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S. HRG. 108–62

INDIAN HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

S. 556

TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND THAT ACT

APRIL 2, 2003
WASHINGTON, DC

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INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION OF 2003

WEDNESDAY, APRIL 2, 2003

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell, Inouye, and Murkowski.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. The committee will be in session.

Good morning and welcome to the Committee on Indian Affairs hearing on Secretary Thompson's proposed reorganization of the Department of Health and Human Services. This proposal, known as the One-HHS Initiative, is being vigorously debated on Capitol Hill, in Indian Country and elsewhere. Today, we will hear how the One-HHS Initiative will impact health delivery to Native people.

We are focusing on this One-HHS Initiative today, but in a sense this hearing is the first in a series this committee will be holding on legislation to reauthorize and extend the Indian Health Care Improvement Act that I introduced, along with my friends and colleagues Senator Inouye and Senator McCain. Effort to consolidate Federal programs are not new and at times have proven very successful, such as the employment and training program known as the 477 Program. We are trying to achieve the same success with alcohol, drug and mental health programs, and will hold a hearing on that bill next week. Nevertheless, the Tribes have expressed concerns with the One-HHS proposal, and today we will hear about some of those concerns.

[Text of S. 556 follows:]

II

108TH CONGRESS
1ST SESSION

S. 556

To amend the Indian Health Care Improvement Act to revise and extend that Act.

IN THE SENATE OF THE UNITED STATES

MARCH 6, 2003

Mr. CAMPBELL (for himself, Mr. INOUYE, and Mr. MCCAIN) 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 Reauthorization of 2003".

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

Sec. 1. Short title.

TITLE I—REAUTHORIZATION AND REVISIONS OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Sec. 101. Amendment to the Indian Health Care Improvement Act.

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

Sec. 201. Limitations on charges.
Sec. 202. Qualified Indian health program.

Subtitle B—Medicaid

Sec. 211. State consultation with Indian health programs.
Sec. 212. FMAP for services provided by Indian health programs.
Sec. 213. Indian Health Service programs.

Subtitle C—State Children's Health Insurance Program

Sec. 221. Enhanced FMAP for State children's health insurance program.
Sec. 222. Direct funding of State children's health insurance program.

Subtitle D—Authorization of Appropriations

Sec. 231. Authorization of appropriations.

TITLE III—MISCELLANEOUS PROVISIONS

Sec. 301. Repeals.
Sec. 302. Severability provisions.
Sec. 303. Effective date.

TITLE I—REAUTHORIZATION AND REVISIONS OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

SEC. 101. AMENDMENT TO THE INDIAN HEALTH CARE IMPROVEMENT ACT.

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'.

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

"Sec. 1. Short title; table of contents.
"Sec. 2. Findings.
"Sec. 3. Declaration of health objectives.
"Sec. 4. Definitions.

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

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"Sec. 102. General requirements.
"Sec. 103. Health professions recruitment program for Indians.
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"Sec. 127. Mental health training and community education.
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"Sec. 202. Catastrophic Health Emergency Fund.
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''Sec. 706. Indian women treatment programs.
''Sec. 707. Indian youth program.
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''SEC. 2. FINDINGS.

''Congress makes the following findings:

''(1) Federal delivery of health services and funding of tribal and urban Indian health programs 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 the American Indian people, as reflected in the

Constitution, treaties, Federal laws, and the course of dealings of the United States with Indian tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

''(2) From the time of European occupation and colonization through the 20th century, the policies and practices of the United States caused or contributed to the severe health conditions of Indians.

''(3) Indian tribes have, through the cession of over 400,000,000 acres of land to the United States in exchange for promises, often reflected in treaties, of health care secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States.

''(4) The population growth of the Indian people that began in the later part of the 20th century increases the need for Federal health care services.

''(5) 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, regardless of where they live, to be raised to the highest possible level, a level that is not less than

that of the general population, and to provide for the maximum participation of Indian tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

"(6) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of illnesses among, and unnecessary and premature deaths of, Indians.

"(7) Despite such services, the unmet health needs of the American Indian people remain alarmingly severe, and even continue to increase, and the health status of the Indians is far below the health status of the general population of the United States.

"(8) The disparity in health status that is to be addressed is formidable. In death rates for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher than the death rate for all races in the United States, a pneumonia and influenza death rate that is 71 percent higher, a tuberculosis death rate that is 533 percent higher, and a death rate from alcoholism that is 627 percent higher.

"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people—

"(1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;

"(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto;

"(3) in order to raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2010, or any successor standards thereto, to permit Indian tribes and tribal organizations to set their own health care priorities and establish goals that reflect their unmet needs;

"(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each geographic service area is raised to at least the level of that of the general population;

"(5) to require meaningful, active consultation with Indian tribes, Indian organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

"(6) that funds for health care programs and facilities operated by tribes and tribal organizations be provided in amounts that are not less than the funds that are provided to programs and facilities operated directly by the Service.

"SEC. 4. DEFINITIONS.

"In this Act:

"(1) ACCREDITED AND ACCESSIBLE.—The term 'accredited and accessible', with respect to an entity, means a community college or other appropriate entity that is on or near a reservation and accredited by a national or regional organization with accrediting authority.

"(2) AREA OFFICE.—The term '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.

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary of the Indian Health as established under section 601.

"(4) CONTRACT HEALTH SERVICE.—The term 'contract health service' means a health service that is provided at the expense of the Service, Indian tribe, or tribal organization by a public or private medical provider or hospital, other than a service funded under the Indian Self-Determination and Education Assistance Act or under this Act.

"(5) DEPARTMENT.—The term 'Department', unless specifically provided otherwise, means the Department of Health and Human Services.

"(6) FUND.—The terms 'fund' or 'funding' mean the transfer of monies from the Department to any eligible entity or individual under this Act by any legal means, including funding agreements, contracts, memoranda of understanding, Buy Indian Act contracts, or otherwise.

"(7) FUNDING AGREEMENT.—The term 'funding agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, functions, services and activities to tribes and tribal organizations from the Secretary under the authority of the Indian Self-Determination and Education Assistance Act.

"(8) HEALTH PROFESSION.—The term 'health profession' means allopathic medicine, family medi-

cine, 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, and allied health professions, or any other health profession.

''(9) HEALTH PROMOTION; DISEASE PREVENTION.—The terms 'health promotion' and 'disease prevention' shall have the meanings given such terms in paragraphs (1) and (2) of section 203(c).

''(10) INDIAN.—The term 'Indian' and 'Indians' shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.

''(11) INDIAN HEALTH PROGRAM.—The term 'Indian health program' shall have the meaning given such term in section 110(a)(2)(A).

''(12) INDIAN TRIBE.—The term 'Indian tribe' shall have the meaning given such term in section 4(e) of the Indian Self Determination and Education Assistance Act.

''(13) RESERVATION.—The term 'reservation' means any federally recognized Indian tribe's res-

ervation, Pueblo or colony, including former reservations in Oklahoma, Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act, and Indian allotments.

"(14) SECRETARY.—The term 'Secretary', unless specifically provided otherwise, means the Secretary of Health and Human Services.

"(15) SERVICE.—The term 'Service' means the Indian Health Service.

"(16) SERVICE AREA.—The term 'service area' means the geographical area served by each area office.

"(17) SERVICE UNIT.—The term 'service unit' means—

"(A) an administrative entity within the Indian Health Service; or

"(B) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

"(18) TRADITIONAL HEALTH CARE PRACTICES.—The term 'traditional health care practices'

means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to western healing sciences) which embodies the influences or forces of innate tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which calls upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation and maintenance of health, well-being, and life's harmony.

''(19) TRIBAL ORGANIZATION.—The term 'tribal organization' shall have the meaning given such term in section 4(l) of the Indian Self Determination and Education Assistance Act.

''(20) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' shall have the meaning given such term in section 126 (g)(2).

''(21) URBAN CENTER.—The term 'urban center' means any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

"(22) URBAN INDIAN.—The term 'urban Indian' means any individual who resides in an urban center and who—

"(A) for purposes of title V and regardless of whether such 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 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) is an Eskimo or Aleut or other Alaskan Native;

"(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

"(D) is determined to be an Indian under regulations promulgated by the Secretary.

"(23) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the participation of all interested Indian groups and individuals, and which is capable of legally cooperating with other public and private

entities for the purpose of performing the activities described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"SEC. 101. PURPOSE.

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health services to Indian people.

"SEC. 102. GENERAL REQUIREMENTS.

''(a) SERVICE AREA PRIORITIES.—Unless specifically provided otherwise, amounts appropriated for each fiscal year to carry out each program authorized under this title shall be allocated by the Secretary to the area office of each service area using a formula—

''(1) to be developed in consultation with Indian tribes, tribal organizations and urban Indian organizations;

''(2) that takes into account the human resource and development needs in each such service area; and

"(3) that weighs the allocation of amounts appropriated in favor of those service areas where the health status of Indians within the area, as measured by life expectancy based upon the most recent data available, is significantly lower than the average health status for Indians in all service areas, except that amounts allocated to each such area using such a weighted allocation formula shall not be less than the amounts allocated to each such area in the previous fiscal year.

"(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations to prioritize the utilization of funds provided under this title within the service area.

"(c) REALLOCATION.—Unless specifically prohibited, an area office may reallocate funds provided to the office under this title among the programs authorized by this title, except that scholarship and loan repayment funds shall not be used for administrative functions or expenses.

"(d) LIMITATION.—This section shall not apply with respect to individual recipients of scholarships, loans or other funds provided under this title (as this title existed 1 day prior to the date of enactment of this Act) until

such time as the individual completes the course of study that is supported through the use of such funds.

"SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall make funds available through the area office to public or nonprofit private health entities, or Indian tribes or tribal 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) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

"(3) establishing other programs which the area office determines will enhance and facilitate the en-

rollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

''(b) ADMINISTRATIVE PROVISIONS.—

''(1) APPLICATION.—To be eligible to receive funds under this section an entity described in subsection (a) shall submit to the Secretary, through the appropriate area office, and have approved, an application in such form, submitted in such manner, and containing such information as the Secretary shall by regulation prescribe.

''(2) PREFERENCE.—In awarding funds under this section, the area office shall give a preference to applications submitted by Indian tribes, tribal organizations, or urban Indian organizations.

''(3) AMOUNT.—The amount of funds to be provided to an eligible entity under this section shall be determined by the area office. Payments under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations promulgated pursuant to this Act.

''(4) TERMS.—A funding commitment under this section shall, to the extent not otherwise prohib-

ited by law, be for a term of 3 years, as provided for in regulations promulgated pursuant to this Act.

''(c) DEFINITION.—For purposes of this section and sections 104 and 105, the terms 'Indian' and 'Indians' shall, in addition to the definition provided for in section 4, mean any individual who—

''(1) irrespective of whether such 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;

''(2) is an Eskimo or Aleut or other Alaska Native;

''(3) is considered by the Secretary of the Interior to be an Indian for any purpose; or

''(4) is determined to be an Indian under regulations promulgated by the Secretary.

''SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall provide scholarships through the area offices to Indians who—

''(1) have successfully completed their high school education or high school equivalency; and

"(2) have demonstrated the capability to successfully complete courses of study in the health professions.

"(b) PURPOSE.—Scholarships provided under this section shall be for the following purposes:

"(1) Compensatory preprofessional education of any recipient. Such scholarship shall not exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act).

"(2) Pregraduate education of any 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 (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act) except that an extension of up to 2 years may be approved by the Secretary.

"(c) USE OF SCHOLARSHIP.—Scholarships made under this section may be used to cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school.

"(d) LIMITATIONS.—Scholarship assistance to an eligible applicant under this section shall not be denied solely on the basis of—

"(1) the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; or

"(2) the applicant's eligibility for assistance or benefits under any other Federal program.

"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

"(a) SCHOLARSHIPS.—

"(1) IN GENERAL.—In order to meet the needs of Indians, Indian tribes, tribal organizations, and urban Indian organizations for health professionals, the Secretary, acting through the Service and in accordance with this section, shall provide scholarships through the area offices to Indians who are enrolled full or part time in accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall, except as provided in subsection (b), be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l).

"(2) NO DELEGATION.—The Director of the Service shall administer this section and shall not

delegate any administrative functions under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act.

''(b) ELIGIBILITY.—

''(1) ENROLLMENT.—An Indian shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full or part time in a course of study referred to in subsection (a)(1).

''(2) SERVICE OBLIGATION.—

''(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an 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 on an equivalent year for year obligation, by service—

''(i) in the Indian Health Service;

''(ii) in a program conducted under a funding agreement entered into under the Indian Self-Determination and Education Assistance Act;

''(iii) in a program assisted under title V; or

"(iv) 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.

"(B) DEFERRING ACTIVE SERVICE.—At the request of any Indian who has entered into a contract referred to in subparagraph (A) 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) 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.

"(ii) 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) The active duty service obligation will be served in the health profession of that individual, in a manner consistent with clauses (i) through (iv) of subparagraph (A).

"(C) NEW SCHOLARSHIP RECIPIENTS.—A recipient of an Indian Health Scholarship that is awarded after December 31, 2003, shall meet the active duty service obligation under such scholarship by providing service within the service area from which the scholarship was awarded. In placing the recipient for active duty the area office shall give priority to the program that funded the recipient, except that in cases of special circumstances, a recipient may be placed in a different service area pursuant to an agreement between the areas or programs involved.

"(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) 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.

"(3) PART-TIME ENROLLMENT.—In the case of an Indian receiving a scholarship under this section who is enrolled part time in an approved course of study—

"(A) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the appropriate area office;

"(B) the period of obligated service described in paragraph (2)(A) shall be equal to the greater of—

"(i) the part-time equivalent of 1 year for each year for which the individual was

provided a scholarship (as determined by the area office); or

"(ii) two years; and

"(C) 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)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

"(4) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with the area office pursuant to a scholarship under this section 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) is dismissed from such educational institution for disciplinary reasons;

"(iii) 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) 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 her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A) an individual breaches his or her written contract by failing either to begin such individual's service obligation under this section 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.

"(C) DEATH.—Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

"(D) WAIVER.—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, in consultation with the appropriate area office, Indian tribe, tribal organization, and urban Indian organization, 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.

"(E) HARDSHIP OR GOOD CAUSE.—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) 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 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) FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.—

"(1) PROVISION OF FUNDS.—

"(A) IN GENERAL.—The Secretary shall make funds available, through area offices, 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.

"(B) LIMITATION.—The Secretary shall ensure that amounts available for grants under subparagraph (A) for any fiscal year shall not exceed an amount equal to 5 percent of the amount available for each fiscal year for Indian Health Scholarships under this section.

"(C) APPLICATION.—An application for funds under subparagraph (A) shall be in such form and contain such agreements, assurances and information as consistent with this section.

"(2) REQUIREMENTS.—

"(A) IN GENERAL.—An Indian tribe or tribal organization receiving funds under paragraph (1) shall agree to provide scholarships to Indians in accordance with the requirements of this subsection.

"(B) MATCHING REQUIREMENT.—With respect to the costs of providing any scholarship pursuant to subparagraph (A)—

"(i) 80 percent of the costs of the scholarship shall be paid from the funds provided under paragraph (1) to the Indian tribe or tribal organization; and

"(ii) 20 percent of such costs shall be paid from any other source of funds.

"(3) ELIGIBILITY.—An Indian tribe or tribal organization shall provide scholarships under this subsection only to Indians who are enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in this Act.

"(4) CONTRACTS.—In providing scholarships under paragraph (1), the Secretary and the Indian tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

"(A) obligate such recipient to provide service in an Indian health program (as defined in section 110(a)(2)(A)) in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—

"(i) 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

"(ii) such greater period of time as the recipient and the Indian tribe or tribal organization may agree;

"(B) provide that 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), such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance 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 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 the health profession involved.

"(5) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An individual who has entered into a written contract with the Secretary and an Indian tribe or tribal organization under this subsection and who—

"(i) fails to maintain an acceptable level of academic standing in the education institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) is dismissed from such education for disciplinary reasons;

"(iii) voluntarily terminates the training in such an educational institution for which he or she has been provided a scholarship under such contract before the completion of such training; or

"(iv) 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 Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A), an individual breaches his or her 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.

"(C) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Indian tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary deems appropriate.

"(6) REQUIRED AGREEMENTS.—The recipient of a scholarship under paragraph (1) shall agree, in providing health care pursuant to the requirements of this subsection—

"(A) 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 the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

"(B) 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 of such Act to provide service to individuals entitled to medical assistance under the plan.

"(7) PAYMENTS.—The Secretary, through the area office, shall make payments under this subsection to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary or area office determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has not complied with the requirements of this subsection.

"SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

"(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds 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. These programs shall be located at various colleges and universities 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 AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.—The Secretary shall provide funds 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 American Indians Into Nursing Program authorized under section 115, the Quentin N. Burdick Indians into Health Program authorized under section 117, and existing university research and communications networks.

"(c) REQUIREMENTS.—

"(1) REGULATIONS.—The Secretary shall promulgate regulations pursuant to this Act for the competitive awarding of funds under this section.

"(2) PROGRAM.—Applicants for funds 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 accredited and accessible community colleges 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 various fields of psychology through research, clinical, and experimental 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 accredited and accessible entities to enhance the education of Indian students;

"(F) utilizes, to the maximum extent feasible, existing university tutoring, counseling and student support services; and

"(G) employs, to the maximum extent feasible, qualified Indians in the program.

"(d) ACTIVE DUTY OBLIGATION.—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 (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

"(1) in the Indian Health Service;

"(2) in a program conducted under a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act;

"(3) in a program assisted under title V; 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.

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. 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.

"(b) ENROLLEES IN COURSE OF STUDY.—Any individual who is enrolled in a course of study in the health professions may be employed by the Service or by an In-

dian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(c) HIGH SCHOOL PROGRAMS.—Any individual who is in a high school program authorized under section 103(a) may be employed by the Service, or by a Indian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(d) ADMINISTRATIVE PROVISIONS.—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.

"SEC. 108. CONTINUING EDUCATION ALLOWANCES.

"In order to encourage health professionals, including for purposes of this section, community health representatives and emergency medical technicians, to join or continue in the Service or in any program of an Indian tribe, tribal organization, or urban Indian organization and to provide their services in the rural and remote areas where a significant portion of the Indian people reside, the Secretary, acting through the area offices, may provide allowances to health professionals employed in the Service or such a program to enable such professionals to take leave of their duty stations for a period of time each year (as prescribed by regulations of the Secretary) for professional consultation and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE 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 maintain a Community Health Representative Program under which the Service, Indian tribes and tribal organizations—

"(1) provide for the training of Indians as community health representatives; and

"(2) use such community health representatives in the provision of health care, health promotion,

and disease prevention services to Indian communities.

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Representative Program, shall—

"(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such 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 for continuing education in health care, health promotion,

and disease prevention and maintain 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 served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

''SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (referred to in this Act as the 'Loan Repayment Program') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

''(2) DEFINITIONS.—In this section:

"(A) INDIAN HEALTH PROGRAM.—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 funding agreement under—

"(I) the Indian Self-Determination and Educational Assistance Act; or

"(II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47) (commonly known as the 'Buy-Indian Act'); or

"(iii) by an urban Indian organization pursuant to title V.

"(B) STATE.—The term 'State' has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.

"(b) ELIGIBILITY.—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 institution, as determined by the Secretary, within any State 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 without a service obligation; and

"(3) submit to the Secretary an application for a contract described in subsection (f).

"(c) FORMS.—

"(1) IN GENERAL.—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 (l) 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) FORMS TO BE UNDERSTANDABLE.—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) AVAILABILITY.—The Secretary shall make such application forms, contract forms, and other in-

formation 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) PRIORITY.—

"(1) ANNUAL DETERMINATIONS.—The Secretary, acting through the Service and in accordance with subsection (k), shall annually—

"(A) identify the positions in each Indian health program for which there is a need or a vacancy; and

"(B) rank those positions in order of priority.

"(2) PRIORITY IN APPROVAL.—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 individual Indians; and

"(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—

"(i) individuals recruited through the efforts an Indian tribe, tribal organization, or urban Indian organization; and

"(ii) other individuals based on the priority rankings under paragraph (1).

"(e) CONTRACTS.—

"(1) IN GENERAL.—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).

"(2) NOTICE.—Not later than 21 days after considering an individual for participation in the Loan Repayment Program under paragraph (1), the Secretary shall provide written notice to the individual of—

"(A) the Secretary's approving 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) WRITTEN CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

"(1) an agreement under which—

"(A) subject to paragraph (3), the Secretary agrees—

"(i) to pay loans on behalf of the individual in accordance with the provisions of this section; and

"(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 organization, or urban Indian organization as provided in subparagraph (B)(iii); and

"(B) subject to paragraph (3), the individual agrees—

"(i) to accept loan payments on behalf of the individual;

"(ii) in the case of an individual described in subsection (b)(1)—

"(I) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

"(II) 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);

"(iii) to serve for a time period (referred to in this section 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 to which the individual may be assigned by the Secretary;

"(2) 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);

"(3) 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) a statement of the damages to which the United States is entitled under subsection (l) for the individual's breach of the contract; and

"(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

"(g) LOAN REPAYMENTS.—

"(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) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act) 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) 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) provides an incentive to serve in Indian health programs with the greatest shortages of health professionals; and

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program 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) TIME FOR PAYMENT.—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 not later than the end of the fiscal year in which the individual completes such year of service.

"(3) SCHEDULE FOR PAYMENTS.—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) COUNTING OF INDIVIDUALS.—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.

"(i) RECRUITING PROGRAMS.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other health professional programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

"(j) NONAPPLICATION OF CERTAIN PROVISION.—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) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian health programs 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 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 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) BREACH OF CONTRACT.—

"(1) IN GENERAL.—An individual who has entered into a written contract with the Secretary under this section and who—

"(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 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 who 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) AMOUNT OF RECOVERY.—If, for any reason not specified in paragraph (1), an individual breaches his written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (f), the United States shall be entitled to re-

cover 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 of the United States;

"(C) 't' is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

"(D) 's' is the number of months of such period served by such individual in accordance with this section.

Amounts not paid within such period shall be subject to collection through deductions in medicare payments pursuant to section 1892 of the Social Security Act.

"(3) DAMAGES.—

"(A) TIME FOR PAYMENT.—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 of contract or such longer period beginning on such date as shall be specified by the Secretary.

"(B) DELINQUENCIES.—If damages described in subparagraph (A) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

"(i) utilize 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) CONTRACTS FOR RECOVERY OF DAMAGES.—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, United

States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

"(m) CANCELLATION, WAIVER OR RELEASE.—

"(1) CANCELLATION.—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.

"(2) WAIVER OF SERVICE OBLIGATION.—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.

"(3) WAIVER OF RIGHTS OF UNITED STATES.—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) RELEASE.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bank-

ruptcy under 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) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be submitted to the Congress under section 801, a report concerning the previous fiscal year which sets forth—

''(1) the health professional positions maintained by the Service or by tribal or Indian organizations for which recruitment or retention is difficult;

''(2) the number of Loan Repayment Program applications filed with respect to each type of health profession;

''(3) the number of contracts described in subsection (f) that are entered into with respect to each health profession;

''(4) the amount of loan payments made under this section, in total and by health profession;

''(5) the number of scholarship grants that are provided under section 105 with respect to each health profession;

"(6) the amount of scholarship grants provided under section 105, in total and by health profession;

"(7) the number of providers of health care that will be needed by Indian health programs, by location and profession, during the 3 fiscal years beginning after the date the report is filed; and

"(8) the measures the Secretary plans to take to fill the health professional positions maintained by the Service or by tribes, tribal organizations, or urban Indian organizations for which recruitment or retention is difficult.

"SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

"(a) ESTABLISHMENT.—Notwithstanding section 102, 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 (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

"(1) such amounts as may be collected from individuals under subparagraphs (A) and (B) of section 105(b)(4) and section 110(l) for breach of contract;

"(2) such funds as may be appropriated to the LRRF;

"(3) such interest earned on amounts in the LRRF; and

"(4) such additional amounts as may be collected, appropriated, or earned relative to the LRRF.

Amounts appropriated to the LRRF shall remain available until expended.

"(b) USE OF LRRF.—

"(1) IN GENERAL.—Amounts in the LRRF may be expended by the Secretary, subject to section 102, acting through the Service, to make payments to the Service or to an Indian tribe or tribal organization administering a health care program pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act—

"(A) to which a scholarship recipient under section 105 or a loan repayment program participant under section 110 has been assigned to meet the obligated service requirements pursuant to 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 105 or section 110.

"(2) SCHOLARSHIPS AND RECRUITING.—An Indian tribe or tribal organization receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or to recruit and employ, directly or by contract, health professionals to provide health care services.

"(c) INVESTING OF FUND.—

"(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary determines are not required to meet current withdrawals from the 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) SALE PRICE.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

"SEC. 112. RECRUITMENT ACTIVITIES.

"(a) REIMBURSEMENT OF EXPENSES.—The Secretary may reimburse health professionals seeking positions in the Service, Indian tribes, tribal organizations, or

urban Indian organizations, including unpaid student volunteers and individuals considering entering into a contract under section 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) ASSIGNMENT OF PERSONNEL.—The Secretary, acting through the Service, shall assign one individual in each area office to be responsible on a full-time basis for recruitment activities.

"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

"(a) FUNDING OF PROJECTS.—The Secretary, acting through the Service, shall fund innovative projects for a period not to exceed 3 years to enable Indian tribes, tribal organizations, and urban Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 110(a)(2)(A)).

"(b) ELIGIBILITY.—Any Indian tribe, tribal organization, or urban Indian organization may submit an application for funding of a project pursuant to this section.

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

"(a) DEMONSTRATION PROJECT.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian health program (as defined in section 110) for a substantial period of time to pursue advanced training or research in areas of study for which the Secretary determines a need exists.

"(b) SERVICE OBLIGATION.—

"(1) IN GENERAL.—An individual who participates in the project under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to at least the period of time during which the individual participates in such project.

"(2) FAILURE TO COMPLETE SERVICE.—In the event that an individual fails to complete a period of obligated service under paragraph (1), the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the project after the date of the enactment of this Act, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula speci-

fied in subsection (l) of section 110 in the manner provided for in such subsection.

"(c) OPPORTUNITY TO PARTICIPATE.—Health professionals from Indian tribes, tribal organizations, and urban Indian organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to participate in the program under subsection (a).

"SEC. 115. NURSING PROGRAMS; QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

"(a) GRANTS.—Notwithstanding section 102, the Secretary, acting through the Service, shall provide funds to—

"(1) public or private schools of nursing;

"(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) nurse midwife programs, and advance practice nurse programs, that are provided by any tribal college accredited nursing program, or in the absence of such, any other public or private institution,

for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians.

"(b) USE OF GRANTS.—Funds provided under subsection (a) may be used to—

"(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses;

"(2) provide scholarships to Indian individuals enrolled in such programs that may be used to pay the tuition charged for such program and for other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses;

"(3) provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians;

"(4) provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses; or

"(5) provide any program that is designed to achieve the purpose described in subsection (a).

"(c) APPLICATIONS.—Each application for funds under subsection (a) 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) PREFERENCES.—In providing funds under subsection (a), the Secretary shall extend a preference to—

"(1) programs that provide a preference to Indians;

"(2) programs that train nurse midwives or advanced practice nurses;

"(3) programs that are interdisciplinary; and

"(4) programs that are conducted in cooperation with a center for gifted and talented Indian students established under section 5324(a) of the Indian Education Act of 1988.

"(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available 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 American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

"(f) SERVICE OBLIGATION.—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 individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) that is funded under subsection (a). 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 and Education Assistance Act;

"(3) in a program assisted under title V; or

"(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.

"SEC. 116. TRIBAL CULTURE AND HISTORY.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian tribes in each service area receive educational instruction in the history and culture of such tribes and their relationship to the Service.

"(b) REQUIREMENTS.—To the extent feasible, the educational instruction to be provided under subsection (a) shall—

"(1) be provided in consultation with the affected tribal governments, tribal organizations, and urban Indian organizations;

"(2) be provided through tribally-controlled community colleges (within the meaning of section 2(4) of the Tribally Controlled Community College Assistance Act of 1978) and tribally controlled post-secondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) include instruction in Native American studies.

"SEC. 117. INMED PROGRAM.

"(a) GRANTS.—The Secretary may provide grants to 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruitment program known as the 'Indians into Medicine Program' (referred to in this section as 'INMED') as a means of encouraging Indians to enter the health professions.

"(b) QUENTIN N. BURDICK INDIAN HEALTH PROGRAM.—The Secretary shall provide 1 of the grants under

subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', 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 106(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

"(c) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall develop regulations to govern grants under to this section.

"(2) PROGRAM REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program that—

"(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community colleges located on Indian reservations which will be served by the program;

"(B) incorporates a program advisory board comprised of representatives from the tribes and communities which will be served by the program;

"(C) 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) 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) to the maximum extent feasible, employs qualified Indians in the program.

"SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

"(a) ESTABLISHMENT GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such 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 reservation, in the Service, or in a tribal health program.

"(2) AMOUNT.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is pro-

vided to the community college shall not exceed $100,000.

"(b) CONTINUATION GRANTS.—

"(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) for the purpose of maintaining the program and recruiting students for the program.

"(2) ELIGIBILITY.—Grants may only be made under this subsection to a community college that—

"(A) is accredited;

"(B) has 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 train health professionals; and

"(ii) stipulate certifications necessary to approve internship and field placement opportunities at health programs of the Service or at tribal health programs;

"(D) has a qualified staff which has the appropriate certifications;

"(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

"(F) agrees to provide for Indian preference for applicants for programs under this section.

"(c) SERVICE PERSONNEL AND TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) 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) SPECIFIED COURSES OF STUDY.—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) has already received a degree or diploma in such health profession; and

"(2) provides clinical services on an Indian reservation, at a Service facility, or at a tribal clinic.

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).

"(e) PRIORITY.—Priority shall be provided under this section to tribally controlled colleges in service areas that meet the requirements of subsection (b).

"(f) DEFINITIONS.—In this section:

"(1) COMMUNITY COLLEGE.—The term 'community college' means—

"(A) a tribally controlled community college; or

"(B) a junior or community college.

"(2) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college' has the meaning given such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

"(3) TRIBALLY CONTROLLED COLLEGE.—The term 'tribally controlled college' has the meaning

given the term 'tribally controlled community college' by section 2(4) of the Tribally Controlled Community College Assistance Act of 1978.

"SEC. 119. RETENTION BONUS.

"(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an 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 for which recruitment or retention of personnel is difficult;

"(2) the Secretary determines is needed by the Service, tribe, tribal organization, or urban organization;

"(3) has—

"(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban 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, Indian tribe, tribal organization, or urban Indian organization for continued employment for a period of not less than 1 year.

"(b) RATES.—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), but in no event shall the annual rate be more than $25,000 per annum.

"(c) FAILURE TO COMPLETE TERM OF SERVICE.—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 110(l)(2)(B).

"(d) FUNDING AGREEMENT.—The Secretary may pay a retention bonus to any health professional employed by an organization providing health care services to Indians pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act 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.

"SEC. 120. NURSING RESIDENCY PROGRAM.

"(a) ESTABLISHMENT.—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 110(a)(2)(A)), and have done so for a period of not less than 1 year, to pursue advanced training.

"(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) 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 an advanced degree in nursing and public health.

"(c) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an

obligation to serve in an Indian health program for a period of obligated service equal to the amount of time during which the individual 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 110 in the manner provided for in such subsection.

"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.

"(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 maintain 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) ACTIVITIES.—The Secretary, acting through the Community Health Aide Program under subsection (a), 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 objective specified in section 3(b);

"(3) establish and maintain a Community Health Aide Certification Board to certify as com-

munity health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or who 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.

''SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

''Subject to Section 102, the Secretary, acting through the Service, shall, through a funding agreement or otherwise, provide training for Indians in the administration and planning of tribal health programs.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROJECT.

"(a) PILOT PROGRAMS.—The Secretary may, through area offices, fund pilot programs for tribes and tribal organizations to address chronic shortages of health professionals.

"(b) PURPOSE.—It is the purpose of the health professions demonstration project under this section to—

"(1) provide direct clinical and practical experience in a service area to health professions students and residents from medical schools;

"(2) improve the quality of health care for Indians by assuring access to qualified health care professionals; and

"(3) provide academic and scholarly opportunities for health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

"(c) ADVISORY BOARD.—A pilot program established under subsection (a) shall incorporate a program advisory board that shall be composed of representatives from the tribes and communities in the service area that will be served by the program.

"SEC. 124. SCHOLARSHIPS.

"Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'quali-

fied scholarships' for purposes of section 117 of the Internal Revenue Code of 1986.

"SEC. 125. NATIONAL HEALTH SERVICE CORPS.

"(a) LIMITATIONS.—The Secretary shall not—

"(1) remove a member of the National Health Services Corps from a health program operated by Indian Health Service or by a tribe or tribal organization under a funding agreement with the Service under the Indian Self-Determination and Education Assistance Act, or by urban Indian organizations; or

"(2) withdraw the funding used to support such a member;

unless the Secretary, acting through the Service, tribes or tribal organization, has ensured that the Indians receiving services from such member will experience no reduction in services.

"(b) DESIGNATION OF SERVICE AREAS AS HEALTH PROFESSIONAL SHORTAGE AREAS.—All service areas served by programs operated by the Service or by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization, shall be designated under section 332 of the Public Health Service Act (42 U.S.C. 254e) as Health Professional Shortage Areas.

"(c) FULL TIME EQUIVALENT.—National Health Service Corps scholars that qualify 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 such scholars serve as commissioned corps officers in a health program operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization.

"SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT.

"(a) DEMONSTRATION PROJECTS.—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 accredited and accessible 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) TERM OF GRANT.—A contract entered into or a grant provided under this section shall be for a period

of 1 year. Such contract or grant may be renewed for an additional 1 year period upon the approval of the Secretary.

"(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, 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 projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

"(e) TECHNICAL 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.—The Secretary shall submit to the President, for inclusion in the report required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.

"(g) DEFINITIONS.—In this section:

"(1) EDUCATIONAL CURRICULUM.—The term 'educational curriculum' means 1 or more of the following:

"(A) Classroom education.

"(B) Clinical work experience.

"(C) Continuing education workshops.

"(2) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' has the meaning given such term in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

"(3) TRIBALLY CONTROLLED POSTSECONDARY VOCATIONAL INSTITUTION.—The term 'tribally controlled postsecondary vocational institution' has the meaning given such term in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)).

"SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION.

"(a) STUDY AND LIST.—

"(1) IN GENERAL.—The Secretary 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 in-

clude or should include, training in the identification, prevention, education, referral or treatment of mental illness, dysfunctional or self-destructive behavior.

"(2) POSITIONS.—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, family and child welfare;

"(iii) law enforcement and judicial services; and

"(iv) alcohol and substance abuse;

"(B) staff positions within the Service; and

"(C) staff positions similar to those specified in subsection (b) and established and maintained by Indian tribes, tribal organizations, and urban Indian organizations, including positions established pursuant to funding agreements under the Indian Self-determination and Education Assistance Act, and this Act.

"(3) TRAINING CRITERIA.—

"(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position specified in subsection (b)(1) and ensure that appropriate training has been or will be provided to any individual in any such position.

"(B) TRAINING.—With respect to any such individual in a position specified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training or provide funds to an Indian tribe, tribal organization, or urban Indian organization for the training of appropriate individuals. In the case of a funding agreement, the appropriate Secretary shall ensure that such training costs are included in the funding agreement, if necessary.

"(4) CULTURAL RELEVANCY.—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.

"(5) COMMUNITY EDUCATION.—

"(A) DEVELOPMENT.—The Service shall develop and implement, or on request of an Indian tribe or tribal organization, assist an In-

dian tribe or tribal organization, in developing and implementing a program of community education on mental illness.

"(B) TECHNICAL ASSISTANCE.—In carrying out this paragraph, the Service shall, upon the request of an Indian tribe or tribal organization, provide technical assistance to the Indian tribe or tribal organization to obtain and develop community educational materials on the identification, prevention, referral and treatment of mental illness, dysfunctional and self-destructive behavior.

"(b) STAFFING.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of the Act, the Director of the Service shall develop a plan under which the Service will increase the number of health care staff that are providing mental health services by at least 500 positions within 5 years after such date of enactment, with at least 200 of such positions devoted to child, adolescent, and family services. The allocation of such positions shall be subject to the provisions of section 102(a).

"(2) IMPLEMENTATION.—The plan developed under paragraph (1) shall be implemented under the

Act of November 2, 1921 (25 U.S.C. 13) (commonly know as the 'Snyder Act').

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

''(a) IN GENERAL.—The Secretary may expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, that are appropriated under the authority of this section, for the purposes of—

''(1) eliminating the deficiencies in the health status and resources of all Indian 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;

''(4) eliminating inequities in funding for both direct care and contract health service programs; and

''(5) augmenting the ability of the Service to meet the following health service responsibilities with

respect to those Indian tribes with the highest levels of health status and resource deficiencies:

"(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

"(B) preventive health, including mammography and other cancer screening in accordance with section 207;

"(C) dental care;

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional health care practitioners;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

"(G) accident prevention programs;

"(H) home health care;

"(I) community health representatives;

"(J) maintenance and repair; and

"(K) traditional health care practices.

"(b) USE OF FUNDS.—

"(1) 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 this Act, the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

"(2) ALLOCATION.—

"(A) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to service units or Indian tribes or tribal organizations. The funds allocated to each tribe, tribal organization, or service unit under this subparagraph shall be used to improve the health status and reduce the resource deficiency of each tribe served by such service unit, tribe or tribal organization. Such allocation shall weigh the amounts appropriated in favor of those service areas where the health status of Indians within the area, as measured by life expectancy based upon the most recent data available, is significantly lower than the average health status for Indians for all service areas, except that amounts allocated to each such area

using such a weighted allocation formula shall not be less than the amounts allocated to each such area in the previous fiscal year.

"(B) APPORTIONMENT.—The apportionment of funds allocated to a service unit, tribe or tribal organization under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes in accordance with this section and such rules as may be established under title VIII.

"(c) HEALTH STATUS AND RESOURCE DEFICIENCY.—In this section:

"(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

"(A) the health status objective set forth in section 3(2) is not being achieved; and

"(B) the Indian 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) RESOURCES.—The health resources available to an Indian tribe or tribal organization shall include health resources provided by the Service as well as health resources used by the Indian tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

"(3) REVIEW OF DETERMINATION.—The Secretary shall establish procedures which allow any Indian 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 or tribal organization.

"(d) ELIGIBILITY.—Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act 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.

"(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, 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, including newly recognized or acknowledged tribes. Such report shall set out—

"(1) the methodology then in use by the Service for determining 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 served by the Service;

"(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service; and

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this 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, Indian tribe, or comparable entity;

"(B) the number of Indians eligible for health services in each service unit or Indian tribe or tribal organization; and

"(C) the number of Indians using the Service resources made available to each service unit or 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) BUDGETARY RULE.—Funds appropriated under the 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) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs or to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

''(h) DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is hereby established an Indian Catastrophic Health Emergency Fund (referred to in this section as the 'CHEF') consisting of—

''(A) the amounts deposited under subsection (d); and

"(B) any amounts appropriated to the CHEF under this Act.

"(2) ADMINISTRATION.—The CHEF shall be administered by the Secretary 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) EQUITABLE ALLOCATION.—The CHEF shall be equitably allocated, apportioned or delegated on a service unit or area office basis, based upon a formula to be developed by the Secretary in consultation with the Indian tribes and tribal organizations through negotiated rulemaking under title VIII. Such formula shall take into account the added needs of service areas which are contract health service dependent.

"(4) NOT SUBJECT TO CONTRACT OR GRANT.—No part of the CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

"(5) ADMINISTRATION.—Amounts provided from the CHEF shall be administered by the area offices based upon priorities determined by the In-

dian tribes and tribal organizations within each service area, including a consideration of the needs of Indian tribes and tribal organizations which are contract health service-dependent.

''(b) REQUIREMENTS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section—

''(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the CHEF;

''(2) provide that a service unit, Indian tribe, or tribal organization shall not be eligible for reimbursement for the cost of treatment from the CHEF until its cost of treatment for any victim of such a catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

''(A) for 1999, not less than $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 incurred by—

"(A) service units, Indian tribes, or tribal organizations, or facilities of the Service; or

"(B) non-Service facilities or providers whenever otherwise authorized by the Service;

in rendering treatment that exceeds threshold cost described in paragraph (2);

"(4) establish a procedure for payment from the 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 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) LIMITATION.—Amounts appropriated to the CHEF under this section shall not be used to offset or limit appropriations made to the Service under the author-

ity of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act) or any other law.

"(d) DEPOSITS.—There shall be deposited into the 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 CHEF.

"SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

"(a) FINDINGS.—Congress finds that health promotion and disease prevention activities will—

"(1) improve the health and well-being of Indians; and

"(2) reduce the expenses for health care of Indians.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and through Indian tribes and tribal organizations, shall provide health promotion and disease prevention services to Indians so as to achieve the health status objective set forth in section 3(b).

"(c) DISEASE PREVENTION AND HEALTH PROMOTION.—In this section:

"(1) DISEASE PREVENTION.—The term 'disease prevention' means the reduction, limitation, and pre-

vention of disease and its complications, and the reduction in the consequences of such diseases, including—

"(A) controlling—

"(i) 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) for the fluoridation of water; and

"(ii) immunizations.

"(2) HEALTH PROMOTION.—The term 'health promotion' means fostering social, economic, environmental, and personal factors conducive to health, including—

"(A) raising people's awareness about health matters and enabling them 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 suitable housing, safe water, and sanitary facilities;

"(E) improving the physical economic, cultural, psychological, and social environment;

"(F) promoting adequate opportunity for spiritual, religious, and traditional practices; and

"(G) adequate and appropriate programs including—

"(i) abuse prevention (mental and physical);

"(ii) community health;

"(iii) community safety;

"(iv) consumer health education;

"(v) diet and nutrition;

"(vi) disease prevention (communicable, immunizations, HIV/AIDS);

"(vii) environmental health;

"(viii) exercise and physical fitness;

"(ix) fetal alcohol disorders;

"(x) first aid and CPR education;

"(xi) human growth and development;

"(xii) injury prevention and personal safety;

"(xiii) mental health (emotional, self-worth);

"(xiv) personal health and wellness practices;

"(xv) personal capacity building;

"(xvi) prenatal, pregnancy, and infant care;

"(xvii) psychological well being;

"(xiii) reproductive health (family planning);

"(xix) safe and adequate water;

"(xx) safe housing;

"(xxi) safe work environments;

"(xxii) stress control;

"(xxiii) substance abuse;

"(xxiv) sanitary facilities;

"(xxv) tobacco use cessation and reduction;

"(xxvi) violence prevention; and

"(xxvii) such other activities identified by the Service, an Indian tribe or tribal or-

ganization, to promote the achievement of the objective described in section 3(b).

"(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement which is required to be submitted to Congress under section 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 to meet such needs; and

"(4) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs.

"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

"(a) DETERMINATION.—The Secretary, in consultation with Indian tribes and tribal organizations, shall determine—

"(1) by tribe, tribal organization, and service unit of the Service, the prevalence of, and the types

of complications resulting from, diabetes among Indians; and

"(2) based on paragraph (1), the measures (including patient education) each service unit should take to reduce the prevalence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that service unit.

"(b) SCREENING.—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. Such screening may be done by an Indian tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act.

"(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2015, each effective model diabetes project in existence on the date of the enactment of this Act and such other diabetes programs operated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with

tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.

''(d) DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian tribes and tribal organizations to establish dialysis programs, including funds to purchase dialysis equipment and provide necessary staffing.

''(e) OTHER ACTIVITIES.—The Secretary shall, to the extent funding is available—

''(1) in each area office of the Service, 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 a registry of patients with diabetes to track the prevalence of diabetes and the complications from diabetes in that area; and

''(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to tribes, tribal organizations, and all other area offices.

"SEC. 205. SHARED SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into funding agreements or

other arrangements with Indian tribes or tribal organizations for the delivery of long-term care and similar services to Indians. Such projects shall provide for the sharing of staff or other services between a Service or tribal facility and a long-term care or other similar facility owned and operated (directly or through a funding agreement) by such Indian tribe or tribal organization.

"(b) REQUIREMENTS.—A funding agreement or other arrangement entered into pursuant to subsection (a)—

"(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 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 long-term care or other similar facility (including the construction of a facility attached to a Service facility).

"(c) TECHNICAL 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.

"(d) USE OF EXISTING FACILITIES.—The Secretary shall encourage the use for long-term or similar care of existing facilities that are under-utilized or allow the use of swing beds for such purposes.

"SEC. 206. HEALTH SERVICES RESEARCH.

"(a) FUNDING.—The Secretary shall make funding available for research to further the performance of the health service responsibilities of the Service, Indian tribes, and tribal organizations and shall coordinate the activities of other Agencies within the Department to address these research needs.

"(b) ALLOCATION.—Funding under subsection (a) shall be allocated equitably among the area offices. Each area office shall award such funds competitively within that area.

"(c) ELIGIBILITY FOR FUNDS.—Indian tribes and tribal organizations receiving funding from the Service under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

"(d) USE.—Funds received under this section may be used for both clinical and non-clinical research by Indian tribes and tribal organizations and shall be distributed to the area offices. Such area offices may make grants using such funds within each area.

"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

"The Secretary, through the Service or through Indian tribes or tribal organizations, shall provide for the following screening:

"(1) Mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act.

"(2) Other cancer screening meeting national standards.

"SEC. 208. PATIENT TRAVEL COSTS.

"The Secretary, acting through the Service, Indian tribes and tribal organizations shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving

health care services provided (either through direct or contract care or through funding agreements entered into pursuant to the Indian Self-Determination and Education Assistance Act) under this Act:

"(1) Emergency air transportation and non-emergency air transportation where ground transportation is infeasible.

"(2) Transportation by private vehicle, specially equipped vehicle and ambulance.

"(3) Transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

"SEC. 209. EPIDEMIOLOGY CENTERS.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this Act, (including those centers for which funding is currently being provided through funding agreements under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in paragraph (2). Any centers established under the preceding sen-

tence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

"(2) FUNCTIONS.—In consultation with and upon the request of Indian tribes, tribal organizations and urban Indian organizations, each area epidemiology center established under this subsection shall, with respect to such area shall—

"(A) collect data related to the health status objective described in section 3(b), and monitor the progress that the Service, Indian tribes, tribal organizations, and urban Indian organizations have made in meeting such health status objective;

"(B) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

"(C) assist 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) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities;

"(E) make recommendations to improve health care delivery systems for Indians and urban Indians;

"(F) provide requested technical assistance to Indian tribes 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

"(G) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian organizations to promote public health.

"(3) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

"(b) FUNDING.—The Secretary may make funding available to Indian tribes, tribal organizations, and eligible intertribal consortia or urban Indian organizations to conduct epidemiological studies of Indian communities.

"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide funding to Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and urban Indian children.

"(b) USE OF FUNDS.—Funds awarded under this section may be used to—

"(1) develop and implement health education curricula both for regular school programs and after school programs;

"(2) train teachers in comprehensive school health education curricula;

"(3) integrate school-based, community-based, and other public and private health promotion efforts;

"(4) encourage healthy, tobacco-free school environments;

"(5) coordinate school-based health programs with existing services and programs available in the community;

"(6) develop school programs on nutrition education, personal health, oral health, and fitness;

"(7) develop mental health wellness programs;

"(8) develop chronic disease prevention programs;

"(9) develop substance abuse prevention programs;

"(10) develop injury prevention and safety education programs;

"(11) develop activities for the prevention and control of communicable diseases;

"(12) develop community and environmental health education programs that include traditional health care practitioners;

"(13) carry out violence prevention activities; and

"(14) carry out activities relating to such other health issues as are appropriate.

"(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian 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.—The Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian orga-

nizations shall establish criteria for the review and approval of applications for funding under this section.

"(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

"(1) DEVELOPMENT.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary and affected Indian tribes and tribal organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 for use in schools operated by the Bureau of Indian Affairs.

"(2) REQUIREMENTS.—The program developed under paragraph (1) shall include—

"(A) school programs on nutrition education, personal health, oral health, and fitness;

"(B) mental health wellness programs;

"(C) chronic disease prevention programs;

"(D) substance abuse prevention programs;

"(E) injury prevention and safety education programs; and

"(F) activities for the prevention and control of communicable diseases.

"(3) TRAINING AND COORDINATION.—The Secretary of the Interior shall—

"(A) provide training to teachers in comprehensive school health education curricula;

"(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.

"SEC. 211. INDIAN YOUTH PROGRAM.

"(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to provide funding to Indian 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.—

"(1) IN GENERAL.—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 health care practitioners; and

"(B) develop and provide community training and education.

"(2) LIMITATION.—Funds made available under this section may not be used to provide services described in section 707(c).

"(c) REQUIREMENTS.—The Secretary shall—

"(1) disseminate to Indian tribes, tribal organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

"(2) encourage the implementation of such models; and

"(3) at the request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance in the implementation of such models.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes, tribal organization, and urban Indian organizations, shall establish criteria for the review and approval of applications under this section.

"SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

"(a) IN GENERAL.—The Secretary, acting through the Service after consultation with Indian tribes, tribal organizations, urban Indian organizations, and the Centers

for Disease Control and Prevention, may make funding available to Indian tribes and tribal organizations for—

"(1) projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori, which projects may include screening, testing and treatment for HCV and other infectious and communicable diseases;

"(2) public information and education programs for the prevention, control, and elimination of communicable and infectious diseases;

"(3) education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals; and

"(4) a demonstration project that studies the seroprevalence of the Hepatitis C virus among a random sample of American Indian and Alaskan Native populations and identifies prevalence rates among a variety of tribes and geographic regions.

"(b) REQUIREMENT OF APPLICATION.—The Secretary may provide funds under subsection (a) only if an application or proposal for such funds is submitted.

"(c) TECHNICAL ASSISTANCE AND REPORT.—In carrying out this section, the Secretary—

"(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

"(2) shall prepare and submit, biennially, a report to Congress on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.

"SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objective set forth in section 3 through health care related services and programs not otherwise described in this Act. Such services and programs shall include services and programs related to—

"(1) hospice care and assisted living;

"(2) long-term health care;

"(3) home- and community-based services;

"(4) public health functions; and

"(5) traditional health care practices.

"(b) AVAILABILITY OF SERVICES FOR CERTAIN INDIVIDUALS.—At the discretion of the Service, Indian tribe, or tribal organization, services hospice care, home health care (under section 201), home- and community-based care, assisted living, and long term care may be provided (on a cost basis) to individuals otherwise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to a tribe or tribal organization.

"(c) DEFINITIONS.—In this section:

"(1) HOME- AND COMMUNITY-BASED SERVICES.—The term 'home- and community-based services' means 1 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) Training for family members.

"(F) Adult day care.

"(G) Such other home- and community-based services as the Secretary or a tribe or tribal organization may approve.

"(2) HOSPICE CARE.—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 such care.

"(3) PUBLIC HEALTH FUNCTIONS.—The term 'public health functions' means public health related programs, functions, and services including assessments, assurances, and policy development that Indian tribes and tribal organizations are authorized and encouraged, in those circumstances where it meets their needs, to carry out by forming collaborative relationships with all levels of local, State, and Federal governments.

"SEC. 214. INDIAN WOMEN'S HEALTH CARE.

"The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding 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.

"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

"(a) STUDY AND MONITORING PROGRAMS.—The Secretary and the Service shall, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and tribal organizations, conduct a study and carry out ongoing monitoring programs to determine the trends that exist in the health hazards posed to Indian miners and to Indians on or near Indian reservations and in Indian communities as a result of environmental hazards that may result in chronic or life-threatening health problems. Such hazards include nuclear resource development, petroleum contamination, and contamination of the water source or of the food chain. Such study (and any reports with respect to such study) 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 Indian reservations and communities including the cumulative effect of such development 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 Indian reservations or communities, and other development that could affect the health of Indians and their water supply and food chain;

"(4) a summary of any findings or recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of this Act that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

"(5) a description of 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) DEVELOPMENT OF HEALTH CARE PLANS.—Upon the completion of the study under subsection (a),

the Secretary and the Service shall take into account the results of such study and, in consultation with Indian tribes and tribal organizations, develop a health care plan to address the health problems that were the subject of such study. 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 TO CONGRESS.—

"(1) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Service shall submit to Congress a report concerning the study conducted under subsection (a).

"(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan 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 the health problems involved.

"(d) TASK FORCE.—

"(1) ESTABLISHED.—There is hereby established an Intergovernmental Task Force (referred to in this section as the 'task force') that shall be composed of the following individuals (or their designees):

"(A) The Secretary of Energy.

"(B) The Administrator 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.

"(2) DUTIES.—The Task Force shall 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 an Indian reservation or in an Indian community, and 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) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson 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) PROVISION OF APPROPRIATE MEDICAL CARE.—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 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 or entity responsible for the environmental hazard;

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 or entity from such operator or entity. 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.

"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, 2015, 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) LIMITATION.—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).

"SEC. 216A. NORTH DAKOTA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of North 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.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of North Dakota 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. 216B. SOUTH DAKOTA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of 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 South Dakota.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of South Dakota 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. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM.

"(a) IN GENERAL.—The Secretary may fund a program that utilizes the California Rural Indian Health Board as a contract care intermediary to improve the accessibility of health services to California Indians.

"(b) REIMBURSEMENT OF BOARD.—

"(1) AGREEMENT.—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 pursuant to this section in providing medical treatment under contract to California Indians described in section 809(b) throughout the California contract health services delivery area described in section 218 with respect to high-cost contract care cases.

"(2) ADMINISTRATION.—Not more than 5 percent of the amounts provided to the Board under

this section for any fiscal year may be used for reimbursement for administrative expenses incurred by the Board during such fiscal year.

"(3) LIMITATION.—No payment may be made for treatment provided under this section to the extent that payment may be made for such treatment under the 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.

"(c) ADVISORY BOARD.—There is hereby established an advisory board that shall advise the California Rural Indian Health Board in carrying out 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 this section, at least 50 percent of whom are not affiliated with the California Rural Indian Health Board.

"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 Indians in such State, except that any of the counties described in this section may 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) IN GENERAL.—The Secretary, acting through the Service, shall 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) RULE OF CONSTRUCTION.—Nothing in this section shall 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 Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act 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 Indian tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

"SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES.

''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.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

"(a) REQUIREMENT.—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 RESPOND.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

"(c) PAYMENT.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

"(a) NO LIABILITY.—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.

"(c) LIMITATION.—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 involved.

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE III—FACILITIES

"SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

"(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm 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) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

"(1) consult with any Indian 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, that such facility meets the construction standards of any nationally recognized accrediting body by not later

than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURE OF FACILITIES.—

"(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by the Service, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such proposed closure an evaluation of the impact of such proposed closure which 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 served by such hospital or facility concerning such closure;

"(F) the level of utilization 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) TEMPORARY CLOSURE.—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 safety reasons.

"(c) PRIORITY SYSTEM.—

"(1) ESTABLISHMENT.—The Secretary shall establish a health care facility priority system, that shall—

"(A) be developed with Indian tribes and tribal organizations through negotiated rulemaking under section 802;

"(B) give the needs of Indian tribes the highest priority, with additional priority being given to those service areas where the health status of Indians within the area, as measured by life expectancy based upon the most recent data available, is significantly lower than the average health status for Indians in all service areas; and

"(C) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E);

except that the priority of any project established under the construction priority system in effect on the date of this Act shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as one of the top 10 priority inpatient projects or one of the top 10 outpatient projects in the Indian Health Service budget justification for fiscal year 2003, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of this Act.

"(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report that includes—

"(A) a description of the health care facility priority system of the Service, as established under paragraph (1);

"(B) health care facility lists, including—

"(i) the total health care facility planning, design, construction and renovation needs for Indians;

"(ii) the 10 top-priority inpatient care facilities;

"(iii) the 10 top-priority outpatient care facilities;

"(iv) the 10 top-priority specialized care facilities (such as long-term care and alcohol and drug abuse treatment); and

"(v) any staff quarters associated with such prioritized facilities;

"(C) the justification for the order of priority among facilities;

"(D) the projected cost of the projects involved; and

"(E) the methodology adopted by the Service in establishing priorities under its health care facility priority system.

"(3) CONSULTATION.—In preparing each report required under paragraph (2) (other than the initial report) the Secretary shall annually—

"(A) consult with, and obtain information on all health care facilities needs from, Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the

Indian Self-Determination and Education Assistance Act; and

"(B) review the total unmet needs of all tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

"(4) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

"(5) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities, operated under funding agreements in accordance with the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the health care facility priority system.

"(d) REVIEW OF NEED FOR FACILITIES.—

"(1) REPORT.—Beginning in 2004, the Secretary shall annually submit to the President, for in-

clusion in the report required to be transmitted to Congress under section 801 of this Act, a report which sets forth the needs of the Service and all Indian tribes and tribal organizations, including urban Indian organizations, for inpatient, outpatient and specialized care facilities, including the needs for renovation and expansion of existing facilities.

"(2) CONSULTATION.—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 programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

"(3) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

"(4) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of facilities operated under funding agreements, in accordance with the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the development of the health facility priority system.

"(5) ANNUAL NOMINATIONS.—Each year the Secretary shall provide an opportunity for the nomination of planning, design, and construction projects by the Service and all Indian tribes and tribal organizations for consideration under the health care facility priority system.

"(e) INCLUSION OF CERTAIN PROGRAMS.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act.

"(f) 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 construction of health facilities, including those

provided for in other sections of this title and other approaches.

"SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

"(a) FINDINGS.—Congress finds and declares that—

"(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal 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 facilities;

"(3) 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 facilities and other preventive health measures;

"(4) many Indian homes and communities still lack safe water supply facilities and sanitary sewage and solid waste disposal facilities; and

"(5) 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 sup-

ply facilities and sanitary sewage waste disposal facilities as soon as possible.

"(b) PROVISION OF FACILITIES AND SERVICES.—

"(1) IN GENERAL.—In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(2) ASSISTANCE.—The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

"(A) financial and technical assistance to Indian tribes, tribal organizations and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the tribe or tribal organization;

"(B) ongoing technical assistance and training in the management of utility organiza-

tions which operate and maintain sanitation facilities; and

"(C) priority funding for the operation, and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

"(3) PROVISIONS RELATING TO FUNDING.—Notwithstanding any other provision of law—

"(A) 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 to the Secretary of Health and Human Services;

"(B) 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 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

"(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services 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;

"(D) the Secretary of Health and Human Services is authorized to accept all Federal funds that are available for the purpose of providing sanitation facilities and related services and place those funds into funding agreements, authorized under the Indian Self-Determination and Education Assistance Act, between the Secretary and Indian tribes and tribal organizations;

"(E) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to fund up to 100 percent of the amount of a tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

"(F) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

"(G) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned or appropriated and thereafter the Department's applicable policies, rules, regulations shall apply in the implementation of such projects;

"(H) the Secretary of Health and Human Services shall enter into inter-agency agreements with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the Department of Agriculture, the Environmental Protection Agency and other appropriate Federal agencies, for the purpose of providing financial assistance for safe water supply and sanitary sewage disposal facilities under this Act; and

"(I) the Secretary of Health and Human Services shall, by regulation developed through

rulemaking under section 802, establish standards applicable to the planning, design and construction of water supply and sanitary sewage and solid waste disposal facilities funded under this Act.

''(c) 10-YEAR FUNDING PLAN.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, shall develop and implement a 10-year funding plan to provide safe water supply and sanitary sewage and solid waste disposal facilities serving existing Indian homes and communities, and to new and renovated Indian homes.

''(d) CAPABILITY OF TRIBE OR COMMUNITY.—The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

''(e) FINANCIAL ASSISTANCE.—The Secretary may provide financial assistance to Indian tribes, tribal organizations and communities for the operation, management, and maintenance of their sanitation facilities.

''(f) RESPONSIBILITY FOR FEES FOR OPERATION AND MAINTENANCE.—The Indian family, community or tribe involved shall have the primary responsibility to establish, collect, and use reasonable user fees, or otherwise

set aside funding, for the purpose of operating and maintaining sanitation facilities. If a community facility is threatened with imminent failure and there is a lack of tribal capacity to maintain the integrity or the health benefit of the facility, the Secretary may assist the tribe in the resolution of the problem on a short term basis through cooperation with the emergency coordinator or by providing operation and maintenance service.

"(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANIZATIONS.—Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

"(1) any funds appropriated pursuant to this section; and

"(2) any funds appropriated for the purpose of providing water supply, sewage disposal, or solid waste facilities;

on an equal basis with programs that are administered directly by the Service.

"(h) REPORT.—

"(1) IN GENERAL.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report which sets forth—

"(A) the current Indian sanitation facility priority system of the Service;

"(B) the methodology for determining sanitation deficiencies;

"(C) the level of initial and final sanitation deficiency for each type sanitation facility for each project of each Indian tribe or community; and

"(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian tribes and communities to a level I sanitation deficiency as described in paragraph (4)(A).

"(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any funding agreements entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe and in developing the criteria on which the needs will be evaluated through a process of negotiated rulemaking.

"(3) 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 communities.

"(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual or community sanitation facility serving Indian homes are as follows:

"(A) A level I deficiency is a sanitation facility serving an individual or community—

"(i) which complies with all applicable water supply, 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 deficiency is a sanitation facility serving an individual or community—

"(i) which substantially or recently complied with all applicable water supply, pollution control and solid waste laws, in which the deficiencies relate to small or minor capital improvements needed to bring the facility back into compliance;

"(ii) in which the deficiencies relate to capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

"(iii) in which the deficiencies relate to the lack of equipment or training by an Indian tribe or community to properly operate and maintain the sanitation facilities.

"(C) A level III deficiency is an individual or community facility with water or sewer service in the home, piped services or a haul system with holding tanks and interior plumbing, or where major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies. There is no access to or no approved or permitted solid waste facility available.

"(D) A level IV deficiency is an individual or community facility where there are no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure or where only a washeteria or central facility exists.

"(E) A level V deficiency is the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater disposal.

"(i) DEFINITIONS.—In this section:

"(1) FACILITY.—The terms 'facility' or 'facilities' shall have the same meaning as the terms 'system' or 'systems' unless the context requires otherwise.

"(2) 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.

"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), 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 in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water

and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, 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 such 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) EXEMPTION FROM DAVIS-BACON.—For the purpose of implementing the provisions of this title, construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are exempt from the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act). For all health facilities, staff quarters and sanitation facilities, construction and renovation subcontractors shall

be paid wages at rates that are not less than the prevailing wage rates for similar construction in the locality involved, as determined by the Indian tribe, tribes, or tribal organizations served by such facilities.

"SEC. 304. SOBOBA SANITATION FACILITIES.

"Nothing in the Act of December 17, 1970 (84 Stat. 1465) shall be construed to 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. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

"(a) PERMISSIBILITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to accept any major expansion, renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act, including—

"(A) any plans or designs for such expansion, renovation or modernization; and

"(B) any expansion, renovation or modernization for which funds appropriated under any Federal law were lawfully expended;

but only if the requirements of subsection (b) are met.

"(2) PRIORITY LIST.—The Secretary shall maintain a separate priority list to address the need for increased operating expenses, personnel or equipment for such facilities described in paragraph (1). The methodology for establishing priorities shall be developed by negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian tribes and tribal organizations.

"(3) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, the priority list maintained pursuant to paragraph (2).

"(b) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation or modernization if—

"(1) the 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

"(2) the expansion renovation or modernization—

"(A) is approved by the appropriate area director of the Service for Federal facilities; and

"(B) is administered by the Indian tribe or tribal organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

"(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FACILITY TO BE USED AS A SERVICE FACILITY.—If any Service facility which has been expanded, renovated or modernized by an Indian tribe 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 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. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

"(a) AVAILABILITY OF FUNDING.—

"(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to 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 for in subsections (b)(2) and (c)(1)(C)). Funding 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) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or con-

structed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian tribe or tribal organization) pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—Funds 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—

''(A) located apart from a hospital;

''(B) not funded under section 301 or section 307; and

''(C) which, upon completion of such construction, expansion, or modernization will—

''(i) have a total capacity appropriate to its projected service population;

''(ii) provide annually not less than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B); and

"(iii) provide ambulatory care in a service area (specified in the funding agreement entered into under the Indian Self-Determination and Education Assistance Act) with a population of not less than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B).

"(2) LIMITATION.—Funding 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 described in clauses (ii) and (iii) of paragraph (1)(C). The requirements of such clauses (ii) and (iii) shall not apply to a tribe or tribal organization applying for funding under this section whose principal office for health care administration is located on an island or where such office is not located on a road system providing direct access to an inpatient hospital where care is available to the service population.

"(c) APPLICATION AND PRIORITY.—

"(1) APPLICATION.—No funding may be made available under this section unless an application for such funding has been submitted to and approved by the Secretary. An application or proposal for fund-

ing under this section shall be submitted in accordance with applicable regulations and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding 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 funds under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

"(A) a need for increased ambulatory care services; and

"(B) insufficient capacity to deliver such services.

"(d) FAILURE TO USE FACILITY AS HEALTH FACILITY.—If any facility (or portion thereof) with respect to

which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing 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) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

"(a) HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, may enter into funding agreements with, or make grants or loan guarantees to, Indian tribes or tribal organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through health facili-

ties, including hospice, traditional Indian health and child care facilities, to Indians.

"(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding 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 other available funds;

"(4) permit the use of funds or property donated from any source for project purposes;

"(5) provide for the reversion of donated real or personal property to the donor; and

"(6) permit the use of Service funds to match other funds, including Federal funds.

"(c) CRITERIA.—

"(1) IN GENERAL.—The Secretary shall develop and publish regulations through rulemaking under section 802 for the review and approval of applications submitted under this section. The Secretary may enter into a contract, funding agreement or award a grant under this section for projects which meet the following criteria:

"(A) There is a need for a new facility or program or the reorientation of an existing facility or program.

"(B) A significant number of Indians, including those 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) The project has the potential to deliver services in an efficient and effective manner.

"(E) The project is economically viable.

"(F) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

"(G) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

"(2) PEER REVIEW PANELS.—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 ap-

plications using the criteria developed pursuant to paragraph (1).

"(3) PRIORITY.—The Secretary shall give priority to applications for demonstration projects under this section in each of the following service units to the extent that such applications are filed in a timely manner and otherwise meet the criteria specified in paragraph (1):

"(A) Cass Lake, Minnesota.

"(B) Clinton, Oklahoma.

"(C) Harlem, Montana.

"(D) Mescalero, New Mexico.

"(E) Owyhee, Nevada.

"(F) Parker, Arizona.

"(G) Schurz, Nevada.

"(H) Winnebago, Nebraska.

"(I) Ft. Yuma, California.

"(d) TECHNICAL 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) SERVICE TO INELIGIBLE PERSONS.—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 facilities to non-

Service health care practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

"(f) EQUITABLE TREATMENT.—For purposes of subsection (c)(1)(A), the Secretary shall, in evaluating facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

"(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation and expansion needs of Service and non-Service facilities which are the subject of a funding agreement for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

"SEC. 308. LAND TRANSFER.

"(a) GENERAL AUTHORITY FOR TRANSFERS.—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.

"(b) CHEMAWA INDIAN SCHOOL.—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.

"SEC. 309. LEASES.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes and tribal organizations for periods not in excess of 20 years. Property leased by the Secretary from an Indian tribe or tribal organization may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe or tribal organization.

"(b) FACILITIES FOR THE ADMINISTRATION AND DELIVERY OF HEALTH SERVICES.—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, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. 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 pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

"SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAYMENT.

"(a) HEALTH CARE FACILITIES LOAN FUND.—There is established in the Treasury of the United States a fund to be known as the 'Health Care Facilities Loan Fund' (referred to in this Act as the 'HCFLF') to provide to Indian tribes and tribal organizations direct loans, or

guarantees for loans, for the construction of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities such as behavioral health and elder care facilities).

"(b) STANDARDS AND PROCEDURES.—The Secretary may promulgate regulations, developed through rulemaking as provided for in section 802, to establish standards and procedures for governing loans and loan guarantees under this section, subject to the following conditions:

"(1) The principal amount of a loan or loan guarantee may cover up to 100 percent of eligible costs, including costs for the planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, other facility related costs and capital purchase (but excluding staffing).

"(2) The cumulative total of the principal of direct loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

"(3) In the discretion of the Secretary, the program under this section may be administered by the Service or the Health Resources and Services Administration (which shall be specified by regulation).

"(4) The Secretary may make or guarantee a loan with a term of the useful estimated life of the facility, or 25 years, whichever is less.

"(5) The Secretary may allocate up to 100 percent of the funds available for loans or loan guarantees in any year for the purpose of planning and applying for a loan or loan guarantee.

"(6) The Secretary may accept an assignment of the revenue of an Indian tribe or tribal organization as security for any direct loan or loan guarantee under this section.

"(7) In the planning and design of health facilities under this section, users eligible under section 807(b) may be included in any projection of patient population.

"(8) The Secretary shall not collect loan application, processing or other similar fees from Indian tribes or tribal organizations applying for direct loans or loan guarantees under this section.

"(9) Service funds authorized under loans or loan guarantees under this section may be used in matching other Federal funds.

"(c) FUNDING.—

"(1) IN GENERAL.—The HCFLF shall consist of—

"(A) such sums as may be initially appropriated to the HCFLF and as may be subsequently appropriated under paragraph (2);

"(B) such amounts as may be collected from borrowers; and

"(C) all interest earned on amounts in the HCFLF.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the HCFLF during the preceding fiscal year, and all accrued interest on such amounts.

"(3) AVAILABILITY OF FUNDS.—Amounts appropriated, collected or earned relative to the HCFLF shall remain available until expended.

"(d) FUNDING AGREEMENTS.—Amounts in the HCFLF and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service, to make loans under this section to an Indian tribe or tribal organization pursuant to a funding agreement entered

1 into under the Indian Self-Determination and Education
2 Assistance Act.

3 ''(e) INVESTMENTS.—The Secretary of the Treasury
4 shall invest such amounts of the HCFLF as such Sec-
5 retary determines are not required to meet current with-
6 drawals from the HCFLF. Such investments may be made
7 only in interest-bearing obligations of the United States.
8 For such purpose, such obligations may be acquired on
9 original issue at the issue price, or by purchase of out-
10 standing obligations at the market price. Any obligation
11 acquired by the fund may be sold by the Secretary of the
12 Treasury at the market price.

13 ''(f) GRANTS.—The Secretary is authorized to estab-
14 lish a program to provide grants to Indian tribes and trib-
15 al organizations for the purpose of repaying all or part
16 of any loan obtained by an Indian tribe or tribal organiza-
17 tion for construction and renovation of health care facili-
18 ties (including inpatient facilities, outpatient facilities, as-
19 sociated staff quarters and specialized care facilities).
20 Loans eligible for such repayment grants shall include
21 loans that have been obtained under this section or other-
22 wise.

23 **''SEC. 311. TRIBAL LEASING.**

24 ''Indian tribes and tribal organizations providing
25 health care services pursuant to a funding agreement con-

tract entered into under the Indian Self-Determination and Education Assistance Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

"SEC. 312. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

"(a) AUTHORITY.—

"(1) 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 exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility.

"(2) USE OF RESOURCES.—A tribe or tribal organization may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

"(3) ELIGIBILITY OF CERTAIN ENTITIES.—A tribe that has begun and substantially completed the

process of acquisition or construction of a health facility shall be eligible to establish a joint venture project with the Service using such health facility.

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall enter into an arrangement under subsection (a)(1) with an Indian tribe or tribal organization only if—

"(A) 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 health facility described in subsection (a)(1); and

"(B) the Indian tribe or tribal organization meets the needs criteria that shall be developed through the negotiated rulemaking process provided for under section 802.

"(2) CONTINUED OPERATION OF FACILITY.—The Secretary shall negotiate an agreement with the Indian tribe or tribal organization regarding the continued operation of a facility under this section at the end of the initial 10 year no-cost lease period.

"(3) BREACH OR TERMINATION OF AGREEMENT.—An Indian tribe or tribal organization that has entered into a written agreement with the Sec-

retary 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 tribe or tribal organization, or paid to a third party on the 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 shall not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

''(d) RECOVERY FOR NON-USE.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility should at any time within 10 years the Service ceases to use the facility or otherwise breaches the agreement.

''(e) DEFINITION.—In this section, the terms 'health facility' or 'health facilities' include staff quarters needed to provide housing for the staff of the tribal health program.

"SEC. 313. LOCATION OF FACILITIES.

"(a) PRIORITY.—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 owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

"(b) DEFINITION.—In this section, the term 'Indian lands' means—

"(1) all lands within the exterior boundaries of any Indian reservation;

"(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 and over which an Indian tribe exercises governmental power; and

"(3) all lands in Alaska owned by any Alaska Native village, or any village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

"SEC. 314. 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 that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

"(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

"(1) IN GENERAL.—The Secretary may expend maintenance and improvement funds to support the maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian tribe or tribal organization.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'supportable space allocation' shall be defined through the negotiated rulemaking process provided for under section 802.

"(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

"(1) IN GENERAL.—In addition to using maintenance and improvement funds for the maintenance

of facilities under subsection (b)(1), an Indian tribe or tribal organization may use such funds for the construction of a replacement facility if the costs of the renovation of such facility would exceed a maximum renovation cost threshold.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'maximum renovation cost threshold' shall be defined through the negotiated rulemaking process provided for under section 802.

"SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED QUARTERS.

''(a) ESTABLISHMENT OF RENTAL RATES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may 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 under paragraph (1), an Indian tribe or tribal orga-

nization shall attempt to achieve the following objectives:

"(A) The rental rates should be based on the reasonable value of the quarters to the occupants thereof.

"(B) The rental rates should generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and, subject to the discretion of the Indian tribe or tribal organization, to supply reserve funds for capital repairs and replacement of the quarters.

"(3) ELIGIBILITY FOR QUARTERS IMPROVEMENT AND REPAIR.—Any quarters whose rental rates are established by an Indian tribe or tribal organization under this subsection shall continue to be eligible for quarters improvement and repair funds to the same extent as other federally-owned quarters that are used to house personnel in Service-supported programs.

"(4) NOTICE OF CHANGE IN RATES.—An Indian tribe or tribal organization that exercises the authority provided under this subsection shall provide occupants with not less than 60 days notice of any change in rental rates.

"(b) COLLECTION OF RENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), an Indian tribe or a tribal organization that operates federally-owned quarters pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

"(A) The Indian tribe or tribal organization shall notify the Secretary and the Federal employees involved of its election to exercise its authority to collect rents directly from such Federal employees.

"(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization 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 Indian tribe or tribal organization 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 Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

"(2) RETROCESSION.—If an Indian tribe or tribal organization 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—

"(A) the first day of the month that begins not less than 180 days after the Indian tribe or tribal organization notifies the Secretary of its desire to retrocede; or

"(B) such other date as may be mutually agreed upon by the Secretary and the Indian tribe or tribal organization.

"(c) RATES.—To the extent that an Indian tribe or tribal organization, 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 rent-

al housing in the nearest established community with a year-round population of 1,500 or more individuals.

"SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

"(a) IN GENERAL.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to the authorization contained in section 318, except that Indian tribes and tribal organizations shall be exempt from such requirements.

"(b) FALSE OR MISLEADING LABELING.—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 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

"(c) DEFINITION.—In this section, the term '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.).

"SEC. 317. OTHER FUNDING FOR FACILITIES.

''Notwithstanding any other provision of law—

''(1) the Secretary may 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 funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

''(2) the Secretary may enter into interagency agreements with other Federal or State agencies and other entities and to accept funds from such Federal or State agencies or other entities to provide for the planning, design and construction of health care facilities to be administered by the Service or by Indian tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act in

order to carry out the purposes of this Act, together with the purposes for which such funds are appropriated to such other Federal or State agency or for which the funds were otherwise provided;

''(3) any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency; and

''(4) the Secretary, acting through the Service, shall establish standards under regulations developed through rulemaking under section 802, for the planning, design and construction of health care facilities serving Indians under this Act.

''SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE IV—ACCESS TO HEALTH SERVICES

"SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE PROGRAM.

''(a) IN GENERAL.—Any payments received by the Service, by an Indian tribe or tribal organization pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization pursuant to title V of this Act for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care and services to Indians.

''(b) EQUAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act in preference to an Indian beneficiary without such coverage.

''(c) SPECIAL FUND.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first 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 which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for benefits under title XVIII of the Social Security Act.

"SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM.

"(a) SPECIAL FUND.—

"(1) USE OF FUNDS.—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 re-

tarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such title. Any payments which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes. In making payments from such fund, the Secretary shall ensure that each service unit of the Service receives 100 percent of the amounts to which the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal

organization under section 405 to receive direct payments for services provided to Indians eligible for medical assistance under title XIX of the Social Security Act.

''(b) PAYMENTS DISREGARDED FOR APPROPRIATIONS.—Any payments received under section 1911 of the Social Security Act for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405.

''SEC. 403. REPORT.

''(a) INCLUSION IN ANNUAL REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 801, an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements under titles XVIII and XIX of the Social Security Act.

"(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian tribe or tribal organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an urban Indian organization receives funding from the Service under title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian tribe or tribal organization, or urban Indian organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

"SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and 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 sections 1818, 1836, and 1837 of the Social Security Act;

"(2) pay premiums for health insurance coverage; and

"(3) apply for medical assistance provided pursuant to titles XIX and XXI of the Social Security Act.

"(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or 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 or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

"(2) assist individual Indians in becoming familiar with and utilizing such benefits and assistance;

"(3) provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits and assistance;

"(4) develop and implement—

"(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for health insurance coverage of needy individuals; and

1 "(B) methods of improving the participa-
2 tion of Indians in receiving the benefits and as-
3 sistance provided under titles XVIII, XIX, and
4 XXI of the Social Security Act.
5 "(c) AGREEMENTS FOR RECEIPT AND PROCESSING
6 OF APPLICATIONS.—The Secretary may enter into an
7 agreement with an Indian tribe or tribal organization, or
8 an urban Indian organization, which provides for the re-
9 ceipt and processing of applications for medical assistance
10 under title XIX of the Social Security Act, child health
11 assistance under title XXI of such Act and benefits under
12 title XVIII of such Act by a Service facility or a health
13 care program administered by such Indian tribe or tribal
14 organization, or urban Indian organization, pursuant to
15 a funding agreement under the Indian Self-Determination
16 and Education Assistance Act or a grant or contract en-
17 tered into with an urban Indian organization under title
18 V of this Act. Notwithstanding any other provision of law,
19 such agreements shall provide for reimbursement of the
20 cost of outreach, education regarding eligibility and bene-
21 fits, and translation when such services are provided. The
22 reimbursement may be included in an encounter rate or
23 be made on a fee-for-service basis as appropriate for the
24 provider. When necessary to carry out the terms of this
25 section, the Secretary, acting through the Health Care Fi-

nancing Administration or the Service, may enter into agreements with a State (or political subdivision thereof) to facilitate cooperation between the State and the Service, an Indian tribe or tribal organization, and an urban Indian organization.

"(d) GRANTS.—

"(1) IN GENERAL.—The Secretary shall make grants or enter into contracts with urban Indian organizations to assist such organizations in establishing and administering programs to assist individual urban Indians to—

"(A) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(B) pay premiums on behalf of such individuals for coverage under title XVIII of such Act; and

"(C) apply for medical assistance provided under title XIX of such Act and for child health assistance under title XXI of such Act.

"(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or entered into under paragraph (1) requirements that are—

"(A) consistent with the conditions imposed by the Secretary under subsection (b);

"(B) appropriate to urban Indian organizations and urban Indians; and

"(C) necessary to carry out the purposes of this section.

"SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

"(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 may elect to directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), under the medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or from any other third party payor.

"(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social

Security Act (42 U.S.C. 1396d(b)) shall apply for purposes of reimbursement under title XIX of the Social Security Act for health care services directly billed under the program established under this section.

"(b) DIRECT REIMBURSEMENT.—

"(1) USE OF FUNDS.—Each hospital or clinic participating in the program described in subsection (a) of this section shall be reimbursed directly under titles XVIII and XIX of the Social Security Act for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 402(a) and 807(b)(2)(A), but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under title XVIII or XIX of the Social Security Act. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—

"(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 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 under titles XVIII and XIX of the Social Security Act.

"(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 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a), 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 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);

"(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 2000 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 Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, 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, including any agreements with States that may be necessary to provide for direct billing under title XIX of the Social Security Act; and

"(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 2000. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

"(e) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that a tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

"(a) RIGHT OF RECOVERY.—Except as provided in subsection (g), the United States, an Indian tribe or tribal organization shall have the right to recover the reasonable charges billed or expenses incurred by the Secretary or an Indian tribe or tribal organization in providing health services, through the Service or 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 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 expenses.

"(b) URBAN INDIAN ORGANIZATIONS.—Except as provided in subsection (g), an urban Indian organization shall have the right to recover the reasonable charges billed or expenses incurred by the organization in providing health services to any individual to the same extent that such individual, or any other nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if such individual had been required to pay such charges or expenses and did pay such charges or expenses.

"(c) LIMITATIONS ON RECOVERIES FROM STATES.—Subsections (a) and (b) 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.

"(d) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States or an Indian tribe or tribal organization under subsection (a), or an urban Indian organization under subsection (b).

"(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery provided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), 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).

"(f) METHODS OF ENFORCEMENT.—

"(1) IN GENERAL.—The United States or an Indian tribe or tribal organization may enforce the right of recovery provided under subsection (a), and an urban Indian organization may enforce the right of recovery provided under subsection (b), 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 urban Indian organization; or

"(ii) by any representative or heirs of such individual; or

"(B) instituting a civil action.

"(2) NOTICE.—All reasonable efforts shall be made to provide notice of an action instituted in accordance with paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

"(g) LIMITATION.—Notwithstanding this section, 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), neither the United

1 States through the Service, nor an Indian tribe or tribal
2 organization under a funding agreement pursuant to the
3 Indian Self-Determination and Education Assistance Act,
4 nor an urban Indian organization funded under title V,
5 shall have a right of recovery under this section if the in-
6 jury, illness, or disability for which health services were
7 provided is covered under a self-insurance plan funded by
8 an Indian tribe or tribal organization, or urban Indian or-
9 ganization. Where such tribal authorization is provided,
10 the Service may receive and expend such funds for the
11 provision of additional health services.

12 ''(h) COSTS AND ATTORNEYS' FEES.—In any action
13 brought to enforce the provisions of this section, a prevail-
14 ing plaintiff shall be awarded reasonable attorneys' fees
15 and costs of litigation.

16 ''(i) RIGHT OF ACTION AGAINST INSURERS AND EM-
17 PLOYEE BENEFIT PLANS.—

18 ''(1) IN GENERAL.—Where an insurance com-
19 pany or employee benefit plan fails or refuses to pay
20 the amount due under subsection (a) for services
21 provided to an individual who is a beneficiary, par-
22 ticipant, or insured of such company or plan, the
23 United States or an Indian tribe or tribal organiza-
24 tion shall have a right to assert and pursue all the
25 claims and remedies against such company or plan,

and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal, State or tribal law.

"(2) URBAN INDIAN ORGANIZATIONS.—Where an insurance company or employee benefit plan fails or refuses to pay the amounts due under subsection (b) for health services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the urban Indian organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal or State law.

"(j) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization, or an urban Indian organization shall have a right of recovery for any otherwise reimbursable claim filed on a current HCFA–1500 or UB–92 form, or the current NSF electronic format, or their successors. No health plan shall deny payment because a claim has not been submitted in a unique format that differs from such forms.

"SEC. 407. CREDITING OF REIMBURSEMENTS.

"(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87–693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, 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) NO OFFSET OF FUNDS.—The Service may not offset or limit the amount of funds obligated to any service unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

"SEC. 408. PURCHASING HEALTH CARE COVERAGE.

"An Indian tribe or tribal organization, and an urban Indian organization may utilize funding from the Secretary under this Act to purchase managed care coverage for Service beneficiaries (including insurance to limit the financial risks of managed care entities) from—

"(1) a tribally owned and operated managed care plan;

"(2) a State or locally-authorized or licensed managed care plan; or

"(3) a health insurance provider.

"SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VETERAN'S AFFAIRS, AND OTHER FEDERAL AGENCY HEALTH FACILITIES AND SERVICES SHARING.

"(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

"(1) IN GENERAL.—The Secretary shall examine the feasibility of entering into arrangements or expanding existing arrangements for the sharing of medical facilities and services between the Service and the Veterans' Administration, and other appropriate Federal agencies, including those within the Department, and shall, in accordance with subsection (b), prepare a report on the feasibility of such arrangements.

"(2) SUBMISSION OF REPORT.—Not later than September 30, 2003, the Secretary shall submit the report required under paragraph (1) to Congress.

"(3) CONSULTATION REQUIRED.—The Secretary may not finalize any arrangement described in paragraph (1) without first consulting with the affected Indian tribes.

"(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;

"(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 Veterans' Administration;

"(4) the quality of health care services provided to any veteran by the Veteran's Administration;

"(5) the eligibility of any Indian to receive health services through the Service; or

"(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration provided, however, the Service or the Indian tribe or tribal organization shall be reimbursed by the Veterans' Administration where services are provided through the Service or Indian tribes or tribal organizations to beneficiaries eligible for services from the Veterans' Administration, notwithstanding any other provision of law.

"(c) AGREEMENTS FOR PARITY IN SERVICES.—The Service may enter into agreements with other Federal agencies to assist in achieving parity in services for Indians. Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Service.

"SEC. 410. PAYOR OF LAST RESORT.

"The Service, and programs operated by Indian tribes or tribal organizations, or urban Indian organizations shall be the payor of last resort for services provided to individuals eligible for services from the Service and such programs, notwithstanding any Federal, State or local law to the contrary, unless such law explicitly provides otherwise.

"SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH CARE PROGRAMS.

"Notwithstanding any other provision of law, the Service, Indian tribes or tribal organizations, and urban Indian organizations (notwithstanding limitations on who is eligible to receive services from such entities) shall be entitled to receive payment or reimbursement for services provided by such entities from any federally funded health care program, unless there is an explicit prohibition on such payments in the applicable authorizing statute.

"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

"(a) IN GENERAL.—Notwithstanding any other provision of law, including the Anti-Deficiency Act, provided the Indian tribes to be served approve, the Service in the Tuba City Service Unit may—

"(1) enter into a demonstration project with the State of Arizona under which the Service would provide certain specified medicaid services to individuals dually eligible for services from the Service and for medical assistance under title XIX of the Social Security Act in return for payment on a capitated basis from the State of Arizona; and

"(2) purchase insurance to limit the financial risks under the project.

"(b) EXTENSION OF PROJECT.—The demonstration project authorized under subsection (a) may be extended to other service units in Arizona, subject to the approval of the Indian tribes to be served in such service units, the Service, and the State of Arizona.

"SEC. 413. ACCESS TO FEDERAL INSURANCE.

"Notwithstanding the provisions of title 5, United States Code, Executive Order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act or an urban Indian organization carrying out programs under title V of this Act shall be enti-

tled to purchase coverage, rights and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.

"SEC. 414. CONSULTATION AND RULEMAKING.

"(a) CONSULTATION.—Prior to the adoption of any policy or regulation by the Health Care Financing Administration, the Secretary shall require the Administrator of that Administration to—

"(1) identify the impact such policy or regulation may have on the Service, Indian tribes or tribal organizations, and urban Indian organizations;

"(2) provide to the Service, Indian tribes or tribal organizations, and urban Indian organizations the information described in paragraph (1);

"(3) engage in consultation, consistent with the requirements of Executive Order 13084 of May 14, 1998, with the Service, Indian tribes or tribal organizations, and urban Indian organizations prior to enacting any such policy or regulation.

"(b) RULEMAKING.—The Administrator of the Health Care Financing Administration shall participate in the negotiated rulemaking provided for under title VIII with regard to any regulations necessary to implement the provisions of this title that relate to the Social Security Act.

"SEC. 415. LIMITATIONS ON CHARGES.

"No provider of health services that is eligible to receive payments or reimbursements under titles XVIII, XIX, or XXI of the Social Security Act or from any federally funded (whether in whole or part) health care program may seek to recover payment for services—

"(1) that are covered under and furnished to an individual eligible for the contract health services program operated by the Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization, in an amount in excess of the lowest amount paid by any other payor for comparable services; or

"(2) for examinations or other diagnostic procedures that are not medically necessary if such procedures have already been performed by the referring Indian health program and reported to the provider.

"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHORITY.

"Notwithstanding any other provision of law, the Secretary may not waive the application of section 1902(a)(13)(D) of the Social Security Act to any State plan under title XIX of the Social Security Act.

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

"Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

"(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

"(1) any Indian tribe or tribal organization or an urban Indian organization that administers

health programs under the authority of the Indian Self-Determination and Education Assistance Act;

"(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

"(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2003); or

"(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of this Act (as so in effect), or other applicable law, to pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization;

provided the exchange arises from or relates to such health programs.

"(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act

or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES AND PREMIUMS.

"(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an Indian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an In-

dian tribe or tribal organization or an urban Indian organization and another health provider.

"(b) EXEMPTION FROM PREMIUMS.—

"(1) MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for medical assistance under title XIX of the Social Security Act or child health assistance under title XXI of such Act may be charged a premium as a condition of receiving such assistance under title XIX or XXI of such Act.

"(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

"For the purpose of determining the eligibility under section 1902(a)(10)(A)(ii)(IV) of the Social Security Act of an Indian for medical assistance under a State plan under title XIX of such Act, the cost of providing services to an Indian in a health program of the Service, an Indian tribe or tribal organization, or an urban Indian organization shall be deemed to have been an expenditure for health care by the Indian.

"SEC. 421. ESTATE RECOVERY PROVISIONS.

"Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

"(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

"(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

"(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

"(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

"SEC. 422. MEDICAL CHILD SUPPORT.

"Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization. For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

"(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization or an urban Indian organization shall have a right of recovery under section

408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian tribe or tribal organization or an urban Indian organization.

"(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement may not be made a prerequisite for such payments to be made.

"(c) PARITY.—Payments due under subsection (a) from a managed care entity may not be paid at a rate that is less than the rate paid to a 'preferred provider' by the entity or, in the event there is no such rate, the usual and customary fee for equivalent services.

"(d) NO CLAIM REQUIREMENT.—A managed care entity may not deny payment under subsection (a) because an enrollee with the entity has not submitted a claim.

"(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

"(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

"(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under

1 any managed care entity participating in a State plan
2 under title XIX or XXI of the Social Security Act unless
3 the Indian had the option of enrolling in a managed care
4 plan or health program administered by the Service, an
5 Indian tribe or tribal organization, or an urban Indian or-
6 ganization.

7 "(h) INDIAN MANAGED CARE PLANS.—Notwith-
8 standing any other provision of law, any State entering
9 into agreements with one or more managed care organiza-
10 tions to provide services under title XIX or XXI of the
11 Social Security Act shall enter into such an agreement
12 with the Service, an Indian tribe or tribal organization or
13 an urban Indian organization under which such an entity
14 may provide services to Indians who may be eligible or
15 required to enroll with a managed care organization
16 through enrollment in an Indian managed care organiza-
17 tion that provides services similar to those offered by other
18 managed care organizations in the State. The Secretary
19 and the State are hereby authorized to waive requirements
20 regarding discrimination, capitalization, and other matters
21 that might otherwise prevent an Indian managed care or-
22 ganization or health program from meeting Federal or
23 State standards applicable to such organizations, provided
24 such Indian managed care organization or health program

offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

"(i) ADVERTISING.—A managed care organization entering into a contract to provide services to Indians on or near an Indian reservation shall provide a certificate of coverage or similar type of document that is written in the Indian language of the majority of the Indian population residing on such reservation.

"SEC. 424. NAVAJO NATION MEDICAID AGENCY.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary may treat the Navajo Nation as a State under title XIX of the Social Security Act for purposes of providing medical assistance to Indians living within the boundaries of the Navajo Nation.

"(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

"(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

"(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such Nation, include Western and traditional Navajo healing services) within the Navajo Nation. Such assistance may include providing funds for demonstration projects conducted with such Nation.

"(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per cent with respect to amounts the Navajo Nation Medicaid agency expends for medical assistance and related administrative costs.

"(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

"(g) SCHIP.—At the option of the Navajo Nation, the Secretary may treat the Navajo Nation as a State for purposes of title XXI of the Social Security Act under terms equivalent to those described in the preceding subsections of this section.

"SEC. 425. INDIAN ADVISORY COMMITTEES.

"(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

"(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the

Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

"SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2015 to carry out this title.''.

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"SEC. 501. PURPOSE.

''The purpose of this title is to establish programs in urban centers to make health services more accessible and available to urban Indians.

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, through the Service, 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. The Secretary, through the Service, subject to section 506, shall include

such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

"(a) AUTHORITY.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

"(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

"(2) estimate the current health status of urban Indians residing in such urban center or centers;

"(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

"(4) provide basic health education, including health promotion and disease prevention education, to urban Indians;

"(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 Indians; and

"(6) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

"(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting urban Indian 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 Indians in the urban center or centers involved;

"(2) the size of the urban Indian population in the urban center or centers involved;

"(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

"(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

"(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center or centers; and

"(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

"(c) HEALTH PROMOTION AND DISEASE PREVENTION.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a).

"(d) IMMUNIZATION SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or pro-

vide, immunization services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

"(e) MENTAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) to provide outreach, educational, and referral services to urban Indians regarding the availability of direct behavioral health services, to educate urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to urban Indians;

"(C) to provide outpatient behavioral health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment; and

"(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

"(f) CHILD ABUSE.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts

entered into pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the 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) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) for the development of prevention, training, and education programs for urban Indian populations, 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 provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to 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 Indian perpetrators of child abuse (including sexual abuse).

"(4) CONSIDERATIONS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

"(A) the support for the urban Indian 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 Indian organization to address the complex problem of child sexual abuse in the community; and

"(C) the assessment required under paragraph (2).

"(g) MULTIPLE URBAN CENTERS.—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 one urban center.

"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

"(a) AUTHORITY.—

"(1) IN GENERAL.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503.

"(2) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary

has entered into a contract with, or made a grant to, under this section.

"(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake to—

"(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

"(B) with respect to urban Indians in the urban center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

"(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

"(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

"(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title and compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) COMPLIANCE WITH TERMS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

"(1) conduct, through the Service, an annual onsite evaluation of the organization; or

"(2) accept, in lieu of an 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.—

"(1) IN GENERAL.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

"(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with such organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract or grant is not renewed under this section.

"(d) DETERMINATION OF RENEWAL.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has com-

pleted performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

"(a) APPLICATION OF FEDERAL LAW.—Contracts with urban Indian organizations entered into pursuant to this 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.).

"(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

"(1) be made in their entirety by the Secretary to the urban Indian organization by not 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 payments in their entirety; and

"(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, 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 expenditure of such funds.

"(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

"(d) FAIR AND UNIFORM PROVISION OF SERVICES.—Contracts with, or grants to, urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

"(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indians, as defined in section 4(f), shall be eligible for health care or referral services provided pursuant to this title.

"SEC. 507. REPORTS AND RECORDS.

"(a) REPORT.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into, or a grant received, pursuant to this title, such organization shall submit to the Secretary, on a basis no more frequent than every 6 months, a report including—

"(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract or grant;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary, after consultations consistent with section 514, with urban Indian organizations.

"(b) AUDITS.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(c) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

"(1) a certified public accountant; or

"(2) a certified public accounting firm qualified to conduct Federal compliance audits.

"SEC. 508. 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.

"SEC. 509. FACILITIES.

"(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

"(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

"(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

"(2) The total amount of the principal of loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriations Acts.

"(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility, or 25 years.

"(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the revenue of the organization as security for a loan or loan guarantee under this subsection.

"(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

"(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

"(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

"(A) such amounts as may be appropriated to the URLF;

"(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

"(C) interest earned on amounts in the URLF under paragraph (3).

"(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

"(3) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet

current withdrawals from the URLF. 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. Any obligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

''There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to urban Indian organizations.

"SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES.

''(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom

the Secretary has entered into a contract under this title or under section 201.

"(b) GOALS OF GRANT.—Each grant made pursuant to subsection (a) 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), including criteria relating to the—

"(1) size of the urban Indian population;

"(2) capability of the organization to adequately perform the activities required under the grant;

"(3) satisfactory performance standards for the organization in meeting the goals set forth in such grant, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and

"(4) identification of need for services.

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

"(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance

abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

"(a) TULSA AND OKLAHOMA CITY CLINICS.—Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

"(b) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects specified in subsection (a).

"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

"(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2004, with urban Indian or-

ganizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section to as 'NIAAA') and transferred to the Service.

''(b) USE OF 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 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.—Urban Indian organizations that operate Indian alcohol programs originally funded under NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

''SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with

urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

''(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

''SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

''For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting

from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian organization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

"(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for 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) STATES.—A State described in this subsection is a State in which—

"(1) there reside urban Indian youth with a 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. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

"(a) IN GENERAL.—The Secretary shall permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within

the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

"(b) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

"(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

"(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian tribe or tribal organization, the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization if the Secretary receives the request from the Indian tribe

or tribal organization before the date on which the Secretary transfers title to the property or, if earlier, the date on which the Secretary transfers the property physically, to the urban Indian organization.

"(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

"(a) AUTHORITY.—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, treatment, 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 upon between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

"(1) the size and location of the urban Indian population to be served;

"(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

"(3) performance standards for the urban Indian 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 urban Indian organization to adequately perform the activities required under the grant; and

"(5) the willingness of the urban Indian 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) APPLICATION OF 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. 519. COMMUNITY HEALTH REPRESENTATIVES.

"The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

"SEC. 520. REGULATIONS.

"(a) EFFECT OF TITLE.—This title shall be effective on the date of enactment of this Act regardless of whether the Secretary has promulgated regulations implementing this title.

"(b) PROMULGATION.—

"(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

"(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270

days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

"(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursuant to section 565 of title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

"(d) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of this Act.

"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"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, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

"(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

"(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

"(2) 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) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(A) this 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, et seq.);

"(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

"(4) all scholarship and loan functions carried out under title I.

"(d) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the 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, 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 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).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, 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;

"(C) a privacy component that protects the privacy of patient information;

"(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 office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—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 automated management information systems which—

"(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

"(2) meet the management information needs of the Service.

"(c) ACCESS TO 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.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—It is the purpose of this section to—

''(1) 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) 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) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

"(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

"(5) 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; and

"(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(b) BEHAVIORAL HEALTH PLANNING.—

"(1) AREA-WIDE PLANS.—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, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for In-

dian Behavioral Health Services. The plans shall, to the extent feasible, include—

"(A) an assessment of the scope of the problem of alcohol or other substance abuse, mental illness, 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; 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, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

"(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 shall establish a national clearinghouse of

plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such 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 utilized and adopted locally.

"(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

"(1) a comprehensive continuum of behavioral health care that provides for—

"(A) community based prevention, intervention, outpatient and behavioral health aftercare;

"(B) detoxification (social and medical);

"(C) acute hospitalization;

"(D) intensive outpatient or day treatment;

"(E) residential treatment;

"(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

"(G) emergency shelter;

"(H) intensive case management;

"(I) traditional health care practices; and

"(J) diagnostic services, including the utilization of neurological assessment technology; and

"(2) behavioral health services for particular populations, including—

"(A) for persons from birth through age 17, child behavioral health services, that include—

"(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

"(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (multiple diagnosis);

"(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

"(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

"(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

"(vii) co-morbidity services;

"(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

"(i) early intervention, treatment and aftercare services;

"(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

"(iv) healthy choices and life style services (related to parenting, partners, do-

mestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

"(v) female specific treatment services for—

"(I) women at risk of giving birth to a child with a fetal alcohol disorder;

"(II) substance abuse requiring gender specific services;

"(III) sexual assault and domestic violence; and

"(IV) healthy choices and life style (parenting, partners, obesity, suicide and other related behavioral risk); and

"(vi) male specific treatment services for—

"(I) substance abuse requiring gender specific services;

"(II) sexual assault and domestic violence; and

"(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

"(C) family behavioral health services, including—

"(i) early intervention, treatment and aftercare for affected families;

"(ii) treatment for sexual assault and domestic violence; and

"(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

"(D) for persons age 56 years and older, elder behavioral health services including—

"(i) early intervention, treatment and aftercare services that include—

"(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

"(III) healthy choices and life style services (managing conditions related to aging);

"(ii) elder women specific services that include—

"(I) treatment for substance abuse requiring gender specific services and

"(II) treatment for sexual assault, domestic violence and neglect;

"(iii) elder men specific services that include—

"(I) treatment for substance abuse requiring gender specific services; and

"(II) treatment for sexual assault, domestic violence and neglect; and

"(iv) services for dementia regardless of cause.

"(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

"(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, 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 alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and

family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

"(2) TECHNICAL ASSISTANCE.—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 Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

"(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting 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) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organiza-

tions, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

"(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, 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.

"SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

"(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 mental 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 mental health services to which all citizens have access;

"(B) the right of Indians to participate in, and receive the benefit of, such services; and

"(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 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) 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 Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) 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 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); and

"(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

"(b) SPECIFIC PROVISIONS.—The memorandum of agreement updated or entered into pursuant to 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, 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 alco-

hol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

''(1) Indian tribes and tribal organizations;

''(2) Indian individuals;

''(3) urban Indian organizations and other Indian organizations;

''(4) behavioral health service providers.

''(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Federal Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including systems

of care and traditional health care practices, which shall include—

"(A) prevention, through educational intervention, in Indian communities;

"(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

"(C) community-based rehabilitation and aftercare;

"(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

"(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children;

"(F) diagnostic services utilizing, when appropriate, neuropsychiatric assessments which include the use of the most advances technology available; and

"(G) a telepsychiatry program that uses experts in the field of pediatric psychiatry, and that incorporates assessment, diagnosis and

treatment for children, including those children with concurrent neurological disorders.

"(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

"(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

"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) TRAINING.—In carrying out subsection (a)(1), 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.

"(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

"(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section involves the utilization and promotion of the traditional

Indian health care and treatment practices of the Indian tribes to be served.

"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

"Subject to section 220, 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 Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

"(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling 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.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

"(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

"(b) USE OF FUNDS.—Funding provided pursuant to this section may be used to—

"(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

"(2) identify and provide 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 health care practices, cultural values, and community and family involvement.

"(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

"(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 707. INDIAN YOUTH PROGRAM.

"(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. 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.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment

center or treatment network in each area under the jurisdiction of an area office.

"(B) AREA OFFICE IN CALIFORNIA.—For purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction 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 for the purpose of implementing California treatment networks.

"(2) FUNDING.—For the purpose of staffing and operating centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

"(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) that is agreed upon (by appropriate tribal resolution) by a majority of the tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this 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;

"(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 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l));

"(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

"(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treat-

ment Center, a residential youth treatment facility in New Mexico.

"(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—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, which may incorporate traditional health care practices, to Indian children and adolescents, including—

"(A) pre-treatment assistance;

"(B) inpatient, outpatient, and after-care 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; and

"(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

"(E) to provide intensive home- and community-based services, including collaborative systems of care.

"(3) CRITERIA.—The Secretary shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of ap-

plications or proposals for funding made available pursuant to this subsection.

"(d) FEDERALLY OWNED STRUCTURES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

"(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youth; and

"(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

"(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.

"(e) REHABILITATION AND AFTERCARE SERVICES.—

"(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and implement within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

"(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate.

1 Not less than 10 percent of the funds appropriated for
2 the purposes of carrying out subsection (e) shall be used
3 for outpatient care of adult family members related to the
4 treatment of an Indian youth under that subsection.

5 ''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
6 acting through the Service, Indian tribes, tribal organiza-
7 tions and urban Indian organizations, shall provide, con-
8 sistent with section 701, programs and services to prevent
9 and treat the abuse of multiple forms of substances, in-
10 cluding alcohol, drugs, inhalants, and tobacco, among In-
11 dian youth residing in Indian communities, on Indian res-
12 ervations, and in urban areas and provide appropriate
13 mental health services to address the incidence of mental
14 illness among such youth.

15 **"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL**
16 **HEALTH FACILITIES DESIGN, CONSTRUCTION**
17 **AND STAFFING ASSESSMENT.**

18 ''(a) IN GENERAL.—Not later than 1 year after the
19 date of enactment of this section, the Secretary, acting
20 through the Service, Indian tribes and tribal organiza-
21 tions, shall provide, in each area of the Service, not less
22 than 1 inpatient mental health care facility, or the equiva-
23 lent, for Indians with behavioral health problems.

24 ''(b) TREATMENT OF CALIFORNIA.—For purposes of
25 this section, California shall be considered to be 2 areas

of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

''(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

''(a) COMMUNITY EDUCATION.—

''(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each 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.

''(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

"(3) TRAINING.—Community-based training (oriented toward local capacity development) under a program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

"(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of 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 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 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

"(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with 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 behavioral health problems faced by children of alcoholics;

"(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 710. BEHAVIORAL HEALTH PROGRAM.

"(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

"(1) Whether the project will address significant unmet behavioral health needs among Indians.

"(2) Whether the project will serve a significant number of Indians.

"(3) Whether the project has the potential to deliver services in an efficient and effective manner.

"(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

"(5) Whether the project will deliver services in a manner consistent with traditional health care.

"(6) Whether the project is coordinated with, and avoids duplication of, existing services.

"(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

"(a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the pur-

poses of meeting the health status objective specified in section 3(b).

"(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

"(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

"(B) identify and provide behavioral health treatment to high-risk women;

"(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

"(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

"(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

"(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

"(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

"(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

"(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

"(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

"(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

"(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the

special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

''(c) TASK FORCE.—

''(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

''(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

''(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian

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 Indians affected by fetal alcohol disorders.

"(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

"(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

"(1) victims of child sexual abuse; and

"(2) perpetrators of child sexual abuse.

"(b) USE OF FUNDS.—Funds provided under this section shall be used to—

"(1) develop and provide community education and prevention programs related to child sexual abuse;

"(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

"(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

"(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

"(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made 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 to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

"SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

"(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to 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 inter-relationship and inter-dependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

"(2) the development of models of prevention techniques.

"(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

"SEC. 714. DEFINITIONS.

"In this title:

"(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.—The term 'alcohol related

neurodevelopmental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(4) BEHAVIORAL HEALTH AFTERCARE.—

"(A) IN GENERAL.—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, to help prevent or treat relapse, including the development of an aftercare plan.

"(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

"(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.

"(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

"(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be 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: microphthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

"(C) Prenatal or postnatal growth delay.

"(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means 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: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

"(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.

"(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

"SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

"TITLE VIII—MISCELLANEOUS

"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 Congress a report containing—

"(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment 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, including specific comparisons of appropriations provided and those required for such parity;

"(2) 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 Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the 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;

"(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

"(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

"(4) a report of contractors concerning health care educational loan repayments under section 110;

"(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

"(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

"(7) a report on infectious diseases as required under section 212;

"(8) a report on environmental and nuclear health hazards as required under section 214;

"(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

"(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

"(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

"(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

"(13) a report providing an accounting of reimbursement funds made available to the Secretary

under titles XVIII and XIX of the Social Security Act as required under section 403(a);

"(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

"(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

"(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

"(17) a report on the evaluation of programs as required under section 513; and

"(18) a report on alcohol and substance abuse as required under section 701(f).

"SEC. 802. REGULATIONS.

"(a) INITIATION OF RULEMAKING PROCEDURES.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, 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 this Act.

"(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

"(b) RULEMAKING 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, tribal organizations, and urban Indian organizations from each service area.

"(c) ADAPTION 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.

"(d) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

"(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

"SEC. 803. PLAN OF IMPLEMENTATION.

"Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

"SEC. 804. AVAILABILITY OF FUNDS.

"Amounts appropriated under this Act shall remain available until expended.

"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

"Any limitation on the use of funds contained in an Act providing appropriations for the Department for a pe-

riod 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 Service.

"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(A) Any member of a federally recognized Indian tribe.

"(B) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(i) is a member of the Indian community served by a local program of the Service; and

"(ii) is regarded as an Indian by the community in which such descendant lives.

"(C) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(D) Any Indian in California who is listed on the plans for distribution of the assets of

California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(b) RULE OF CONSTRUCTION.—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) INELIGIBLE PERSONS.—

"(1) IN GENERAL.—Any individual who—

"(A) has not attained 19 years of age;

"(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

"(C) 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 year after the date such disability has been removed.

"(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but 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 the Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the 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) PROGRAMS AND SERVICES.—

"(1) PROGRAMS.—

"(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs 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—

"(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 program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

"(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under

such funding agreement is authorized to determine whether health services should be provided under such funding agreement 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 shall take into account the considerations described in subparagraph (A)(ii).

"(2) LIABILITY FOR PAYMENT.—

"(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of 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 of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the

account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

"(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be 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.

"(3) SERVICE AREAS.—

"(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian 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 revokes its concurrence to the provision of such health services.

"(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal 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 in the service area revoke their concurrence to the provision of such health services.

"(c) PURPOSE FOR PROVIDING 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; or

"(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

"(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of 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 as a part of the conditions under which such hospital privileges are extended.

"(e) DEFINITION.—In 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.

"SEC. 808. REALLOCATION OF BASE RESOURCES.

"(a) REQUIREMENT OF REPORT.—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 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 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

''SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

''SEC. 810. PROVISION OF SERVICES IN MONTANA.

''(a) IN GENERAL.—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 Cr. 1987).

''(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the 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 by Public Law 100–446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the 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 such time as new criteria governing eligibility for services are developed in accordance with section 802.

"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 funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

"For purposes of section 4 of Public Law 102–585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be deemed to be an executive agency and part of the Service and, as such, may act as an ordering agent of the Service

and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

"(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

"(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

"(1) Ten members of Congress, of which—

"(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

"(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

"(C) two members shall be from the Senate and shall be appointed by the majority leader; and

"(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the pro-

vision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

"(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected 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 with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

"(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian tribes.

"(c) TERMS.—

"(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

"(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

"(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

"(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

"(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

"(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian tribes;

"(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

"(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, and which may include authorizing and funding 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) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provided, and the

cost, including mechanisms for funding of the health services to be provided;

"(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

"(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

"(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

"(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

"(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a

recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

''(e) ADMINISTRATIVE PROVISIONS.—

''(1) COMPENSATION AND EXPENSES.—

''(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) 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.

''(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), 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, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes 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.

"(2) MEETINGS AND QUORUM.—

"(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

"(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

"(3) DIRECTOR AND STAFF.—

"(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

"(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

"(C) APPLICABILITY OF CIVIL SERVICE LAWS.—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).

"(D) EXPERTS AND CONSULTANTS.—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.

"(E) FACILITIES.—The Administrator of the General Services Administration 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.

"(f) POWERS.—

"(1) HEARINGS AND OTHER ACTIVITIES.—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, except that at least 6 regional hearings shall be held in different areas of the United States in which large numbers of Indians are present. Such hearings shall be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this paragraph, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established under this section may be counted towards the number of regional hearings required by this paragraph.

"(2) STUDIES BY GAO.—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) COST ESTIMATES.—

"(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, 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) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

"(4) DETAIL OF FEDERAL EMPLOYEES.—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) TECHNICAL ASSISTANCE.—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) USE OF MAILS.—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) OBTAINING INFORMATION.—The Commission may secure directly from the 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 chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

"(8) SUPPORT SERVICES.—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) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

''SEC. 815. APPROPRIATIONS; AVAILABILITY.

''Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) 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. 816. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.''.

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period and inserting '', and''; and

(3) by adding at the end the following:

''(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.''.

SEC. 202. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

''QUALIFIED INDIAN HEALTH PROGRAM

''SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

"(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by—

"(A) the Indian Health Service;

"(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; or

"(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

"(2) INCLUDED PROGRAMS AND ENTITIES.—Such term may include 1 or more hospital, nursing home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

"(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under

this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

"(c) DETERMINATION OF PAYMENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

"(2) DEFINITION OF FULL COST RECOVERY.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

"(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into account the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

"(ii) indirect costs which, in the case of a qualified Indian health program—

"(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

"(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

"(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

"(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

"(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

"(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

"(B) NO SINGLE REPORT REQUIREMENT.—Not all qualified Indian health programs provided or administered by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

"(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report

shall be made on a fee-for-service, encounter, or per diem basis.

"(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

"(A) a significant decrease in discharges;

"(B) costs for graduate medical education programs;

"(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

"(D) payment for outlier cases.

"(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

"(A) on the full cost recovery basis provided in paragraphs (1) through (5);

"(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

"(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

"(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian tribe or tribal organization; or

"(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

"(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

"(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal

organization, or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

"(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

"(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

"(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health set-

ting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

''(C) preventive primary health services as described under section 330 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

''(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screening, diagnostic, and treatment services as described in section 1905(r);

''(E) influenza and pneumococcal immunizations;

''(F) other immunizations for prevention of communicable diseases when targeted; and

''(G) the cost of transportation for providers or patients necessary to facilitate access for patients.''.

Subtitle B—Medicaid

SEC. 211. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (64), by striking ''and'' at the end:

(2) in paragraph (65), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (65), the following:

''(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

''(A) the term 'meaningful consultation' is defined through the negotiated rulemaking

process provided for under section 802 of the Indian Health Care Improvement Act; and

"(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.".

SEC. 212. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

"Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.".

SEC. 213. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

"INDIAN HEALTH SERVICE PROGRAMS

"SEC. 1911. (a) IN GENERAL.—The Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan by such entities if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable generally to the service for which it seeks reimbursement under this title and for services provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be

deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations, or urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.".

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking "For purposes" and inserting the following:

"(1) IN GENERAL.—Subject to paragraph (2), for purposes"; and

(2) by adding at the end the following:

"(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).".

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting "an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)," after "Service,".

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

"(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

"(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

"(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

"(2) under an agreement entered into under subsection (a) between the entity and the Secretary.".

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2015 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101–630 (25 U.S.C. 1653 note) is repealed.

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. 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. 303. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect on October 1, 2003.

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The CHAIRMAN. Senator Inouye will not be able to be here today. He is in a defense appropriations hearing. As you might know, that is extremely important now, so we will just go ahead with the testimony.

We will start with the first panel, Charles Grim, interim director of the Indian Health Service. He will be accompanied by Mr. Lincoln, Craig Vanderwagen, and Gary Hartz.

Dr. Grim, before I start, I also wanted to congratulate you. I understand 2 days ago we received official papers from the White House nominating you to be the permanent director of the IHS, and we will schedule a hearing on your nomination right after the Easter break, and we look forward to your service in that capacity. Congratulations.

Mr. GRIM. Thank you, Chairman Campbell.

The CHAIRMAN. Go ahead and proceed.

STATEMENT OF CHARLES GRIM, M.D., INTERIM DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. GRIM. It is a pleasure to be here before you and the committee, Mr. Chairman. I would like to request that my written statement that has been submitted be entered to the record.

The CHAIRMAN. Your complete statement will be in the record.

Mr. GRIM. Thank you.

I am Dr. Charles W. Grim, interim director of the Indian Health Service. I am accompanied today by several of my staff, Michel Lincoln, deputy director for the Indian Health Service; Craig Vanderwagen, acting chief medical officer for the Indian Health Service; Gary Hartz, acting director for the Office of Public Health; and Bob McSwain, director for the Office of Management Support.

Today we are here to speak about the reauthorization of the Indian Health Care Improvement Act. There is no single piece of legislation that will affect the future health status of the American Indians and the Alaska Natives more than the Indian Health Care Improvement Act Reauthorization of 2003, S. 556. In the intervening 28 years since it was first authorized, achievements in tribal self-determination, decisions by this committee and other authorizing and appropriations committees of Congress, and the Indian Health Service Programs have improved the health status of Indian people.

To continue the momentum of improvement and to achieve the goals shared by Indian country, this committee and the Administration, to eliminate health disparities between all Americans, it is critical that the Indian Health Care Improvement Act reflect the health and world realities of today, and not those of 28 years ago.

From the beginning of the tribal-Federal relationship, the provision of health care services to Indians has been a key component of the Federal Government's trust responsibility. Two major pieces of legislation are at the core of the Federal Government's responsibilities for meeting the health needs of American Indians and Alaska Natives—the Snyder Act of 1921, Public Law 67–85 and the Indian Health Care Improvement Act, Public Law 94–437. The Snyder Act authorized regular appropriations for relief of distress and conservation of health of American Indians and Alaska Na-

tives. It remains the basic authority for appropriations for major Indian programs.

The Indian Health Care Improvement Act was originally authorized in 1976, and was enacted to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of the Federal Indian health programs, and encouraging maximum participation of tribes in such programs.

Like the Snyder Act, the Indian Health Care Improvement Act provided the authority for the programs of the Federal Government to deliver health services to Indian people, but it also provided additional guidance in several areas. The Indian Health Care Improvement Act contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities. It focused on health services for urban Indian people and addressed the construction, replacement and repair of health care facilities.

S. 556 is the product of extensive consultation that the Indian Health Service undertook during 1999 with Indian country. In anticipation of the reauthorization of the act and the changes in the health care environment of the country, IHS wanted to consult with Indian country to ascertain how these changes have impacted on the ability of tribes and urban Indian health programs to deliver high quality and much-needed services.

During consultation with Indian country, we learned that tribes were anxious to discuss the impact of managed care and other changes in the health care field that affected their ability to administer quality health programs and services. Based on this consultation, the tribes and urban Indian health programs determined that they would draft a legislative proposal reflecting their concerns and issues.

S. 556 contains a variety of new, expanded and strengthened provisions, activities and services. The Department supports the reauthorization of this cornerstone legislative authority, and Secretary Thompson has made Indian health care a priority of the Department. In the Department's review of the proposed language, to ascertain its relationship to its policies and budget priorities during this time in our Nation's history, there are certain provisions in S. 556 that generate some concern.

Key provisions in S. 556 are inconsistent with current Medicare and Medicaid provider payment practices and could inappropriately increase costs. As an example, the bill proposes a new provider type called Qualified Indian Health Provider for IHS, tribal and urban Indian providers participating in Medicare and Medicaid programs. The most problematic aspects of the QIHP are the structure and operation of the payment provisions, which are not only burdensome, but more importantly would not be feasible to administer. In addition to the burden and feasibility issues, on a more fundamental level, the full cost, plus other costs of the QIHP payment approach would be contrary to the way that Medicare generally pays providers.

The bill also expands the current 100 percent Federal matching rates to States for Medicare and SCHIP services provided through IHS facilities to include services provided to American Indians and

Alaska Natives by non-Indian health care providers. This proposed change would substantially increase the Federal program and administrative costs, with no guarantee and little likelihood of increasing access to services for Indian beneficiaries or better payments to Indian providers.

We are also concerned that S. 556 would appear to broadly mandate the use of negotiated rulemaking to develop all regulations to implement the act. Negotiated rulemaking is very resource-intensive for both Federal and non-Federal participants. While it can be effective and appropriate in certain circumstances, it may not be the most effective way to obtain the necessary Indian input in the development of the Indian Health Care Improvement Act rules and regulations in every given case.

In addition to our expressed concerns with S. 556, I would like to present a little bit of an explanation of the Secretary's One-Department Initiative and its benefits to the Indian Health Service. The Secretary's One–Department Initiative has been of great benefit to the IHS, as well as the Native American constituents of the Department. The fundamental premise of the initiative is that the Department of Health and Human Services must speak with one consistent voice. Nothing is more important to our success as a Department.

With regard to our tribal constituents, the Secretary observed on his first trip to Indian country that tribal programs were often stovepiped and that their existed within HHS an assumption that the Indian Health Service has sole responsibility for the health issues facing tribes.

In the 2 short years since the Secretary launched this initiative, he has reestablished the Intradepartmental Council for Native American Affairs. The membership on this council is comprised of the heads of all HHS operating and staff divisions, with the IHS director serving as the vice-chair. This council serves as an advisory body to the Secretary and has the responsibility to assure that Indian policy is implemented across all divisions. The council provides the Secretary with policy guidance and budget formulation recommendations that span all divisions of HHS. The profound impact of this council on the IHS is the revised premise within HHS that all agencies bear responsibility for the government's responsibility and obligation to the Native people of this country.

I want to assure you and the committee that we are committed to working with you to ensure that this key legislative authority can be reauthorized. We will be happy to answer any questions that you may have regarding the Department's view on S. 556.

Thank you.

[Prepared statement of Mr. Grim appears in appendix.]

The CHAIRMAN. Thank you, Dr. Grim.

I was listening very carefully to your explanation about the One-HHS, and we are getting quite a bit of uncomfortable feelings back from the tribes. Is it still on track? Has it been revised to reflect the comments and recommendations from the review group or from tribes themselves?

Mr. GRIM. The Indian Health Service at the current time is also going through a reorganization of its own, as part of the President's management agenda. This is an initiative that we started prior to

the President's management agenda, which asked agencies to delayer their bureaucracies and try to become more effective and efficient. As part of the IHS HQ reorganizatiobn process, we have been taking input for the Department relative to some of the One-HHS initiatives.

We received numerous comments from tribes, as well as resolutions. Primarily the comments have been around the consolidation efforts of the Human Resources Department. We have made those informations known at all departmental meetings on such consolidations.

The Indian Health service has had a seat at the table. We have been involved in all of the planning sessions that the Department is holding relative to the HR consolidations. We are making all of our unique considerations known in those meetings.

The CHAIRMAN. I see. Well, as I understand it, the initiative is going to involve the transfer of $838,000 from the IHS to the HHS. Clearly, that is one of the tribal concerns, that they are going to lose their tribal shares. I think you can understand their worry. How do you propose to preserve the tribal shares?

Mr. GRIM. One of the initial issues that you brought up, Senator, on the $838,000 transfer of funds from Indian Health Service into the Department was actually dealt with by the Congress. That was restored to the Indian Health Service budget. One of the things that we are trying to do to ensure that Indian country and Indian Health Service needs are dealt with is that our staff, both in legislative and public affairs and in HR, have been in attendance at all of the meetings that the Department has called relative to having public affairs, legislative affairs and other departments try to speak with one voice.

The CHAIRMAN. I understand that sometimes when they speak with one voice, though, it is a majority voice that leaves a lot of people out in the cold. If that money was transferred, can the functions that they are now used for under IHS and the dollars that are going to be associated with it, are they still be contractable once they are consolidated with the HHS?

Mr. GRIM. One of the things we have been making the Department aware of are the special needs relative to our budget around tribal shares. A large portion of our headquarters and regional office budgets, as well as 100 percent of our service unit budgets, are contractable and compactable for tribal shares. One of the things that the Department is looking at right now in these consolidation efforts are just those issues. Many of these things are still in the planning phases, and as I said, we do attend those meetings. One of the things the Department is aware of, though, is that the Indian Health Service HR budget, parts of the legislative and public affairs budget, are eligible for tribal shares. Should a tribe who is not currently taking those shares come in and ask for said shares, then we would—make those moneys available. So those issues have been made known to the Department.

The CHAIRMAN. And I further understand that you believe the IHS will realize a cost of $21.3 million from the reduction of 195 FTEs and $9.3 million from information technology. Your testimony says that every effort will be made to minimize the impact at the service delivery level of the organization. I can tell you, In-

dian people from the health standpoint, they do not have an awful lot of slack. A lot of them are right on the edge, and I would be interested in knowing the specific impacts that, if you foresee any now, that it is going to have on service delivery because of the reduction of those FTEs.

Mr. GRIM. One of the things that we have always tried to do, Senator, in the past when the agency has been asked to take any sort of budget reductions or FTE reductions, a primary policy of the agency has been to take those in the administrative realm, to try to reduce the impact on the care delivery level. The 195 FTE reduction that is being proposed in the Indian Health Service budget is because of savings that are being requested in that amount for the Indian Health Service. The way that the Indian Health Service plans on dealing with those is that we will be looking at any sorts of economies and efficiencies that we can achieve in the way of administrative operations of the agency, as well as consolidating and streamlining certain functions like IT and the HR consolidations that are occurring within the Health and Human Services Department.

We do not have specific information yet because it is a fiscal year 2004 budget proposal on exactly where those 195 FTEs might come from. What we will be looking at, however, will be administrative vacancies that currently exist. We are at both the headquarters and regional levels being very careful now about the administrative vacancies that we are filling. Also the Department is going forward with some early-out and buyout authority requests that were granted in the Homeland Security Act. We will make wise and judicious use of buyout and early-out authorities targeted at areas where we may have overages in certain areas. And then, as a last resort, we would touch the service unit or the health care delivery level, if necessary.

The agency will look very, very closely, though, at our administrative ranks to ensure that what is left will be able to fulfill our fiduciary and accountability standards that are expected of us.

The CHAIRMAN. Well, I appreciate your answering, but they are somewhat broad terms for me. Do you foresee the elimination of any existing programs or disease prevention or health promotion activities that now tribes avail themselves to?

Mr. GRIM. No, sir; we do not.

The CHAIRMAN. I did not ask all the way. I should have. Would any of the other people that are accompanying you—were they going to make statements, too?

Mr. GRIM. They do not have any initial statements, no sir.

The CHAIRMAN. Okay. Tell me about the consultation that has taken place, if any, with tribes on this proposal.

Mr. GRIM. On the One-HHS?

The CHAIRMAN. Yes.

Mr. GRIM. As I said, the Indian Health Service, as part of our own internal reorganization, had a restructuring initiative work group that was put together well over 1 year ago—about 1 year ago January. They had a series of meetings, and in those meetings—and that was a group composed of primarily tribal leaders from all regions of Indian Health Service—with four Federal representatives. In that process, they dealt extensively in discussions about

the One-HHS Initiative. They provided both an interim and a final report to the director of Indian Health Service. As part of the restructuring initiatives that we are doing at headquarters of Indian Health Service, we put together then a final team that developed essentially the organizational charts, functional statements and things like that, that took into account all of the comments that came in from the restructuring initiative work group.

Further, we sent comments after that out to Indian country to each of our regions and asked that they hold meetings with their tribes in whatever format they used to do tribal consultation. They would then take a look at the restructuring of Indian Health Service headquarters as currently proposed in draft. We have also been making the Department aware, as we and other of the operating divisions have meetings on the HR consolidation, of the issues that the tribes have brought forward relative to their concerns about HR consolidation.

The CHAIRMAN. How long has this been going on—the consultation process?

Mr. GRIM. The consultation process started, I believe it was in January 2002 for the restructuring of Indian Health Service.

The CHAIRMAN. Well, my own personal view is that I would want to know a lot more about any specific impacts, particularly if they are going to adversely affect tribes, before the 2004 money is going to be triggered. I would think that Senator Inouye would be equally interested in that.

Over the years, the success of tribes with 638 contracts and self-governance compacts has resulted in the reduction of the IHS headquarters and area staff offices. Are there administrative functions that are essentially Federal in nature that they cannot be contracted-out to tribes now?

Mr. GRIM. Yes, sir.

The CHAIRMAN. What are a couple of those?

Mr. GRIM. We take a lot of these from an OMB circular that talks about inherently Federal functions. One, for example, is doing a Federal budget, proposing a Federal budget; dealing with Federal contracting; supervising Federal employees—things like that. If you would like, I could submit to the record a further list.

The CHAIRMAN. Would you please submit that for the record?

Now that the RIW final report is completed, what is your next step in meeting the goals of this One-HHS program?

Mr. GRIM. The agency is almost ready to make some final decisions on an organizational structure for the Indian Health Service.

The CHAIRMAN. Will there be any further consultation with tribes before that report is issued?

Mr. GRIM. What we had indicated to tribes was that at the same time we submitted our reorganization plan to the Department, we would be submitting it out to Indian country for a final look at the plan. At that point, there is still time for very minor adjustments in the plan, but the majority of the comments received back from Indian country relative to the headquarters reorganization itself were relatively minor sorts of changes that were requested. We think we have got most of those incorporated into the final changes. So we will send it out at the same time.

I think the Department would be willing to allow us to make minor adjustments as it is going through its approval process there.

The CHAIRMAN. In Alaska for a number of years, the health care has been delivered under one compact. In a sense, they have already consolidated for literally a unified health system. Have you looked at that consolidation process in Alaska to see if there is anything you can apply to this One-HHS program?

Mr. GRIM. I think we always try to learn from some of the things that the tribes are doing. Many times they have flexibilities, as you are aware, that we do not, when they take over their programs under that act. It frees them from some of the constraints that we have as a Federal program.

The Alaska region and some of those tribes have been making us aware of some of the efficiencies they have realized. As an example, regarding their human resources that are being managed up there, they have a more efficient HR employee to total employees ratio now than we are trying to achieve as a Department. So I think we do have some things that we can learn from looking at the way things are done by some of our compact tribes.

The CHAIRMAN. Okay. Well, I have no further questions, Dr. Grim, but I may submit some and request an answer in writing. Senator Inouye may also, or other members of the committee.

With that, I appreciate your appearing today and thank you very much.

We will now move to the second panel, which will be Julia Davis-Wheeler, the Chairperson for the National Indian Health Board, from Denver; and Don Kashevaroff, who is the Representative of the Tribal Self-Governance Advisory Committee from Anchorage, AK.

We will go ahead and start with you, Julia, if you would. And just as the former panel, you are welcome to submit your complete written testimony. That will be included in the record if you would like to just summarize.

STATEMENT OF JULIA DAVIS-WHEELER, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD

Ms. DAVIS-WHEELER. Yes; thank you, Senator Campbell. It is good to see you this morning.

Good morning, everyone. It is a pleasure to be here to testify on behalf of the National Indian Health Board. I would like to state that I have two Board members with me in the audience. I would request Buford Rolin from Nashville and Everett Vigil from Albuquerque, stand please with our NIHB staff. Thank you.

I also represent the Northwest Portland Area Indian Health Board. I serve as chair for that. I am also the secretary for the Nez Perce Tribal Council.

So it is a pleasure to appear before you today to make comments on the Indian Health Care Improvement Act, which is important authorizing legislation for the care of all of our American Indians and Alaska Natives.

In June 1999, the director of the Indian Health Service at that time, Dr. Michael Trujillo, convened a National Steering Committee composed of representatives from tribes and national Indian or-

ganizations to provide assistance and advice regarding the reauthorization of the Indian Health Care Improvement Act. Over the course of 5 months, the National Steering Committee drafted proposed legislation. In October 1999, the National Steering Committee forwarded their final proposed bill to the Director of the Indian Health Service and to each authorizing committee in the House and Senate. I have testified on the Indian Health Care Improvement Act before and I once again want to express my appreciation to you.

Last year, the Northwest Portland Area Indian Health Board, with the Billings tribes, California tribes, and the Nashville tribes, hosted a meeting at Portland, OR on May 28 to 30, to talk about the recommendations on the changes for the current legislation, S. 212. The purpose of the meeting was to address concerns expressed in the September 27, 2001 letter that Senator Inouye received from the Secretary of the Department of Health and Human Services Tommy Thompson. These concerns focused on the large cost of the bill, and it raised legitimate questions about what we were trying to achieve in the bill. The participants at the Portland meeting also discussed concerns raised about high-cost elements from the score on S. 212, prepared by the Congressional Budget Office, CBO, in March 2001.

I am very glad you have chosen to introduce S. 556 this year. The bill has very few apparent changes to S. 212, so we look forward to bringing you up to date on some of the changes recommended by the National Steering Committee.

The National Steering Committee is also working this year on a House bill that is expected to be introduced soon that will reflect the 2002 Portland meeting changes, and the changes discussed in subsequent meetings with House legislative counsel, and other legislative staff meetings at the March 20 and 21, 2002 National Steering Committee meeting at Portland. A lot of good things are possible if we pass the bill with our recommended changes. The titles have exciting new authorities.

I want to briefly review the titles contained in the Indian Health Care Improvement Act. Time only permits mentioning highlights in each title, but I am ready to answer your questions of any of the titles to the best of my ability. Although I have worked on the bill these past 4 years, there are only three or four experts who know everything in the bill and I may have to look to them for assistance in answering some of your questions.

The preamble section of the Act has been revised, including sections on findings, declaration of Nation policy, and definitions. Emphasis has been placed on the trust responsibility of the Federal Government to provide health services and the entitlement of Indian tribes to these services.

Title I, covering the Indian health human resources and development has been substantially rewritten, primarily to shift priority setting and decisionmaking to the local area levels where appropriate. The importance of education is highlighted by changes proposed in this Act.

Title II, the health services, represents a collection of diverse sections addressing issues related to the delivery of health services to American Indians and Alaska Native populations. Diabetes pro-

grams and epidemiology centers are just two of the many health programs authorized by this title. Title II also offers us the opportunity to improve the long-term care needed for Indian elders. As you know, there has never been specific authority for long-term care in the Indian Health Care Improvement Act. Nursing homes are only a small part of the long-term care needs of what we want to accomplish with home and community-based health care for our elders.

Title III, facilities, proposes that tribal consultation be required for any and all facility issues, not just facility closures. It protects and projects on the current priority list, while moving toward a new method of selecting facility projects. This title gives permanent authority to small ambulatory facility construction.

Title IV, access to health services, seeks to maximize recovery from all third-party coverage, including Medicaid, Medicare and State children's health insurance programs, and any new federally funded health care programs. It also will contain protection against estate recovery proceedings, to make heirs pay the Medicaid bills of deceased American Indians and Alaska Natives. This was the title that resulted in the largest dollar total in the CBO score, but the National Steering Committee has agreed to some modifications to the provisions in the first tribal bill, and this has resulted in billions less in costs to the Federal Government.

Title V, the health services for urban Indians, addresses facility construction authority and coverage by the Federal Tort Claims Act for the 35 urban programs. Urban representatives were very active members of the leadership group on the National Steering Committee, and they feel that the changes in Title V will result in millions of dollars in new funding for urban programs.

Title VI, the organizational improvements, includes very few changes, including the elevation of the Indian Health Service Director to Assistant Secretary in the Department of Health and Human Services. Although tribes are generally very satisfied with the relationship that Interim Director Dr. Charles Grim has with top policymakers in the Department of Health and Human Services, we want to institutionalize this access with this change.

Title VII, the newly titled behavioral health title, with major revisions, specifically to integrate alcohol and substance abuse provisions, with mental health and social services authorities. I know the committee is having a hearing next week on consolidation of alcohol and substance abuse programs, and I think this title can be complementary to the goals of that legislation.

Title VIII, miscellaneous, was largely rewritten. It now includes a proposal to establish an Entitlement Commission to study and make recommendations on making Indian health an entitlement in the same manner as Medicaid and Medicare. Ten sections were moved out of Title VIII to more appropriate sections in the Indian Health Care Improvement Act. All the CHS provisions were moved to Title II, a majority of the free-standing and severability provisions from other titles were incorporated into Title VIII.

I pray that this Act will pass this year, with Congress hearing from tribes that it is a priority for us in 2003. The National Indian Health Board and tribes nationwide are renewing their efforts to make this happen. The National Steering Committee, working with

the National Congress of American Indians, the tribal leaders Self-Governance Advisory Committee, and the National Council on Urban Indian Health, stand ready to work with this committee to make necessary changes and improvements to craft a bill that will assist us in our goal of raising the health status of American Indians and Alaska Natives.

I hope this hearing can be the final kick-off of the renewed effort to reauthorize the Indian Health Care Improvement Act. The Indian Health Service is no longer able to assist the National Steering Committee as it did in 1999, with support for travel and staff expenses. So it is a challenge to the tribes and the national Indian organizations, including the National Indian Health Board, to move this effort forward. We will meet this challenge and the continued support of this committee is a critical element of our efforts to pass this bill in this session of this Congress.

Just a note, I would like to support the confirmation of Dr. Grim. I was pleased to hear the announcement by Senator Campbell regarding his confirmation. I would also like to comment, as a tribal leader, that the One-DHHS Initiative that my counterpart here is going to comment on, needs to be reviewed thoroughly by tribal governments. Speaking as a tribal leader, having the head offices in Baltimore is a concern that we have as tribal leaders. The other concern is keeping the government-to-government relationship intact that we have with the Federal Government.

Thank you for this time and I would be happy to answer any questions that you have.

[Prepared statement of Ms. Davis-Wheeler appears in appendix.]

The CHAIRMAN. Thank you, Julia.

We will now move to Chairman Kashevaroff.

STATEMENT OF DON KASHEVAROFF, REPRESENTATIVE, TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE; PRESIDENT AND CHAIRMAN OF THE ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Mr. KASHEVAROFF. Thank you, Mr. Chairman.

I would also request that my written testimony be put in the record.

The CHAIRMAN. Yes; it will be included in the record.

Mr. KASHEVAROFF. Thank you. And I would like to thank you for the opportunity to testify here on the reauthorization of the Indian Health Care Improvement Act and on the One-HHS proposal that is going through. Since Ms. Davis-Wheeler touched a lot on the Indian Health Care Improvement Act, I would just like to add a few things from my viewpoint.

First, I also represent the Tribal Self-Governance Advisory Committee. This committee is of tribal leaders, convened by the Indian Health Service, to address the health care needs of all eligible American Indian and Alaska Natives, especially those served by tribal health programs operated through self-governance compacts. Even though we have somewhat compacted and separated and started to do our own direct operations apart from the IHS, we are still very concerned and take both the Indian Health Care Improvement Act Reauthorization and the One-HHS proposals—we take them both seriously.

The Indian Health Care Improvement Act, as stated before, was worked out in 1999, 4 years ago, and a lot has happened since then. We have been going through and making modifications. We have been making compromises to some of the requests that came down. I think even though we have some compromises, we have a much better bill that the House side again is working up, and we would ask that that bill when it becomes available in the next couple of weeks be substituted for the current bill on the Senate side.

There were a couple of criticisms that we heard back on the 1999 bill that took immediate offense. There was discussion about the high score of the bill, and looking at the Medicaid-Medicare provisions and the amount of costs that they will require. My viewpoint is that the Indian Health Service and the U.S. Government should fully fund the tribes in this country. We do not get fully funded. We are basically forced to go out and find the funding on our own.

As compacted tribes, we have taken that on as our own responsibility and have been trying to run our hospitals, our clinics, like a private organization. Private organizations, go out and bill for everything they can bill. They bill private insurance. They bill Medicaid. They bill Medicare. We have been doing that also. It would be nice if we did not have to. It would be nice if we were 100 percent fully funded, but knowing that is not the case, I do not think it should be an issue that we are doing the same thing the rest of the country does in health care. I think we should be allowed to do that. There are also some demonstration projects that were underway that we think should be made available to all tribes, and I think contributed somewhat to the high score also.

So when the substitute bill comes, we hope, or when the House bill comes, we hope that that can be substituted and we look forward to working with this committee and taking on any extra questions or extra concerns, and working with this committee to make sure that we have a good bill for you.

[Prepared statement of Mr. Kashevaroff appears in appendix.]

The CHAIRMAN. Okay. Thank you, Mr. Kashevaroff.

You have a major job, Alaska being so big, and I am delighted to see Senator Murkowski has just arrived. I am sure you know that your new Senator is doing a great job, just like her Dad did when he was here.

I note with interest that neither one of you talked very much, or in fact almost not at all, about the One-HHS proposal. Would either one of you like to comment on that? If you don't, I would like to ask you to give us some feedback, some written explanation or evaluation of the proposal, if you could.

Mr. KASHEVAROFF. Thank you, Mr. Chairman. I will comment on that. In my written testimony, we have a couple of pages on it. Basically, I understand that HHS is a very large Department, and in a large Department there should be efficiencies that can be obtained. Change is not bad. Change is usually good. I would have no problem, actually. I applaud Secretary Thompson for trying to make change, trying to create efficiencies, and trying to do a better service.

What I think is missing is the understanding that IHS is a unique agency. IHS provides direct health service, and by providing direct health service, that brings a whole host of other parts that

you need. You need a better HR system. You need an HR system that looks at the nursing shortage in America, and says, how can we compete for the same nurses that the private sector is competing for? Now, that is somebody you need there at the hospital, getting those nurses to come to your hospital, not somebody back in Baltimore who is out of the loop, away from the local level, not knowing what is going on.

Similarly, on the information technology—on IT, we need data systems of patients that have clinical data; we need information systems. We need those type of systems. The rest of HHS does not really need those type of systems. We also have what we call the RPMS, or Resource Patient Management System, that collects data from all of IHS and the tribes, combines it together to provide data to the Congress. That is unique among HHS also, and that is something that takes a lot of work to keep going.

It was an antiquated system. We have proposals on the IHS side, the tribes have been putting forth proposals, IHS has put forth proposals—around $36 million for a better centralized system that looks at a business perspective of what a hospital needs to be efficient and be successful. So we are looking for a $36-million increase.

At the same time, HHS has come out and said that we need to reduce the $54 million IT budget by $9 million. At the same time, the IHS hospitals and clinics are very far behind the private sector, we cannot be reducing the budget. We need to be increasing that.

As I said again, I do not mind HHS combining a lot of things. I am sure they can combine like agencies that just do a lot of granting, but when you turn over to the IHS and see the unique status of it, it needs to stand out by itself and be recognized for that.

If they want One-HHS, they should have One-HHS. They should look at the disparities in health for the American Indians and Alaska Natives, and see that we have the worst statistics across the country. One-HHS should come together and say, we are going to handle the Indian population, we are going to bring them up to the rest of the population, that would be our One-HHS mission, and that is what we are going to do first.

When they do that, then we can talk about all being equal again, and then putting everybody back together.

The CHAIRMAN. Julia?

Ms. DAVIS-WHEELER. Yes; thank you, Senator Campbell.

As a tribal leader and participating in the One-HHS restructuring initiative with Indian Health Service, one of the concerns that came forward many times and was a very hot issue at the very beginning of our meetings with certain tribal leaders was the downsizing of the Indian Health Service again. I can truly say that in a couple of those meetings, we had some tribal leaders just almost walk out on the whole process, because they felt that down-sizing the Indian Health Service any more was just a catastrophe for us to take care of our people.

The one other big concern that came forward, and I appreciate Dr. Grim's response to you on the question of consultation, was that the timeframe for proper consultation on the One-DHHS Initiative was very short. We had basically seven months to try to

consult with all the tribes across the United States. We did the best that we could under the circumstances, but I think in all reality it really needs to be like hearings or field hearings or that type of issue. I know that the Department of Health and Human Services was really putting a lot of pressure on the Indian Health Service agency to do this. So as a tribal leader, we worked very hard to help the Indian Health Service meet that deadline. It does need some more reviewing.

Thank you.

The CHAIRMAN. Okay. Well, since Dr. Grim is still here, I might say in his presence that if you think that some of the tribes have not had an adequate voice in that, we probably ought to ask him to extend that consultation process at least a few more months, Dr. Grim.

Senator Murkowski, did you have an opening statement or any questions of our witnesses?

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. With your permission I would like to submit my opening remarks for the record.

I did have some questions, just general questions, that I will also submit for the record.

I would like to take the opportunity to welcome my constituent, Mr. Kashevaroff. We had a little bit of a chance yesterday to speak, but I am pleased to have you here this morning and you have you answer the questions from this committee.

You did address briefly in your comments here the issue of the merger and how that might affect, for instance, the IT end of things within the Indian Health Services. A more general and broad question for you this morning would be how tribal self-governance, with the Alaska Natives, has affected the Indian Health Service Program and the delivery of the health services. I am not looking for specifics, but if you can just briefly describe how is this all working with the tribal self-governance.

Mr. KASHEVAROFF. Thank you, Senator Murkowski. Alaska looks forward to another long tenure of a Senator Murkowski, and keep adding the years to the same name. So that will be good.

I appreciate your question. Alaska, as mentioned earlier by Dr. Grim, has pretty much, or is 100 percent contracted-compacted. The tribes all operate their own organizations themselves, and IHS has a residual there. The residual does have 10 HR people that will come over to the tribal side as the number of Federal employees dropped. So there are still some residual, plus some transition.

But we think from Alaska, and think this because we have been told from around the country, and we have many people from around the country coming up to Alaska to see what was accomplished in our compacting. I think the shining example, the first thing that comes to our mind when we talk about what we accomplished, is we took 229 tribes and we built a consensus and built a working relationship amongst each other. We have been able to expand this relationship now to Federal partners, to do projects such as the telemedicine project.

The idea of working together, cooperating is not unique among Indian Nations, but in Alaska, with so many tribes, it was amazing that we could come together, and we pretty much try to speak with one voice now. I think the power we gain by that can be shared across the Nation, not only among Indian tribes, but other groups, to say that if you can come together and work together, there is a lot that can be accomplished.

What we have done for the Indian Health Service is we took over a system back in 1998, 1999—actually it was 1997—that was not meeting the needs of our customers, our owners. We call them customer-owners now because every one of the 115,000 Natives in Alaska own the health system now because we are compacted. We took over a system, and we have been steadily improving it. The reason we improve it now is that control has been passed from Rockville to the local villages, to Anchorage. I sit as Chair of that, the Tribal Health Consortium, but I am also President of my tribe. I am elected by 400-and-some tribal members. When those folks come to our hospital, I want to make sure that they get the best care possible. They are treated with the highest respect possible, because I know that my election depends on it.

Every one of our tribal leaders now that are overseeing health care know that, and we have taken this to heart, that our people come first. Now that we have local control, we can see the needs at a local level and adjust to it. We are very agile now. We can make changes when needed. We can also go out and get more resources. We have been getting new grant funding we are bringing in to supplement what we have. Again, I know that you do not want specifics, but a quick example—my small tribe, IHS just refused to give us a clinic. They gave us contract health money. Unfortunately, with contract money, they would give us 2 or 3 percent a year. Our costs from the private doctor we went to were 14 to 15 percent increase every year. We are going in the red every year. By taking over our own services and doing it ourselves, we then have to go out and get grant money, and now we lease a clinic, and hopefully we are going to build a clinic here, too, pretty quick; but we are leasing a clinic; we are doing it ourselves; we are controlling our costs—something that IHS just would never have been in a position to do.

So there are a lot of examples. I guess one last thing that I want to say about how IHS can work with the compactors, is they can take and look at the success the compactors have had all across the country, not just in Alaska. And they can pick out the items that we have been successful in and try to duplicate those, called best practices, looking at what one organization does best and taking that and spreading it across the rest of IHS.

I think if IHS takes that mentality, and I know Dr. Grim, who I have had some work with the last year, I know he has come to the IHS with a business mind, wanting to do that. I do support his nomination. I think he is a great choice to take a government agency and try to mold it into a very efficient and top-rated health system. I think working with the tribes, he can probably accomplish that.

Senator MURKOWSKI. That is great. It is nice to hear that Alaska can be used as a model throughout the rest of the country. I am pleased to hear that.

Mr. KASHEVAROFF. Thank you.

The CHAIRMAN. Julia?

Ms. DAVIS-WHEELER. Yes, Chairman Campbell, I would like to respond to Senator Murkowski's question on self-governance. The Nez Perce Tribe in Idaho, we just recently in 1999, 2000 went to compact. One of the things that we have done with the compacting process that we went through is we were able to build two clinics—one a small satellite clinic for our up-river people that live 70 or 80 miles away from the main headquarters, because they were in a community building. So we have one building for them. It is not a big one, but a small building where all the health programs are together. We did that with some of our compact money reserves that we had, and then other grants.

Now, recently, we are working on the main tribal health clinic for the Nez Perce Tribe where the headquarters sits. So if we did not do the self-governance compact, we would not have been able to do that. So that shows that if tribes have the initiative or know how to do this, that they can get some things done. Whereas if we would have gone through the facilities priority selection process, we would have never gotten a new facility. So I just wanted to comment on that.

Thank you.

Senator MURKOWSKI. Thank you.

Mr. Chairman, I would just like to take the opportunity to thank you. With your assistance last week, we were able to bump up the number for the funding for IHS. I know it is not as much as some would have liked, but I think we agreed it was an attempt to address the need and we will work toward additional funding. I thank you for your initiative.

The CHAIRMAN. It was a 10-percent increase, was it not?

Senator MURKOWSKI. 10 percent over the President's number. So every little bit, I think we all would agree, helps.

Thank you for your assistance when we worked on that.

The CHAIRMAN. Thank you.

I appreciate your testimony and your support of S. 556. I have to tell you, I am really concerned about this One-HHS proposal. I understand that we need to streamline and consolidate and not duplicate efforts and make better, more efficient use of tax money and so on, but I have seen too many times in the past when Indian programs get folded into bigger programs, money that had formerly been designated for Indian programs somehow gets transferred or moved or something. The Indian people have never had a real strong voice in the Administrations, any Administration or here either, unfortunately. I am really concerned about that.

When one out of every two Pimas on this earth, for instance, suffer from diabetes, and there are people who three out of their whole 7-day week and sometimes four is spent on a road somewhere just so they get dialysis, I sometimes worry that folding things into making things look more efficient sometimes is going to leave Indian people out.

I would appreciate your looking at this One-HHS proposal in depth and giving the committee back some written guidance. We will look forward to that, too, and hopefully you can do that in the next few weeks if you could, Julia. I think Senator Inouye would be equally concerned about it.

With that, I have no further questions, but we may have some that will be submitted in writing. Thank you for appearing.

The committee is adjourned.

[Whereupon, at 10:54 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND OF OJIBWE

Mr. Chairman and members of the committee, this testimony is offered in support of Reauthorization of the Indian Health Care Improvement Act. The Mille Lacs Band of Qjibwe is a federally-recognized tribe with 3,570 enrolled members. Located in east central Minnesota, we operate three separate clinics offering services to more than 2,000 Mille Lacs Band members, as well as other non-members, through 20 different programs.

When Congress first enacted the Indian Health Care Improvement Act (IHCIA) in 1976, one of the major policy reasons for doing so was to address the health disparities in Indian Country by raising the health status of the Indian population to a level consistent with that of the general population of the United States. Unfortunately, the overall health status of Indian people has improved very little, and those same disparities continue to exist in alarming numbers. Reauthorization of the IHCIA would greatly assist efforts to rectify the continuing health disparities in Indian country.

One of the primary purposes of the IHCIA is to authorize appropriations for tribal health programs so that they may better satisfy their health care goals. Even so, federal funding levels have not kept pace with inflation or with the increasing needs that directly impact the costs of health care delivery. In fact, today's medical dollar is worth less than the funding received, making it very difficult to provide comprehensive health care.

As is true for most tribal communities, the Mille Lacs Band is confronting an increased health care burden due to growing incidents of conditions such as diabetes, heart disease, and cardiovascular disease. These health conditions, which are approaching epidemic proportions, are impacting not only our adult population, but also our youth. This weighs heavy on our hearts as our children are our future.

Factors such as poor diet and lack of exercise contribute greatly to the increase of these chronic health conditions. The Mille Lacs Band would like to develop preventative programs addressing these significant health deficiencies. Soaring treatment costs for chronic health conditions quickly drain program dollars, and the reality is that preventative programs are, in the long run, far more cost-effective.

Our health care burden is impacted further by our ever-growing user population, which has increased by more than 30 percent in recent years. As a result, we have outgrown our current facilities. Inadequate space does not permit us to effectively address the existing needs of our members, much less those that continue to emerge each year.

Presently, we are limited as to the services we are able to provide. While we currently employ one full-time dentist, two full-time physicians, and a handful of certified nurse practitioners, we are not capable of providing the comprehensive health care that our people rely upon, and frankly, deserve. Examples are programs targeted at substance abuse, mental health, and other behavioral health programs that contribute toward wellness beyond basic medical and dental care. We greatly need

to expand our facilities and construct additional space to meet those growing demands for health services.

Present funding levels are not sufficient to keep up with increasing health care needs and the associated costs. Level of need funding is designed to bring tribal health care programs to the equivalent of mainstream funding agencies throughout the United States. Our level of need funding is currently at 30 percent, an amount far below comparable non-tribal agencies. As a consequence, the Mille Lacs Band consistently faces a challenge in meeting the health care needs of our members and other tribal members who utilize our clinic services.

The Mille Lacs Band makes every effort to access outside funding services to complement Federal funding. Third party billings are submitted to insurance providers and payments are sought from Medicare and Medicaid reimbursements. Regardless, these efforts are not sufficient to keep up with increased costs of health care delivery and frequently, the Mille Lacs Band must provide the difference. The problem with this is that it means other tribal programs and services are affected when dollars must be shifted.

The impacts of non-reauthorization to the Mille Lacs Band of Ojibwe and other Tribes are numerous. Educational programs and campaigns may be eliminated, which will reduce health awareness. There will be an inability to provide comprehensive health care services to our clinic users, especially if clinic staff numbers are not increased. There will also be reduced access to the latest technology, a problem we already face with outdated technology that does not keep up with the latest medical advances. These are just some of the problems tribes will face without reauthorization of the IHCIA.

Reauthorization of the Indian Health Care Improvement Act is beneficial to the Mille Lacs Band of Ojibwe and to all tribes who depend upon federal funding to provide comprehensive health care for our communities. Reauthorization will allow the Mille Lacs Band of Ojibwe to pursue our health care objectives and goals intended to rectify the significant health disparities that the United States acknowledges exist on our reservation and reservations across the United States.

Underlying the Indian Health Care Improvement Act Reauthorization is the Federal trust responsibility of the United States. The Federal trust responsibility extends to all the federally-recognized tribes of the United States who have a government-to-government relationship with the United States. This trust obligation arises out of the government-to-government relationship that is articulated in article 1, section 8, clause 3, of the U.S. Constitution, the governing instrument of the United States. The trust responsibility also arises out of the numerous treaties, executive orders, court decisions and Federal laws of the United States, and frequently is acknowledged in the same. Reauthorization of the IHCIA is the means by which the United States can continue to fulfill its trust obligation to tribal nations.

Encompassed within the government-to-government relationship is the United States' recognition of tribes' right to self-governance. The Mille Lacs Band of Ojibwe is a self-governance tribe under the Tribal Self-Governance Act of 1994. We were one of the first tribes to enter into a self-governance compact, and not long after, entered into an Annual Funding Agreement, an arrangement which allows the Mille Lacs Band to design its health care programs and services in a manner that best addresses goals and objectives we have identified in our community. The Mille Lacs Band has been able to prioritize its health care needs and attempts to meet those needs as best we can through sound policy decisions. However, our self-governance status does not interfere with the federal trust responsibility of the United States.

Indian health care must be improved. Reauthorization of the Indian Health Care Improvement Act is essential to improving the lives of Indian people and the health care that they receive. Mii Gwetch.

PREPARED STATEMENT OF JULIA DAVIS-WHEELER, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD

Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Julia Davis-Wheeler, chairperson of the National Indian Health Board (NIHB). I am an elected official of the Nez Perce Tribe, serving as Secretary, and also Chair the Northwest Portland Area Indian Health Board. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on S. 556 to reauthorize the Indian Health Care Improvement Act, which is the most important authorizing legislation for American Indian and Alaska Native health delivery. As you recall, I stated in my recent testimony on the FY 2004 Budget that I looked forward to coming back and testifying on the Indian Health Care Improvement Act. I am pleased that this day has come

and it demonstrates your commitment to American Indian and Alaska Natives as we work toward eliminating the unique health problems facing Indian Country.

As you are well aware, the NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. It is our mission to advance the level of health care in Indian Country and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

I have been associated with the reauthorization effort since May 1999 when I first met with other tribal leaders and the Indian Health Service to explore how we, along with Congress and the Administration, could work together to pass this vital legislation.

In June 1999, the director of the IHS, Dr. Michael Trujillo convened a National Steering Committee (NSC) composed of representatives from tribal governments and national Indian organizations to provide assistance and advice regarding the reauthorization of the IHCIA. Over the course of 5 months, the National Steering Committee drafted proposed legislation, which was based upon the consensus recommendations developed at four (4) regional consultation meetings held earlier in that year. The consensus recommendations formed the foundation upon which the National Steering Committee began to draft proposed legislation to reauthorize the IHCIA. In October 1999, the National Steering Committee forwarded their final proposed bill to the IHS Director and to each authorizing committee in the House and Senate and the President. Previously, the House and Senate introduced legislation based on the tribal bill, but neither passed.

Last year the Northwest Portland Area Indian Health Board and other Area Health Boards hosted a May 28–30, 2003 Indian Health Care Improvement Act meeting. The purpose of the meeting was to consider changes and provide recommendations on the proposed legislation in response to concerns raised in a September 27, 2001 letter and memorandum from Health and Human Services Secretary Tommy G. Thompson to Senator Daniel Inouye. The primary issues raised in Secretary Thompson's correspondence focused on the high costs associated with some of the bill provisions, questions about what outcomes were sought in regards to certain sections of the bill, and it also included opposition to certain elements in the bill. The participants at the Portland meeting took a hard look at the high Congressional Budget Office (CBO) score on S. 212 and the other concerns and forwarded recommendations to the House and Senate in July 2002.

I am very pleased you have introduced S. 556 early this year and have held prompt hearings. The Bill appears to be identical to S. 212 introduced during the 107th Congress, so we look forward to bringing you up-to-date on some changes recommended by the National Steering Committee. The National Steering Committee is currently working with House members and committee staff on a House bill that is expected to be introduced very soon that incorporates the recommendations developed at the 2002 NSC meeting in Portland, further changes discussed in subsequent meetings with House Legislative Counsel, other legislative staff meetings, and at the March 20 and 21, 2003 NSC meeting hosted by the Northwest Portland Area Indian Health Board just a couple of weeks ago.

I should tell you that in December 2002 the NSC met in Rockville, MD and selected Lone Pine Paiute Shoshone Tribal Chairperson Rachel Joseph and me to co-chair this year's effort. In addition, Don Kashevaroff representing the Tribal Self-Governance Advisory Committee, former Navajo Nation Vice President Taylor McKenzie, and Kay Culbertson of the National Council of Urban Indian Health make up this years NSC leadership group. The balance of members represent each of the 12 areas of the Indian Health Service and several national Indian organizations that I mention below. A lot of good things are possible if we pass the bill with our recommended changes. The titles have exciting new authorities.

I want to briefly review the titles contained in the Indian Health Care Improvement Act. Time only permits mentioning highlights in each title, but I am ready to answer your questions on any of the titles to the best of my ability. Although I have worked extensively on the bill over the past 4 years, I may have to call upon one of the technical advisers who possess a detailed knowledge of the legislation to assist with my answers to your questions.

The Preamble section of the act has been revised, including sections on Findings, Declaration of Nation Policy and Definitions. Emphasis has been placed on the trust responsibility of the Federal Government to provide health services and the entitlement of Indian tribes to these services

Title I—Indian Health, Human Resources and Development, has been substantially rewritten primarily to shift priority setting and decisionmaking to the local Area levels, where appropriate. The importance of education is highlighted by changes proposed to the act.

Title II—Health Services represents a collection of diverse sections addressing issues related to the delivery of health services to American Indian and Alaska Native populations. Diabetes programs and epidemiology centers are just two of the many health programs authorized by this title.

Title III—Facilities, proposes that tribal consultation be required for any and all facility issues, not just facility closures. It shelters projects on the current priority list while moving toward a new method for selecting facilities projects. This title gives permanent authority to small ambulatory facilities construction.

Title IV—Access to Health Services, seeks to maximize recovery from all third-party coverage, including Medicaid, Medicare, and the State Children's Health Insurance Program (S-CHIP) and any new federally funded health care programs. It also will contain new authority for long-term care and protection against estate recovery. This was a title that resulted in the largest dollar total in the CBO score, but the NSC has agreed to some modifications to the provisions in the first tribal bill and this has resulted in billions less in costs to the Federal Government. The main change is that States will not receive huge increases in reimbursements.

Title V—Health Services for Urban Indians, adds facility construction authority and coverage by the Federal Tort Claims Act for the 35 urban programs. Urban representatives were very active members of the leadership group on the NSC and they feel that the changes in title V will result in million of dollars in new funding for urban programs.

Title VI—Organizational Improvements, includes changes including the elevation of the Indian Health Service Director to Assistant Secretary in the Department of Health and Human Services. Although tribes are generally very satisfied with the relationship Interim Director Dr. Charles Grim has with top policymakers in the Department of Health and Human Services, we want to institutionalize this access with this role change.

Title VII—Contains the newly named Behavioral Health title with major revisions, specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. I know the committee is having a hearing next week on consolidation of alcohol and substance abuse programs and I think this title can be complementary to the goals of that legislation.

Title VIII—Miscellaneous was largely rewritten. It now includes a proposal to establish an entitlement commission to study and make recommendations on making Indian Health an "Entitlement," in the same manner as Medicaid and Medicare. Ten sections were moved out of title VIII to more appropriate sections in the IHCIA. All CHS provisions were moved to title II. A majority of the "free-standing and severability" provisions from other titles were incorporated into title VIII.

Conclusion

On behalf of the National Indian Health Board, I would like to thank the committee for its consideration of our testimony and for your interest in the improvement of the health of American Indian and Alaska Native people. I know that this act will not pass this year unless Congress hears from tribes that it is indeed a priority in 2003. The National Indian Health Board and tribes nationwide are renewing their efforts to make this happen. The National Steering Committee, working with the National Congress of American Indians, the Tribal Leaders Self-Governance Advisory Committee and the National Council of Urban Indian Health stand ready to work with this committee to make necessary changes and improvements to craft a bill that will assist us in our goal of raising the health status of American Indian and Alaska Natives.

STATEMENT OF THE INDIAN HEALTH SERVICE
HEARING ON THE
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

APRIL 2, 2003

Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Michel Lincoln, Deputy Director, Mr. Gary Hartz, Acting Director of the Office of Public Health, and Dr. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Office of Public Health. We are pleased to have this opportunity to testify on behalf of Secretary Thompson on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003". And, at the Committee's request, I will report on the Secretary's One-Department Initiative as it impacts the IHS and the President's FY 04 budget proposal to consolidate automated information systems in the Department.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally- recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs 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 foundation is to uphold the Federal government's obligation 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 pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. 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 provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities focused on health services for urban Indian people and addressed the construction, replacement, and repair of health care facilities.

We are here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. S. 556

reflects the product of an extensive tribal consultation process that took two full years and resulted in a tribally drafted reauthorization bill. IHS staff provided technical assistance and support to the Indian tribes and urban Indian health programs through this lengthy consultation.

The Department supports the purposes of S. 556 to improve the health status of AI/AN people and to raise health status the highest possible level. We do, however, continue to have concerns, as expressed previously to the Committee in the Secretary's September 27, 2001 report on S.212, regarding a number of provisions in that bill. As introduced, S. 556 is identical to S. 212. There are several provisions in S. 556 that are inconsistent with current Medicare and Medicaid provider payment practices and could inappropriately increase costs. For example:

- Title II, Section 202, which describe a new provider type called a Qualified Indian Health Provider (QIHP) and Sections 212 and 221 regarding extension of the 100% Federal matching rate for Medicaid and SCHIP. These sections are further discussed below in the statement.
- In addition, Section 419 proposes to exempt patients eligible for Medicare or Medicaid from standard cost-sharing requirements such as deductibles, copayments, and premiums. We have no concern with the current exception for Indian children exempt from premiums and co-pays in the SCHIP program.

The Department also reported in the staff analysis of its September 27, 2001 bill report some concerns with the managed care provisions in Section 423 which limits appropriate cost and utilization incentives in Medicare and Medicaid by potentially undermining capitated payments in managed care settings.

The Administration is seriously concerned about these provisions, which undermine standard practices in Medicare and Medicaid. The most pressing concerns were outlined in the Secretary's September report which I will present to you today: 1) the Qualified Indian Health Program (QIHP); 2) negotiated rule making; and, 3) extension of 100% Federal matching rate for Medicaid and SCHIP.

While the Administration continues to have serious concerns about S. 556 in its current form, we are committed to working with the Committee on legislation to reauthorize this important cornerstone authority for the provision of health care to American Indians and Alaska Natives.

Qualified Indian Health Program (QIHP)

The bill would amend the Medicare statute to add various detailed provisions for a new provider type called a Qualified Indian Health Provider (QIHP) for IHS, Tribal, and urban Indian (I/T/U) providers participating in the Medicare and Medicaid programs. The most problematic aspects of QIHP are the structure and operation of the payment provisions, which are not only burdensome but, more importantly, would not be feasible to administer. QIHP would require the Federal government to complete a series of

complex payment computations for each I/T/U provider, for each payment period, (including rates and adjustments not available to any other provider) to identify the provider type for each that yields the highest payment amount for that period. However, such computations could only be made after services are provided, when it is too late for the providers to have known or complied with the differing conditions of participation applicable to differing provider types. In addition to the burden and feasibility issues, on a more fundamental level, this "full cost plus other costs" QIHP payment approach would be contrary to the way that Medicare generally pays providers. Moreover, it would impose disproportionately higher costs on a program that is approaching insolvency. Extending such a payment approach to Medicaid and SCHIP would raise similarly serious administrative and budgetary concerns.

Negotiated Rule Making; Tribal Consultation; Administrative Burdens

We are concerned that S. 556 would appear to broadly mandate use of negotiated rule making to develop all regulations to implement the IHCIA. Negotiated rule making is very resource-intensive for both Federal and non-Federal participants. It can be effective in appropriate circumstances, but may not be the most effective way to obtain necessary Indian provider input in the development of IHCIA rules and regulations in a given case.

Additionally, while we appreciate the value of consultation with Tribes, we have concerns about the consultation requirements. The bill would require Tribal consultation prior to the Centers for Medicare & Medicaid Services (CMS) adopting any policy or regulation, as well as require all HHS agencies to consult with urban Indian organizations

prior to taking any action, or approving any action of a State, that may affect such organizations or urban Indians. Such requirements appear to be broader than the existing Tribal consultation requirement and would be very difficult to administer, given the hundreds of regulations and policies potentially covered.

We have similar concerns about the considerable indirect adverse impact of S.556's extensive reporting requirements and other administrative burdens on IHS and CMS that would divert limited resources from other activities. One example is the proposed requirement for a detailed annual report on health care facilities construction needs and the survey of facilities it would entail. As IHS programs and both IHS and CMS administrative functions are funded by capped discretionary accounts, the imposition of additional administrative duties on IHS and CMS would have the practical effect of requiring cutbacks in current activities.

Extension of 100% Federal matching rate for Medicaid and SCHIP

We also are concerned that the bill would extend the 100% Federal matching rate to States for Medicaid and State Children's Health Insurance Program (SCHIP) services (currently applicable to such services provided through an IHS facility) to other services provided to American Indians and Alaska Natives, including those furnished by non-Indian health care providers. This proposed change would substantially increase Federal program and administrative costs, with no guarantee and little likelihood of any more services for Indian beneficiaries or better payments for Indian providers.

As we continue our thorough review of this far-reaching, complex legislation, we may have further comments. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committee, the National Tribal Steering Committee, and other representatives of the American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

One-Department Initiative

In addition to our expressed concerns with S.556, I will now present an explanation of the Secretary's One-Department initiative and its benefit to the IHS.

The Secretary's One Department Initiative has been of great benefit to the IHS as well as the Native American constituents of the Department. The fundamental premise of this initiative is that the Department of Health and Human Services must speak with one, consistent voice. Nothing is more important to our success as a department. With regard to our tribal constituents the Secretary observed on his first trip to Indian Country that tribal programs were often "stove piped" and that there existed within HHS an assumption that the IHS had sole responsibility for the health issues facing tribes. In the two short years since the Secretary launched this initiative he has reestablished the Intradepartmental Council for Native American Affairs. The membership of this Council is comprised of the heads of all the HHS Operating and Staff Division with the IHS Director serving as the Vice-Chair. This Council serves as an advisory body to the Secretary and has the responsibility to assure that Indian policy is implemented across all

Divisions. The Council provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all Agencies bear responsibility for the government's responsibility and obligation to the Native people of this country.

In addition to the Council the Secretary and Deputy Secretary have traveled widely to Indian Country with their senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice on behalf of tribes.

An example of a tangible benefit to the IHS is the FY '04 President's budget request for IHS of $20 million for Sanitation Facilities Program. An evaluation of the program justified an increase in the FY '04 budget for the program's most needy homes. This increase was also a result of the Secretary's visit to Alaska with his senior staff in 2002. They observed the critical need for safe drinking water and sanitation facilities in Indian Country and acted decisively to increase the IHS budget request.

The One Department Initiative can be directly credited for this step forward for the Native people of this nation.

FY '04 Information Technology Consolidation

Also, I would like to address the Committee's request for information on the FY '04 President's budget proposal to consolidate automated information systems in the Department.

The FY '04 President's Budget for IHS includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization.

These investments will enable IHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the IT Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

The IHS budget request includes savings in the IT Budget from ongoing IT consolidation efforts and additional reduced spending through the streamlining or elimination of lower priority projects. As a result, the FY '04 IHS budget request proposes a decrease in spending for information technology below the FY '03 level of $9,282,000. This decrease is the result of IT savings associated with the creation of "one HHS" from the Department's disparate organization units and more efficient and effective management of the base HHS information technology system. Consolidation of IT resources will yield savings necessary to support program requirements.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act and other issues. We will be happy to answer any questions that you may have.

APPENDIX 5

Office of Federal Procurement Policy (OFPP) Policy Letter 92-1, "Inherently Governmental Functions"

September 23, 1992

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Inherently Governmental Functions.

1. Purpose. This policy letter establishes Executive Branch policy relating to service contracting and inherently governmental functions. Its purpose is to assist Executive Branch officers and employees in avoiding an unacceptable transfer of official responsibility to Government contractors.

2. Authority. This policy letter is issued pursuant to subsection 6(a) of the Office of Federal Procurement Policy (OFPP) Act, as amended, codified at 41 U.S.C. 405(a).

3. Exclusions. Services obtained by personnel appointments and advisory committees are not covered by this policy letter.

4. Background. Contractors, when properly used, provide a wide variety of useful services that play an important part in helping agencies to accomplish their missions. Agencies use service contracts to acquire special knowledge and skills not available in the Government, obtain cost effective services, or obtain temporary or intermittent services, among other reasons.

Not all functions may be performed by contractors, however. Just as it is clear that certain functions, such as the command of combat troops, may not be contracted, it is also clear that other functions, such as building maintenance and food services, may be contracted. The difficulty is in determining which of these services that fall between these extremes may be acquired by contract. Agencies have occasionally relied on contractors to perform certain functions in such a way as to raise questions about whether Government policy is being created by private persons. Also, from time to time questions have arisen regarding the extent to which de facto control over contract performance has been transferred to contractors. This policy letter provides an illustrative list of functions, that are, as a matter of policy, inherently governmental (see Appendix A), and articulates the practical and policy considerations that underlie such determinations (see para. 7).

As stated in paragraph 9, however, this policy letter does not purport to specify which functions are, as a legal matter, inherently governmental, or to define the factors used in making such legal determination. Thus, the fact that a function is listed in Appendix A, or a factor is set forth in paragraph 7(b), does not necessarily mean that the function is inherently governmental as a legal matter or that the factor would be relevant in making the legal determination.

5. Definition. As a matter of policy, an "inherently governmental function" is a function that is so intimately related to the public interest as to mandate performance by Government employees. These functions include those activities that require either the exercise of discretion in applying Government authority or the making of value judgements in making decisions for the Government. Governmental functions normally fall into two categories: (1) the act of governing, i.e., the discretionary exercise of Government authority, and (2) monetary transactions and entitlement.

An inherently governmental function involves, among other things, the interpretation and execution of the laws of the United States so as to:

(a) bind the United States to take or not to take some action by contract, policy, regulation, authorization, order, or otherwise;

(b) determine, protect, and advance its economic, political, territorial, property, or other interests by military or diplomatic action, civil or criminal judicial proceedings, contract management, or otherwise;

(c) significantly affect the life, liberty, or property of private persons;

(d) commission, appoint, direct, or control officers or employees of the United States; or

(e) exert ultimate control over the acquisition, use, or disposition of the property, real or personal, tangible or intangible, of the United States, including the collection, control, or disbursement of appropriated and other Federal funds.

Inherently governmental functions do not normally include gathering information for or providing advice, opinions, recommendations, or ideas to Government officials. They also do not include functions that are primarily ministerial and internal in nature, such as building security; mail operations; operation of cafeterias; housekeeping; facilities operations and maintenance, warehouse operations, motor vehicle fleet management and operations, or other routine electrical or mechanical services.

The detailed list of examples of commercial activities found as an attachment to Office of Management and Budget (OMB) Circular No. A-76 is an authoritative, nonexclusive list of functions that are not inherently governmental functions. These functions therefore may be contracted.

6. Policy.

(a) Accountability. It is the policy of the Executive Branch to ensure that Government action is taken as a result of informed, independent judgments made by Government officials who are ultimately accountable to the President. When the Government uses service contracts, such informed, independent judgment is ensured by:

(1) prohibiting the use of service contracts for the performance of inherently governmental functions (See Appendix A);

(2) providing greater scrutiny and an appropriate enhanced degree of management oversight (see subsection 7(f)) when contracting for functions that are not inherently governmental but closely support the performance of inherently governmental functions (see Appendix B);

(3) ensuring, in using the products of those contracts, that any final agency action complies with the laws and policies of the United States and reflects the independent conclusions of agency officials and not those of contractors who may have interests that are not in concert with the public interest, and who may be beyond the reach of management controls otherwise applicable to public employees; and

(4) ensuring that reasonable identification of contractors and contractor work products is made whenever there is a risk that the public, Congress, or other persons outside of the Government might confuse them with Government officials or with Government work products, respectively.

(b) OMB Circular No. A-76. This policy letter does not purport to supersede or otherwise effect any change in OMB Circular No. A-76, Performance of Commercial Activities.

(c) Drafting of congressional testimony, responses to congressional correspondence, and agency responses to audit reports from an Inspector General, the General Accounting Office, or other Federal audit entity. While the approval of a Government document is an inherently governmental function, its drafting is not necessarily such a function. Accordingly, in most situations the drafting of a document, or portions thereof, may be contracted, and the agency should review and revise the draft document, to the extent necessary, to ensure that the final document expresses the agency's views and advances the public interest. However, even though the drafting function is not necessarily an inherently governmental function, it may be inappropriate, for various reasons, for a private party to draft a document in particular circumstances. Because of the appearance of private influence with respect to documents that are prepared for Congress or for law enforcement or oversight agencies and that may be particularly sensitive, contractors are not to be used for the drafting of congressional testimony; responses to congressional correspondence; or agency responses to audit reports from an Inspector General, the General Accounting Office, or other Federal audit entity.

7. Guidelines. If a function proposed for contract performance is not found in

Appendix A, the following guidelines will assist agencies in understanding the application of this policy letter, determining whether the function is, as a matter of policy, inherently governmental and forestalling potential problems.

(a) The exercise of discretion. While inherently governmental functions necessarily involve the exercise of substantial discretion, not every exercise of discretion is evidence that such a function is involved. Rather, the use of discretion must have the effect of committing the Federal Government to a course of action when two or more alternative courses of action exist (e.g., purchasing a minicomputer rather than a mainframe computer, hiring a statistician rather than an economist, supporting proposed legislation rather than opposing it, devoting more resources to prosecuting one type of criminal case than another, awarding a contract to one firm rather than another, adopting one policy rather than another, and so forth).

A contract may thus properly be awarded where the contractor does not have the authority to decide on the course of action to be pursued but is rather tasked to develop options to inform an agency decision maker, or to develop or expand decisions already made by Federal officials. Moreover, the mere fact that decisions are made by the contractor in performing his or her duties (e.g., how to allocate the contractor's own or subcontract resources, what techniques and procedures to employ, whether and whom to consult, what research alternatives to explore given the scope of the contract, what conclusions to emphasize, how frequently to test) is not determinative of whether he or she is performing an inherently governmental function.

(b) Totality of the circumstances. Determining whether a function is an inherently governmental function often is difficult and depends upon an analysis of the facts of the case. Such analysis involves consideration of a number of factors, and the presence or absence of any one is not in itself determinative of the issue. Nor will the same emphasis necessarily be placed on any one factor at different times, due to the changing nature of the Government's requirements.

The following factors should be considered when deciding whether award of a contract might effect, or the performance of a contract has effected, a transfer of official responsibility:

(1) Congressional legislative restrictions or authorizations.

(2) The degree to which official discretion is or would be limited, i.e., whether the contractor's involvement in agency functions is or would be so extensive or his or her work product is so far advanced toward completion that the agency's ability to develop and consider options other than those provided by the contractor is restricted.

(3) In claims adjudication and related services, (i) the finality of any contractor's action affecting individual claimants or applicants, and whether or not review of the contractor's own is de novo (i.e., to be effected without the appellate body's being bound by prior legal rulings or factual determinations) on appeal of his or

her decision to an agency official;

(ii) the degree to which contractor activities may involve wide-ranging interpretations of complex, ambiguous case law and other legal authorities, as opposed to being circumscribed by detailed laws, regulations, and procedures;

(iii) the degree to which matters for decision by the contractor involve recurring fact patterns or unique fact patterns; and

(iv) The contractor's discretion to determine an appropriate award or penalty.

(4) The contractor's ability to take action that will significantly and directly affect the life, liberty, or property of individual members of the public, including the likelihood of the contractor's need to resort to force in support of a police or judicial function; whether force, especially deadly force, is more likely to be initiated by the contractor or by some other person; and the degree to which force may have to be exercised in public or relatively uncontrolled areas. (Note that contracting for guard, convoy security, and plant protection services, armed or unarmed, is not proscribed by these policies.)

(5) The availability of special agency authorities and the appropriateness of their application to the situation at hand, such as the power to deputize private persons.

(6) Whether the function in question is already being performed by private persons, and the circumstances under which it is being performed by them.

(c) Finality of agency determinations. Whether or not a function is an inherently governmental function, for purposes of this policy letter, is a matter for agency determination. However, agency decisions that a function is or is not an inherently governmental function may be reviewed, and, if necessary, modified by appropriate OMB officials.

(d) Preaward responsibilities. Whether a function being considered for performance by contract is an inherently governmental function is an issue to be addressed prior to issuance of the solicitation.

(e) Post-award responsibilities. After award, even when a contract does not involve performance of an inherently governmental function, agencies must take steps to protect the public interest by playing an active, informed role in contract administration. This ensures that contractors comply with the terms of the contract and that Government policies, rather than private ones, are implemented. Such participation should be appropriate to the nature of the contract, and should leave no doubt that the contract is under the control of Government officials. This does not relieve contractors of their performance responsibilities under the contract. Nor does this responsibility to administer the contract require Government officials to exercise such control over contractor activities as to convert the contract, or portion thereof, to a personal service contract.

In deciding whether Government officials have lost or might lose control of the

administration of a contract, the following are relevant considerations: the degree to which agencies have effective management procedures and policies that enable meaningful oversight of contractor performance, the resources available for such oversight, the actual practice of the agency regarding oversight, the duration of the contract, and the complexity of the tasks to be performed.

(f) Management controls. When functions described in Appendix B are involved, additional management attention to the terms of the contract and the manner of performance is necessary. How close the scrutiny or how extensive or stringent the management controls need to be is for agencies to determine. Examples of additional control measures that might be employed are:

(1) developing carefully crafted statements of work and quality assurance plans, as described in OFPP Policy Letter 91-2, Service Contracting, that focus on the issue of Government oversight and measurement of contractor performance;

(2) establishing audit plans for periodic review of contracts by Government auditors;

(3) conducting preaward conflict of interest reviews to ensure contract performance in accordance with objective standards and contract specifications;

(4) physically separating contractor personnel from Government personnel at the worksite; and

(5) requiring contractors to (a) submit reports that contain recommendations and that explain and rank policy or action alternatives, if any, (b) describe what procedures they used to arrive at their recommendations, summarize the substance of their deliberations, (d) report any dissenting views, (e) list sources relied upon, and/or (f) otherwise make clear the methods and considerations upon which their recommendations are based.

(g) Identification of contractor personnel and acknowledgment of contractor participation. Contractor personnel attending meetings, answering Government telephones, and working in other situations where their contractor status is not obvious to third parties must be required to identify themselves as such to avoid creating an impression in the minds of members of the public or the Congress that they are Government officials, unless, in the judgment of the agency, no harm can come from failing to identify themselves. All documents or reports produced by contractors are to be suitably marked as contractor products.

(h) Degree of reliance. The extent of reliance on service contractors is not by itself a cause for concern. Agencies must, however, have a sufficient number of trained and experienced staff to manage Government programs properly. The greater the degree of reliance on contractors the greater the need for oversight by agencies. What number of Government officials is needed to oversee a particular contract is a management decision to be made after analysis of a number of factors. These include, among others, the scope of the activity in question; the technical complexity of the project or its components; the technical capability,

numbers, and workloads of Federal oversight officials; the inspection techniques available; and the importance of the activity. Current contract administration resources shall not be determinative. The most efficient and cost effective approach shall be utilized.

(I) Exercise of approving or signature authority. Official responsibility to approve the work of contractors is a power reserved to Government officials. It should be exercised with a thorough knowledge and understanding of the contents of documents submitted by contractors and a recognition of the need to apply independent judgment in the use of these work products.

8. Responsibilities.

(a) Heads of agencies. Heads of departments and agencies are responsible for implementing this policy letter. While these policies must be implemented in the Federal Acquisition Regulation (FAR), it is expected that agencies will take all appropriate actions in the interim to develop implementation strategies and initiate staff training to ensure effective implementation of these policies.

(b) Federal Acquisition Regulatory Council. Pursuant to subsections 6(a) and 25 (f) of the OFPP Act, as amended, 41 U.S.C. 405(a) and 421(f), the Federal Acquisition Regulatory Council shall ensure that the policies established herein are incorporated in the FAR within 210 days from the date this policy letter is published in the Federal Register. Issuance of final regulations within this 210-day period shall be considered issuance "in a timely manner" as prescribed in 41 U.S.C. 405(b).

(c) Contracting officers. When requirements are developed, when solicitations are drafted, and when contracts are being performed, contracting officers are to ensure:

(1) that functions to be contracted are not among those listed in Appendix A of this letter and do not closely resemble any functions listed there;

(2) that functions to be contracted that are not listed in Appendix A, and that do not closely resemble them, are not inherently governmental functions according to the totality of the circumstances test in subsection 7(b), above;

(3) that the terms and the manner of performance of any contract involving functions listed in Appendix B of this letter are subject to adequate scrutiny and oversight in accordance with subsection 7(f), above; and

(4) that all other contractible functions are properly managed in accordance with subsection 7(e), above.

(d) All officials. When they are aware that contractor advice, opinions, recommendations, ideas, reports, analyses, and other work products are to be considered in the course of their official duties, all Federal Government officials are to ensure that, they exercise independent judgment and critically examine

these products.

9. Judicial review. This policy letter is not intended to provide a constitutional or statutory interpretation of any kind and it is not intended, and should not be construed, to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, its officers, or any person. It is intended only to provide policy guidance to agencies in the exercise of their discretion concerning Federal contracting. Thus, this policy letter is not intended, and should not be construed, to create any substantive or procedural basis on which to challenge any agency action or inaction on the ground that such action or inaction was not in accordance with this policy letter.

10. Information contact. For information regarding this policy letter contact Richard A. Ong, Deputy Associate Administrator, the Office of Federal Procurement Policy, 725 17th Street, N.W., Washington, DC 20503. Telephone (202) 395-7209. (UPDATED 8/1995--contact the Budget Analysis and Systems Division, Office of Management and Budget, 725 17th Street, N.W., Washington, DC 20503. Telephone (202) 395-6104.)

11. Effective date. This policy letter is effective 30 days after the date of publication.

Signed by

ALLAN V. BURMAN
Administrator

Appendix A to OFFP Policy Letter 92-1

The following is an illustrative list of functions considered to be inherently governmental functions:[1]

1. The direct conduct of criminal investigations.

2. The control of prosecutions and performance of adjudicatory functions (other than those relating to arbitration or other methods of alternative dispute resolution).

3. The command of military forces, especially the leadership of military personnel who are members of the combat, combat support or combat service support role.

4. The conduct of foreign relations and the determination of foreign policy.

5. The determination of agency policy, such as determining the content and application of regulations, among other things.

6. The determination of Federal program priorities or budget requests.

7. The direction and control of Federal employees.

8. The direction and control of intelligence and counter-intelligence operations.

9. The selection or nonselection of individuals for Federal Government employment.

10. The approval of position descriptions and performance standards for Federal employees.

11. The determination of what Government property is to be disposed of and on what terms (although an agency may give contractors authority to dispose of property at prices within specified ranges and subject to other reasonable conditions deemed appropriate by the agency).12. In Federal procurement activities with respect to prime contracts,

(a) determining what supplies or services are to be acquired by the Government (although an agency may give contractors authority to acquire supplies at prices within specified ranges and subject to other reasonable conditions deemed appropriate by the agency);

(b) participating as a voting member on any source selection boards;

(c) approval of any contractual documents, to include documents defining requirements, incentive plans, and evaluation criteria;

(d) awarding contracts;

(e) administering contracts (including ordering changes in contract performance or contract quantities, taking action based on evaluations of contractor performance, and accepting or rejecting contractor products or services);

(f) terminating contracts; and (g) determining whether contract costs are reasonable, allocable, and allowable.

13. The approval of agency responses to Freedom of Information Act requests (other than routine responses that, because of statute, regulation, or agency policy, do not require the exercise of judgment in determining whether documents are to be released or withheld), and the approval of agency responses to the administrative appeals of denials of Freedom of Information Act requests.

14. The conduct of administrative hearings to determine the eligibility of any person for a security clearance, or involving actions that affect matters of personal reputation or eligibility to participate in Government programs.

15. The approval of Federal licensing actions and inspections.

16. The determination of budget policy, guidance, and strategy.

17. The collection, control, and disbursement of fees, royalties, duties, fines, taxes and other public funds, unless authorized by statute, such as title 31 U.S.C. 952 (relating to private collection contractors) and title 31 U.S.C. 3718 (relating to private attorney collection services), but not including:

(a) collection of fees, fines, penalties, costs or other charges from visitors to or patrons of mess halls, post or base exchange concessions, national parks, and similar entities or activities, or from other persons, where the amount to be collected is easily calculated or predetermined and the funds collected can be easily controlled using standard cash management techniques, and

(b) routine voucher and invoice examination.

18. The control of the treasury accounts.

19. The administration of public trusts.

[m]With respect to the actual drafting of congressional testimony, of responses to congressional correspondence, and of agency responses to audit reports from an Inspector General, the General Accounting Office, or other Federal audit entity, please see special provisions in subsection 6.c of the text of the policy letter, above.

Appendix B to OFFP Policy Letter 92-1

The following list is of services and actions that are not considered to be inherently governmental functions. However, they may approach being in that category because of the way in which the contractor performs the contract or the manner in which the Government administers contractor performance. When contracting for such services and actions, agencies should be fully aware of the terms of the contract, contractor performance, and contract administration to ensure that appropriate agency control is preserved.

This is an illustrative listing, and is not intended to promote or discourage the use of the following types of contractor services:

1. Services that involve or relate to budget preparation, including workload modeling, fact finding, efficiency studies, and should-cost analyses, etc.

2. Services that involve or relate to reorganization and planning activities.

3. Services that involve or relate to analyses, feasibility studies, and strategy options to be used by agency personnel in developing policy.

4. Services that involve or relate to the development of regulations.

5. Services that involve or relate to the evaluation of another contractor's performance.

6. Services in support of acquisition planning.

7. Contractors' providing assistance in contract management (such as where the contractor might influence official evaluations of other contractors).

8. Contractors' providing technical evaluation of contract proposals.

9. Contractors' providing assistance in the development of statements of work.

10. Contractors' providing support in preparing responses to Freedom of Information Act requests.

11. Contractors' working in any situation that permits or might permit them to gain access to confidential business information and/or any other sensitive information (other than situations covered by the Defense Industrial Security Program described in FAR 4.402(b)).

12. Contractors' providing information regarding agency policies or regulations, such as attending conferences on behalf of an agency, conducting community relations campaigns, or conducting agency training courses.

13. Contractors' participating in any situation where it might be assumed that they are agency employees or representatives.

14. Contractors' participating as technical advisors to a source selection board or participating as voting or nonvoting members of a source evaluation board.

15. Contractors' serving as arbitrators or providing alternative methods of dispute resolution.

16. Contractors' constructing buildings or structures intended to be secure from electronic eavesdropping or other penetration by foreign governments.

17. Contractors' providing inspection services.

18. Contractors' providing legal advice and interpretations of regulations and statutes to Government officials.

19. Contractors' providing special non-law enforcement, security activities that do not directly involve criminal investigations, such as prisoner detention or transport and non-military national security details.

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Senator Ben Nighthorse Campbell
Chairman
U.S. Senate Committee On Indian Affairs
Hearing on IHCIA Reauthorization
April 2, 2003

Questions for Dr. Charles W. Grim
Interim Director
Indian Health Service

1. "One-HHS Initiative". The ideas behind Secretary Thompson's idea to create "One-HHS" are to reduce waste and create a more efficient HHS to better serve the American people. Yet the idea has not been warmly received by Capitol Hill or by the Tribal Restructuring Initiative Workgroup (RIW) that you appointed.

Q: Could you explain the specifics of the initiative to the Committee – especially as it would apply to the IHS?

> **Answer:** The "One-HHS" is Secretary Thompson's goal to ensure that the Department functions as a single entity rather than a collection of independent agencies with separate and often duplicative administrative systems. While each of the HHS agencies have separate and specific missions, the over-arching HHS mission enables collaboration and coordination among the agencies that provide a sharing of ideas and in some cases resources.
>
> The IHS as an Operating Division of the DHHS supports the Secretary's goal and has enjoyed the benefits of the "One-HHS" goal in annual budget requests. The DHHS has been supportive and sensitive to the special needs the IHS has in its field operations. This is most evident by the recent decisions by the Department to ensure that the IHS's human resource management staff can remain in the field, and yet be part of the HHS overall HR consolidation that will result in increased efficiency and effectiveness of the entire system.

Q: After a rough start, is the initiative still on track, i.e. has the plan been revised to reflect the comments and recommendations of the RIW?

> **Answer:** Yes. As noted above, the Department has addressed the concerns about administrative services to the rural and remote field sites in the IHS.

2. FY 2004 Budget. The "One-HHS" plan would involve the transfer 8 FTEs ($838,000) from IHS to HHS. The Tribal concern is that transfer of IHS functions to HHS would lose its "tribal shares" distinction, and, if not tracked properly, could hinder tribal contacting of those functions.

Q: How does the department propose to preserve or track tribal shares related to those functions that are moved to the Office of the Secretary? Could these functions and associated dollars be potentially contractible under P.L. 93-638 once they are consolidated under HHS?

> **Answer:** Recent decisions by the HHS leave all resources in the IHS and the IHS will pay for consolidated services through the HHS Service and Supply Fund. This will enable the IHS to continue to track tribal shares related to those administrative functions affected by the "One-HHS" consolidations. In the case of the Human Resources' consolidation, the service-level agreement between the HHS and IHS, the IHS will stipulate to the continued tracking of tribal shares in the event such are affected by payments to the HHS Service and Supply Fund.

3. FY 2004 Budget. According to the FY 2004 IHS budget request, IHS will realize a cost "savings" of $21.3 from the reduction of 195 FTEs, and $9.3 million from information technology; savings will come from IHS, Tribal, and Urban programs. The budget request states that, "every effort will be made to minimize the impact at the service delivery level of the organization, however, some impact on programs and services may occur."

Q: What specific impacts will there be to the Indian health care service delivery as a result of reduced FTEs and IHS restructuring? Will Indian patients receive even less health care services or will I/T/Us have to eliminate existing programs, e.g. disease prevention or health promotion activities?

> Answer: The $21.3 million in management savings will be achieved primarily by reducing administrative expenses in both IHS and tribally operated programs. IHS will reduce Federal staff use by 195 FTE, a 1.3% reduction compared to FY 2003 estimated usage. Staffing reductions will be targeted to administration (e.g., achieving the Department–wide staffing goal of 1 human resources employee for every 82 Agency employees) in order to minimize the impact on local service delivery. IHS will carefully review replacement of employees who leave and existing staff may be reassigned to ensure that critical positions remain filled. Other areas IHS will examine include more judicious control of: administrative travel, overtime and purchase of administrative supplies/equipment.
>
> The $9.3 million in IT savings will be achieved by reducing the use of maintenance contracts and by limiting enhancement of major systems including RPMS (the information system IHS use to manage patient care and administrative applications at all its IHS hospitals and clinics), telecommunications infrastructure, and the national database. Areas for examination include: reviewing maintenance contracts to see if it would be cheaper to pay for repairs and replacements on an as needed basis, limiting purchase of new hardware/software and limiting development of new applications for RPMS.

4. IHS Consultation Policy. IHS has succeeded in consulting with Tribes on issues small and major, with the RIW being the most recent case.

Q: If the "One-HHS" plan goes through, how will the consultation experience be transferred to HHS?

> **Answer:** The IHS will continue to consult with Tribes on those "One-HHS" initiatives that impact the IHS organization, programs, and services.

5. One-HHS and Self-Governance. As of FY 2002, nearly 50% of all IHS funding and services is "out-sourced" to Tribes through 638 contracts and self-governance compacts.

Q: Does the One-HHS plan include incentives for Tribes to assume responsibility for additional programs and services?

> **Answer:** The IHS will continue to respond to those Tribes who decide to Self-Determine by assuming responsibility for programs, functions, services, and activities. Equally, the IHS will continue to respond to those Tribes who decide to Self-Determine by requesting the IHS to continue to directly provide health care services to their members.

Q: Are you aware of any terms or conditions in 638 contracts or self-governance compacts that might be violated if the administrative reorganization is implemented?

> **Answer:** It is our belief that there are no terms or conditions in 683 contracts, or self governance compacts that will be violated by the administrative reorganization. The IHS is committed to ensuring that Tribal shares are made available to Tribes who exercise Self-Determination and assume health programs for the benefit of their members.

6. Managerial Reform. Over the years, the success of Tribes with 638 contracts and self-governance compacts has resulted in a reduction in IHS headquarters and area office staff.

Q: Are there administrative functions that are essentially Federal in nature, such that they cannot be contracted out by tribes? Can you describe what some of those functions might be?

> **Answer:** Yes. The following are administrative functions that are inherently governmental: determination and formulation of agency policy; personnel management services; supervision and control of Federal employees; selection (or nonselection) of individuals for Federal government employment; property management; acquisition and grants management including awarding and terminating contracts and grants; administering responses to FOIA requests; determining budget policy, guidance, and strategy; determining the acquisition and disposal of Government property; determining what supplies or services are to be acquired by the Government; and, other official functions that mandate performance by Government employees and require either the

exercise of discretion in applying government authority or making decisions for the Government.

The IHS has determined its inherently governmental functions in consultation with Tribal governments and has assumed 100 percent contracting/compacting of the IHS program to determine the residual value of its inherently governmental functions. This determination has been performed at each of the twelve Area Offices and Headquarters.

7. Human Resources. I note that the Tribal report listed reasons why consolidating IHS Human Resources with HHS would not be advantageous.

Q: What are the primary functions of the Human Resources functions located in the 12 IHS Area offices?

Answer: The primary functions in the nine of the 12 IHS Area Offices (Bemidji and Nashville receive their personnel servicing from another Area Office) and Headquarters include: policy advisory; classification; recruitment; staffing; transactions; employee/ labor relations; awards and recognition; retirement counseling; benefits counseling; time and attendance; and, payroll liaison.

Q: Are there advantages to having those positions located in the area offices? Would there be advantages in relocating them to headquarters, or another, more central location?

Answer: There are advantages to having positions located in the area offices, primarily to support recruitment, management, and development of personnel in the field locations. This proximity enables timely support and processing of personnel actions. Another advantage is the need to support Tribal Self-Determination, particularly in the administrative processes related to Intergovernmental Assignments of civilians and Memoranda of Agreements for Commissioned Corps personnel.

The Tribal Restructuring Initiatives Workgroup (RIW) analyzed the advantages of realigning administrative functions into more central or regional locations. The RIW found that realigning functions which require specialized local expertise and are based on close working relationships with customers would be counter productive. Examples cited included self-determination contracts, employee relations, and budget formulation. However, commonplace administrative functions which are best carried out in an efficient standardized fashion are good candidates for regionalization or centralization. Examples cited included processing of personnel actions and supporting paperwork, human resources record keeping and retrieval, reporting and statistics, travel, payroll, claims processing, commercial acquisitions, auditing, and accounting.

Q: Will the costs of relocation offset any "managerial savings" that may be realized?

Answer: The decision point is that any "savings" must exceed the cost of relocation over a short period of time. Namely, there needs to be a "break even point" at which the "savings" will be realized and in accordance with the President's Management Agenda be moved to program services.

8. What to do with RIW Recommendations? Now that the RIW final report is completed, what is your next step in meeting the One-HHS goal? Do you plan to have tribal consultations on any new plans that are developed as a result of the final report?

Answer: The IHS conducted two consultations on the work of the RIW. In June 2002, the preliminary report of the RIW was provided to Tribal Leaders for review and comment. All comments received were incorporated into the work of the RIW. In September 2002, Dr. Charles Grim, Interim Director, IHS, sent the final report of the RIW to Tribal Leaders for review and comment.

In anticipation that the RIW's final report would not include recommendations specific to Headquarters, Dr. Charles Grim charged a group of Headquarters managers, staff and three representatives from the Area Offices, to propose an organization that incorporated the references from RIW and the goals contained in the President's Management Agenda. In December 2002, Dr. Grim transmitted draft documents on the proposed Headquarters' reorganization. Tribal Leaders that requested that additional comments be considered and the Headquarters Restructuring Group has continued (to this date) to receive and incorporate comments as the proposal to reorganization is being finalized for submission to Dr. Grim for his consideration and approval.

9. What to do with savings? The RIW's final report urges that cost "savings" from IHS restructuring be reinvested into additional health care services to Natives.

Q: Have you considered this recommendation or have you developed a plan to redistribute these savings throughout the I/T/U system?

Answer: Cost "savings" resulting from IHS restructuring will be used to enhance Indian health care programs.

10. The One-HHS initiative proposes the consolidation of IHS human resources functions to the full department level.

Q: Based on your study of the area-wide IHS human resources departments, would it be feasible to realign HR functions <u>within</u> IHS?

Answer: The Tribal RIW proposed realigning HR functions within IHS. Although it would be feasible to realign the HR function with IHS, we believe that an internal realignment would not provide the same benefits as being fully engaged in the HHS-wide HR consolidation.

Q: Do you think that is would be less expensive to make operational improvements than to physically transfer or eliminate IHS HR functions or positions?

> **Answer:** IHS could make internal operational improvements in HR that would be less expensive in the short term. However, we believe that the benefits of being part of the HHS-wide HR consolidation are greater than the cost to IHS. For example, HHS-wide HR consolidation with common business practices across the Department will provide greater flexibility to allocate HR resources to meet critical needs. Consolidation will also allow HHS to deploy automated systems for HR that are beyond the reach of the individual components. For IHS this will mean having automated systems for hiring staff, classifying jobs, and maintaining personnel files. IHS's share of these costs will be more than offset by increases in productivity and improved servicing ratio, freeing up resources to be devoted to IHS mission jobs.

11. Information Technology Consolidation.

Q: What are some of the benefits that might be realized with the Information Technology consolidation?

> **Answer:** The Information Technology (IT) consolidation is two-fold. First, the IHS is considered one of the five "large OPDIVs" and consolidation will occur internally. The IHS has a modest IT program and is already predominantly centralized. All national IHS IT programs are supported and administered out of its Information Technology Support Center in Albuquerque, New Mexico. However, there are some independent activities occurring at the Area Office level that need to be reviewed for the feasibility of either centralization or regionalization. This would result in savings while not affecting local management or the delivery of patient care.
>
> Second, the IHS, as an OPDIV in the DHHS, can realize benefits by the ability to move data and information to and from the Department electronically over more compatible systems. This reduces errors resulting from re-keying data and information from one system to another. The consolidation in this instance is actually standardization (to the extent practicable). Another emerging and critical benefit is information and data security. The IHS can benefit enormously (economies of scale) from the protection from a larger system.

12. Alaskan Health Consolidation. For years now health care in Alaska has been delivered under ONE compact and it seems to me that the Alaska Native health group is a step ahead of the One-HHS initiative because, in a sense, they have already consolidated into nearly one unified health system.

Q: Have you looked at how this consolidation was carried out in Alaska to see if there might be lessons learned for other IHS regions?

Answer:

Background. The concept of one compact and several funding agreements is an innovative method for providing health care in Alaska. The operation of the Alaska Native Medical Center, located in Anchorage, is the responsibility of the Alaska Native Tribal Health Consortium, representing all tribes in Alaska, and is under the direction of a tribally directed joint operating board. The individual funding agreements have accommodated the remoteness and isolation of the Alaska tribal governments by providing a mechanism to tailor funding agreements to meet the unique needs of each individual tribal entity. This further supports the government to government relationship that each Tribe has with the United States.

The Alaska compact began with thirteen original funding agreements that included ten regional health entities and three tribes/villages. The funding agreements in Alaska have now grown to a total of twenty-one, all under one compact. The Alaska Tribes initially provided health services through their compact under the authority of the Self-Governance Demonstration Project. Subsequently, the Alaska compactors, in concert with many other Tribes in the lower 48 states, helped to frame the language for P.L. 106-260, the Tribal Self Governance Amendments of 2000 which made Self-Governance a permanent Tribal compacting option within the Indian Health Service.

Alaska as a Model Compact. Alaska has been looked at by many Tribal Governments in the lower 48 states as a mechanism for the provision of health care. The All Indian Pueblo Council in Albuquerque, New Mexico and the Northeastern Tribal Health System (NTHS) in Miami, Oklahoma are examples of groups of Tribes that have looked at the Alaska compact as a model. While the All Indian Pueblo Council has, to date, elected not to compact; the Northeastern Tribal Health System, a consortia of ten (10) Oklahoma Tribal Governments, became a Self-Governance Compactor in 2002.

Under the NTHS, three of the Tribes maintain individual funding agreements as well as participating in the NTHS compact while the remaining six (6) tribes have elected to receive their health services through the NTHS Compact exclusively. The three Tribes that maintain individual funding agreements are not located in close proximity of the NTHS but do have tribal interests, as well as tribal members, residing there. Therefore these three Tribes provide direct services for those tribal members living closest to the tribal headquarters through individual funding agreements as well as providing services for tribal members living in their northeastern Oklahoma districts through the NTHS compact. The IHS accommodates the Tribes by distributing the amounts designated by each tribe to their individual funding agreements and to the NTHS through the NTHS funding agreement.

The Office of Tribal Self-Governance at IHS continues to receive inquiries about Alaska. Most recently a group of eight California Tribes have indicated their interest in compacting and using Alaska as a model.

In summary. The provision of health services in Alaska has proven to be a model for the consolidation of the delivery of health care by Tribal Governments in the lower 48 states. It continues to serve as an example of how tribal governments might consider consolidation of limited resources to provide health services to their tribal members. Key to the consortium concept is that each tribal government must individually meet the requirements to enter Self-Governance as stated by P.L. 106-260

Testimony of
Don Kashevaroff
Tribal Self-Governance Advisory Committee Representative
to the IHCIA Reauthorization National Steering Committee
President, Seldovia Village Tribe
President and Chairman, Alaska Native Tribal Health Consortium

Senate Select Committee on Indian Affairs

April 2, 2003

Regarding
Reauthorization of the Indian Health Care Improvement Act
The Effects of HHS Consolidation On Narrowing the AI/AN Health Disparities Gap

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INTRODUCTION

Mr. Chairman and members of the Committee, thank you for the opportunity to testify regarding the reauthorization of the Indian Health Care Improvement Act (IHCIA). I appear here today on behalf of the Tribes participating in the Self-Governance program. At the invitation of the Committee, I will also briefly touch upon the impact that Department of Health & Human Services (HHS) consolidation will have on the Indian Health Service and on tribes operating health programs trying to narrow the American Indian/Alaska Native health disparities gap.

The Tribal Self-Governance Advisory Committee (TSGAC) is a committee of tribal leaders convened by the Indian Health Service to address the health care needs of all eligible American Indian/Alaska Natives (AI/AN), especially those served by tribal health programs operated through Self-Governance compacts authorized by Public Law 93-638, as amended. Self-Governance compacts:

?? Have been entered into by or on behalf of 279 Tribes;

?? Constitute 27.3% of the IHS budget; and

?? Serve 33% of the IHS user population.

My experience proves the versatility of Self-Governance. My own tribe, Seldovia Village Tribe, is relatively small – only 414 members. Since taking over the tiny contract health services program in 1991, we have been able to expand our services to the point that we were able to open a small direct service clinic through which we have expanded culturally appropriate services provided as efficiently and economically as one can for a small population.

I contrast this with my experience as President and Chairman of the Board of the Alaska Native Tribal Health Consortium, which is the largest Self-Governance program in America ANTHC manages over $125 million annually in IHS program and project funds. With another tribal organization we operate the only Level II Trauma Center in Alaska, the Alaska Native Medical Center, the premier tertiary care hospital in the Indian Health system. We also manage all of the statewide functions previously performed by the IHS Alaska Area Office, including construction of sanitation facilities throughout rural Alaska, operation of one of the three statewide Community Health Aide Training Programs, public health research, and a statewide telemedicine program to name just a few.

Since the formation of the Alaska Tribal Health Compact of which Seldovia Village Tribe and ANTHC are both signatories, the Alaska Area Office of the Indian Health Service has downsized from 350 to 40. While the remaining functions of the IHS Area Office are critical to our success, the transition we have experienced in Alaska, represented by these two extreme examples, proves the importance of the Self-Governance and of the Indian Health Care Improvement Act.

Thus we take very seriously both the reauthorization of the Indian Health Care Improvement Act, and also HHS consolidation, because both have a direct and significant impact on our operations.

S. 556, INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION

It has been over 25 years since the original enactment of the Indian Health Care Improvement Act. This latest effort at reauthorization, in which this Committee has taken a leadership role, truly proves how much has been accomplished. In 1999, tribes from around the country sent representatives to participate with the Indian Health Service and national Indian organizations, including representatives of the Urban Indian programs, in the National Steering Committee. Building on the strong base of existing law, these tribal leaders, supported by their staff and consultants, undertook to draft our own reauthorization bill – one that would reflect the changes wrought by self-determination and self-governance and the changes that have come about in health care delivery.

This product of an extraordinary effort in national consensus building was the base for S. 556, the bill you have before you. In the four intervening years, work has continued. We have had time to reflect on the 1999 National Steering Committee draft. We have had time to consider issues raised by this body and concerns expressed by the Administration. The National Steering Committee has met many times since 1999, and while we have not had perfect unanimity, we have maintained nearly complete consensus about how best to address these points of view and remain true to the principles that underlie the tribal draft of the reauthorization.

We have had the good fortune to have the opportunity to work closely with staff of both houses, with the support of the House Office of Legislative Counsel, to try to improve upon our initial efforts to produce the best legislation possible. We expect to have a clean draft bill reflecting our latest work available in early April and hope this Committee will consider substituting it for the pending bill. In

the meantime, we appreciate the Senate's leadership in conducting hearings on this critical legislation.

While there have been great achievements in improving the health status of American Indians and Alaska Natives, it is the disparities that still are most prominent. Prime among our considerations, is that it is no longer acceptable that the objectives for improvement be lower for American Indians and Alaska Natives than those for the rest of the nation. Thus, we have incorporated the *Healthy People 2010* objectives as our own. They set the benchmark for us, as they do for the nation.

We considered other principles as well. We recognized that while tribal health programs have the good fortune to be part of a national Indian health system, they also have increasingly assumed control of their own health delivery systems and been able to focus more specifically on local needs and demands. They prove the value of local control. Thus, we worked to ensure that tribal autonomy is respected in the bill.

We also approached this bill as the authorization bill that it is, not as an appropriation bill. The Indian health system is desperately under funded. While we deplore that fact, and urge that it be remedied, we cannot as tribal leaders sit back and wait for that day. Thus, we are frustrated by what we consider to be an inflated calculation of the cost of the legislation and are angered by suggestions that it must be pared down. We have never been fully funded and no matter how much we pare down the bill, we will not be fully funded.

For tribes to have the opportunity "to do the best that we can with what we have," however we cannot limit the authority to develop a model system to a few demonstration project sites. We must authorize a modern health care system and strive to achieve it. The experiences in one location will provide the base for improvements in another. Thus, we make the best use of our individual accomplishments and strengths and the entire system improves.

Among the criticisms we have heard is that we have been too aggressive in our pursuit of recovery from the Medicaid and Medicare programs. We have a somewhat different view. The Indian health system did not choose to be reliant on these funding sources. We believe American Indians and Alaska Natives have an absolute right to health care services paid for with the lives and lands of our ancestors. However, the payments have not been made through direct appropriations. Instead, the Congress chose to make us dependent on these other Federal programs to supplement the limited direct appropriations made available. We now merely seek the opportunity to maximize this recovery.

Our goals here have been three. First, that if there is a payment advantage or reimbursable activity available to any other provider, it should be equally available to the Indian health system. Secondly, the cost of recovery should be limited as much as possible so that limited resources are conserved for direct delivery of health care programs. And, finally, "managed care" and other innovations in delivery and payment models must not interfere with the right of American Indians and Alaska Natives to continue to receive care in the culturally competent health care programs operated by the Indian Health Service and by tribes and tribal organizations. To achieve these goals, we have

worked to form a closer relationship with the Centers for Medicare and Medicaid Services. However, in the end, new legislation is needed. It is embodied in our reauthorization proposals.

We have compromised though. Since the initial draft, the National Steering Committee has recentralized certain activities that we initially proposed for area allocation. We have scaled back our effort to authorize a unique Medicare and Medicaid provider type – the Qualified Indian Health Program, which still appears in S. 556 but which, in the updated proposal on which we are working, is reduced to a study of reimbursement in our new proposal.

Now, we need your support. We need your commitment to substitute our new bill as soon as it is available in April, to hold the necessary hearings, and to enact reauthorization this year. We appreciate the challenges facing the Administration and this Congress. We know that your work in support of our troops in Iraq and Afghanistan must take priority. American Indians and Alaska Natives have been disproportionately represented in every military conflict faced by this nation in the last century and this one.

The families of those fighting men and women belong to our communities; the veterans of past service are part of our communities; and these service people will come home, God willing, to our communities. They are fighting to ensure that the American way is preserved. That means progress on front lines other than those in Iraq cannot stop while they are gone. That means that important legislation reflecting America's commitment to its original residents cannot be shelved.

Self-Governance Tribes and the National Steering Committee look forward to working closely with this Committee this year to achieve enactment into law of the Indian Health Care Improvement Act Reauthorization.

THE EFFECTS OF HHS CONSOLIDATION ON THE INDIAN HEALTH SYSTEM

I also appreciate the opportunity to comment briefly on the proposed reorganization of the Department of Health and Human Services and the effects it will have on the Indian health system.

There is little question that the sprawling Department of Health & Human Services is an organizational challenge; nor is there question about the stated objective – "One HHS." I applaud the Secretary for working to improve service, reduce waste and create efficiencies in the Department, similar to what Self Governance Tribes have undertaken since "compacting."

However, as much as we trust the Secretary's intentions, we have some concerns about the potential impact of several elements of the consolidation, that in actuality will not improve service or create efficiencies, including:

(1) IHS Information Technology funding consolidation into the HHS;

(2) IHS Legislative Affairs office consolidation into the HHS;

(3) IHS Human Resource office consolidation into the HHS; and

(4) IHS direct operation and tribal operation budget cuts for managerial reform.

I briefly outline each of these concerns below in the order listed:

1. IHS HUMAN RESOURCE OFFICE CONSOLIDATION INTO HHS

While we believe that the concept of consolidation of Human Resources functions for some HHS operating divisions is sound at the macro-level, we believe the Department needs to acknowledge the unique status and functions of the Indian Health Service, and make exceptions to the consolidation plan in the case of the Indian Health Service because of this status.

Unlike the other HHS operating divisions, the operations of the Indian Health Service are widely-dispersed throughout the United States, primary in small communities and remote, isolated, rural areas. The IHS is unique within HHS in that it must provide direct medical care services and community-based health initiatives. The Indian Health Service is unique in its duty to exercise Indian Preference in hiring and contracting, and to ensure compliance with such legislation as the Indian Child Protection and Family Violence Act. The Indian Health Service is unique in its substantial relationships with tribes and tribal health organizations providing health care to Indian Health Service beneficiaries under self-determination and self-governance agreements.

ANTHC believes that centralizing all of the Indian Health Service Human Resources staffing from all twelve of its area offices and service units to one location in the Washington D.C. area will seriously compromise its ability to fulfill its mission nationwide. We do not believe that a Beltway-based Human Resources office will be able to comprehend, let alone respond adequately to the unique personnel requirements of federal offices and medical facilities located in places like Kotzebue, Alaska or on the Pine Ridge Reservation in South Dakota.

In Alaska, specifically, there are ten Human Resources staff remaining in the Alaska Area Office in Anchorage who will be displaced because of this initiative. Today these individuals work in the same building we do, giving us the opportunity to interact with them daily in the recruiting and support of the federal employees assigned to us and to the other tribal health organizations in Alaska. It is inconceivable that ANTHC would get the same level of service from a Washington-based office as we currently get from this office. E-mail and telephone encounters cannot replace what we have.

Furthermore, resolution of Human Resources issues often involves interaction with the Area Director, the Area Finance office, and other locally-based entities and individuals. Such interaction will be made unnecessarily complicated and ineffective by the proposed consolidation.

Many of these Area Human Resource staff are American Indians and Alaska Natives who are knowledgeable of the unique situations that exist in our state; we believe that the proposed consolidation will result in the loss of this valuable expertise when these employees elect not to

relocate and instead seek employment with other federal agencies here in Anchorage. We are certain that the voice on the other end of the phone will not be that of an American Indian or Alaska Native.

Finally, in the negotiation of the Alaska Tribal Health Compact, the unique self-governance agreement between the Indian Health Service and Alaska Native tribes and tribal organizations, we negotiated a written agreement that committed the Indian Health Service to maintain a specific level of such services at the Area Office here in Alaska. This agreement is one of the underpinnings of the overall Compact. The proposed consolidation will violate the fundamental understandings around which this agreement was negotiated.

Consequently, ANTHC believes that the Indian Health Service should be exempted from the proposed national consolidation of HHS Human Resources functions.

2. IHS INFORMATION TECHNOLOGY FUNDING CONSOLIDATION INTO HHS

With regard to information technology needs, IHS and IHS-funded facilities such as those in Alaska are unique within HHS because, unlike other agencies, we provide direct patient care, which requires unique patient data, billing, facility, provider, and management information systems. These are mission critical software systems not only for administrative systems, but for patient care systems which is unique in HHS.

So for IHS-funded Self-Governance Tribes, our ability to build and maintain sufficient IT infrastructure is a critical component to narrowing the health disparities gap. The IT infrastructure is required to help us record individual patient care, measure our health status, plan and manage services, and generate third party revenues to support vital health programs.

However, despite its unique and significant IT needs, IHS grossly under-invests in IT—IT constitutes only about 2% of its annual budget. By comparison, equivalent private sector IT investment typically constitutes 4-5% of a company's annual budget and that is independent of trying to maintain a truly integrated national health information system like RPMS.

Unfortunately, HHS consolidation efforts appear to be only compounding the effects of the IHS's chronic under-investment in IT. In the FY 2004 budget, the HHS reduced the IT budgets of all HHS agencies, including the IHS, expecting consolidation and "economy of scales" to cover the IT need. Although IHS information systems appear to be similar, it is sufficiently unique that consolidation will cost more than any realized savings.

The result: an IHS Information Technology budget in FY 2004 that is $9 million (16%) less than in FY 2003. For Self-Governance Tribes, this leaves us with two options: (1) continue to let the lack of basic health care IT infrastructure hurt the quantity and quality of care we provide to our people; or (2), build and support the IT infrastructure that we need in the long-run by paying for it out of money we need in the short-term for direct patient care, which in turn will still result in a reduction in the quantity and quality of health care that we can provide to our people.

Our conclusion based on the day-to-day reality of running a health program, is that when it comes to the information technology needs of direct-service hospitals and clinics (including those of the IHS, Tribes and Urban Indian organizations), one size does not fit all.

We would strongly urge the Committee to ask HHS to exempt the IHS from HHS IT budget consolidation activities, because further "consolidating" the IHS IT budget would do great harm to our efforts to narrow the AI/AN health disparities gap.

3. IHS LEGISLATIVE AFFAIRS CONSOLIDATION INTO HHS

In its Report on the Fiscal Year 2003 Omnibus Appropriations Act (C.R. S585), The Senate Committee on Appropriations expressed its views on the Administration's proposal to consolidate the IHS Legislative Affairs Office in a most erudite fashion:

> ...(T)he (Appropriations) Committee does not agree to the proposed transfer of $838,000 for consolidation of the Legislative Affairs Office at IHS with that of the U.S. Department of Health and Human Services (DHHS). The complexity and variety of issues that surround the provision of health services to Native Americans and Alaska Natives demand an unusual degree of expertise and experience. It is the Committee's view that Native American health issues merit greater emphasis and attention than would be gained in a consolidation at the Department's headquarters level.

Self-Governance Tribes concur with this assessment, and urge the Committee to ask HHS, for the reasons stated by the Senate Committee on Appropriations, to exempt the IHS from HHS' Legislative Affairs Office consolidation efforts. We note the same could be said about the other two consolidation efforts discussed above.

4. IHS DIRECT OPERATION AND TRIBAL OPERATION BUDGET CUTS FOR MANAGERIAL REFORM

In its Report on the Fiscal Year 2003 Omnibus Appropriations Act (C.R. S585), The Senate Committee on Appropriations expressed its views on the Administration's proposal for administrative reductions or transfers in IHS direct operations and tribal operations budgets for managerial reform in a most erudite fashion:

> ...(T)he (Appropriations) Committee does not agree to the proposed reductions ... from tribal operations and ... from direct operations for managerial reforms. The budget estimate indicates that these reductions are to be taken from administrative positions and costs associated with travel, training, copying, and similar activities. In the time period from 1993-2001, the FTE levels at IHS headquarters were reduced by 60 percent. Regional program staffing levels were reduced by 58%. Given these statistics, as well as the vast need for improved services, the Committee cannot support these proposals."

Self-Governance Tribes concur with this assessment, and urge the Committee to ask HHS, for reasons stated by the Senate Committee on Appropriations, to permanently abandon this proposed IHS budget consolidation proposal.

CONCLUSION

In conclusion, I thank Chairman Campbell and the Committee members for this opportunity to share our experiences from the "front lines," and to have a say in legislative and agency policy-making that impacts our operations. I welcome your questions.

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Testimony for the Written Record

S. 556, Indian Health Care Improvement Act Reauthorization of 2003
Committee on Indian Affairs
United States Senate

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Submitted by:

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The Burden of Chronic Kidney Disease Among American Indians

End Stage Renal Disease (ESRD) is a life-threatening illness. Individuals with chronic kidney disease that has progressed to ESRD need regular dialysis treatments for the rest of their lives or a kidney transplant in order to survive. Driven by an explosion in the incidence of type 2 diabetes among American Indians, the ESRD prevalence rate in the American Indian population is 3.5 times that of white Americans. There is significant regional variation, with some tribes experiencing ESRD rates over twenty times that of whites. In addition, the number of American Indians with ESRD continues to grow. According to the United States Renal Data System (USRDS), there were 5,861 Native Americans with ESRD as of December 31, 2000, up from 2,662 at year-end in 1991. (1) Most of them have their dialysis treatments covered by Medicare and/or Medicaid.

Since chronic kidney disease tends to worsen gradually over time, the size of the population at risk for ESRD is many times that of the dialysis and transplant community. A National Kidney Foundation Work Group was able to provide rough estimates of the extent of chronic kidney disease among adults in this country based on the Third National Health and Nutrition Examination Study (NHANES III). The Work Group calculated that, while there are approximately 300,000 Americans with ESRD, there could be as many as 19,200,000 Americans in the various stages of chronic kidney disease that precede it. (2) Similarly, it is possible to project that hundreds of thousands of American Indians may have chronic kidney disease. While only a fraction of these individuals will ultimately experience ESRD, many more will suffer from the complications of chronic kidney disease such as bone disease, anemia and cardiovascular disorders.

Interventions for Chronic Kidney Disease

The personal and economic toll of chronic kidney disease can often be prevented or delayed through early identification and treatment. Furthermore, early stages of chronic kidney disease can be detected through routine laboratory measurement. For these reasons, the National Kidney Foundation has developed the "Kidney Early Evaluation Program" (KEEP). KEEP is a community-based initiative designed to identify persons at risk for kidney disease.

Interventions to slow the progression of kidney disease and its complications should be considered for all patients with chronic kidney disease. These might include: strict glucose control in diabetes, strict blood pressure control, use of pharmacological agents such as angiotensin-converting enzyme inhibitors or angiotensin-2 receptor blockers, dietary protein restriction, lipid-lowering therapy, and correction of anemia by means of

(1) United States Renal Data System, 2002 Annual Report, Atlas of End Stage Renal Disease in the United States, Table B.1, page 297.
(2) National Kidney Foundation, Kidney Disease Outcomes Quality Initiative, "Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification," *American Journal of Kidney Diseases*, February, 2002, Table 14.

recombinant erythropoetin. (3) These interventions should be available to American Indians with chronic kidney disease through the Indian Health Service (IHS). Furthermore, there is reason to believe that disease management strategies could enhance the effectiveness of the interventions listed above. IHS should sponsor pilot projects to assess the benefit of disease management for American Indians with chronic kidney disease.

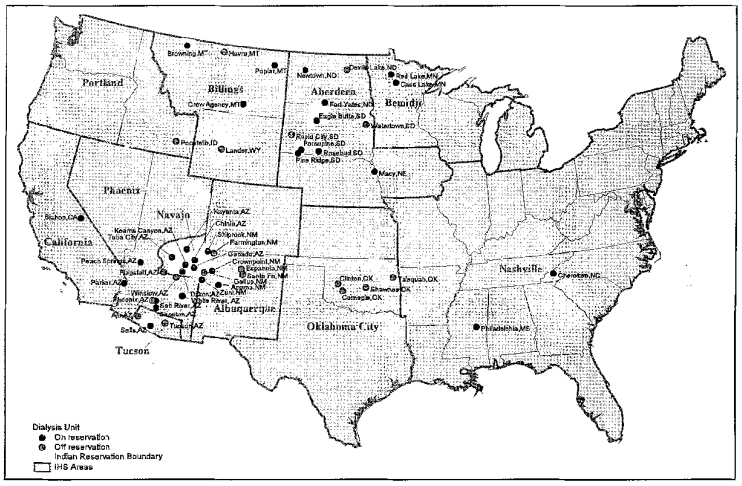
ESRD Care for American Indians

About 40% of American Indians live on reservations that are removed from population centers where health care facilities are located. Accordingly many tribes have sought the establishment of dialysis clinics on or near reservations so as to eliminate the need for ESRD patients to travel long distances three times a week for dialysis treatments. The need to open more dialysis units at or near reservations will increase as the number of American Indians with End Stage Renal Disease escalates. Unfortunately, it is difficult to recruit and retain qualified health care professionals to work in these remote facilities. This phenomenon is compounded by the fact that Medicare dialysis reimbursement rates are adjusted downward for rural providers and staffing costs are the largest single expense in operating a dialysis clinic. Consequently several dialysis clinics that serve American Indians have been forced to close in the last year. We respectfully request that the Committee explore approaches to assure the economic viability of dialysis clinics that serve American Indians. Secondly, pilot projects should be undertaken to test ways to make it easier for American Indians to choose the option of home dialysis. Not only does home dialysis eliminate the need for clinic visits but home dialysis patients tend to have better outcomes. Finally, we need to
improve American Indian access to transplantation. At the end of 1999, only 22% of the American Indian ESRD population had functioning kidney transplants, compared with 36% of white US ESRD patients. American Indians are less likely than whites to be placed on the transplant waiting list, and those listed wait longer for a transplant. (4)

Summary

While American Indians bear a disproportionate burden of kidney disease, implementation of the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (K/DOQI) guidelines should provide opportunities to improve the health and well being of American Indians with chronic kidney disease and End Stage Renal Disease. Additional resources for the Indian Health Service and the Health Resources and Services Administration and through the Centers for Medicare and Medicaid Services may be necessary to make these opportunities a reality.

We appreciate the opportunity to submit these comments for the written record.

(3) Ibid., Guideline 13.
(4) Andrew S. Narva, "The Spectrum of Kidney Disease in American Indians." *Kidney International*, Vol. 63, Supplement 83 (2003), p.3.

Dialysis Units Serving AI/ANs, On- or Near Reservations.