteria (including, at the discretion of the tribe or tribal organization, activities of daily living) developed by the tribe or tribal organization.

[(i) Authorization of appropriations

[There are authorized to be appropriated for each of the fiscal years 1996 through 2000 such sums as may be necessary to carry out this section. Such sums shall remain available until expended.]

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

[§ 1680l. Shared services demonstration project]

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

[(a) Authority of Secretary

[The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into contracts with Indian tribes or tribal organizations to establish not more than 6 shared services demonstration projects for the delivery of long-term care to Indians. Such projects shall provide for the sharing of staff or other services between a Service facility and a nurs-

ing facility owned and operated (directly or by contract) by such Indian tribe or tribal organization.

[(b) Contract requirements

[A contract entered into pursuant to subsection (a) of this section—

[(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

[(2) shall provide that expenses (including salaries) relating to services that are shared between the Service facility and the tribal facility be allocated proportionately between the Service and the tribe or tribal organization; and

[(3) may authorize such tribe or tribal organization to construct, renovate, or expand a nursing facility (including the construction of a facility attached to a Service facility), except that no funds appropriated for the Service shall be obligated or expended for such purpose.

[(c) Eligibility

[To be eligible for a contract under this section, a tribe or tribal organization, shall, as of October 29, 1992—

[(1) own and operate (directly or by contract) a nursing facility;

[(2) have entered into an agreement with a consultant to develop a plan for meeting the long-term needs of the tribe or tribal organization; or

[(3) have adopted a tribal resolution providing for the construction of a nursing facility.

[(d) Nursing facilities

[Any nursing facility for which a contract is entered into under this section shall meet the requirements for nursing facilities under section 1396r of Title 42.

[(e) Assistance to applicants

[The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

[(f) Report

[The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the findings and conclusions derived from the demonstration projects conducted under this section.]

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

[§ 1680m. Results of demonstration projects]

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

the individual under the contract between the entity and the State involved.

[The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this chapter.]

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

[§ 1680n. Priority for Indian reservations]

(b) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by section 206(b)(2), is amended by adding at the end the following new subparagraph:

[(a) Facilities and projects

[Beginning on October 29, 1992, the Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian tribe with jurisdiction over such lands.

[(b) "Indian lands" defined

[For purposes of this section, the term "Indian lands" means—

[(1) all lands within the limits of any Indian reservation; and

[(2) any lands title which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power.]

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

[§ 1680o. Authorization of appropriations]

SEC. 209. ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

[Except as provided in section 1680k of this title, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this subchapter.]

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by the sections 202, 205, and 206, is amended by redesignating subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

[§ 1681. Billing of Indians by Indian Health Service]

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

this Act during the preceding year. Each such report shall include the following:

[The Indian Health Service shall neither bill nor charge those Indians who may have the economic means to pay unless and until such time as Congress has agreed upon a specific policy to do so and has directed the Indian Health Service to implement such a policy.]

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

[§ 1682. Subrogation of claims by]

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

[Hereafter the Indian Health Service may seek subrogation of claims including but not limited to auto accident claims, including no-fault claims, personal injury, disease, or disability claims, and worker's compensation claims, the proceeds of which shall be credited to the funds established by sections 401 and 402 of the Indian Health Care Improvement Act.]

"(3) General information regarding the health status of the Indians described in paragraph (1), disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

[§ 1683. Indian Catastrophic Health Emergency Fund]

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

[$10,000,000 shall remain available until expended, for the establishment of an Indian Catastrophic Health Emergency Fund (hereinafter referred to as the "Fund"). Hereafter, the Fund is to cover the Indian Health Service portion of the medical expenses of catastrophic illness falling within the responsibility of the Service and shall be administered by the Secretary of Health and Human Services, acting through the central office of the Indian Health Service. No part of the Fund or its administration shall be subject to contract or grant under the Indian Self-Determination and Education Assistance Act (Public Law 93–638). There shall be deposited into the Fund all amounts recovered under the authority of the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), which shall become available for obligation upon receipt and which shall remain available for obligation until expended. The Fund shall not be used to pay for health services provided to eligible Indians to the extent that alternate Federal, State, local, or private insurance resources for payment: (1) are available and accessible to the bene-

ficiary; or (2) would be available and accessible if the beneficiary were to apply for them; or (3) would be available and accessible to other citizens similarly situated under Federal, State, or local law or regulation or private insurance program notwithstanding Indian Health Service eligibility or residency on or off a Federal Indian reservation.]

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

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