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INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2005

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

R E P O R T

[To accompany S. 1057]

The Senate Committee on Indian Affairs, to which was referred the bill (S. 1057), to amend the Indian Health Care Improvement Act to revise and extend that Act, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill, as amended, do pass.

PURPOSE

The purpose of the Indian Health Care Improvement Act Amendments of 2005 (S. 1057) is to reauthorize the Act and improve the Indian health care delivery system. This legislation is intended to raise the health status of American Indians and Alaska Natives to the highest possible level in accordance with Healthy People 2010.[1]

S. 1057 sets forth policies, programs and procedures designed to address health care deficiencies in native and urban Indian communities and streamline service delivery to those communities. In addition, S. 1057 addresses the health problems and associated socio-economic conditions in native communities by authorizing the Indian Health Service (IHS) and tribes to adopt current health industry "best practices".

[1] Healthy People 2010 is the major health agenda for the Nation. "It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats." U.S. Department of Health and Human Services, *www.healthypeople.gov* (last reviewed November 8, 2005).

49–010

BACKGROUND

Enacted in 1976, the Act established the first comprehensive framework for the delivery of health care services for native people, including various health programs, projects, and facilities. The Act was last reauthorized in 1992.

THE REAUTHORIZATION PROCESS

The work on the latest reauthorization began in 1999. Bills have been introduced since the 106th Congress[2] to enact a series of improvements and updates to current law, most of which are contained in S. 1057.

NATIONAL STEERING COMMITTEE (NSC)

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

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

By letter dated September 27, 2001, the Administration provided its views on S. 212 to the Committee. During 2002, tribal officials and Committee staff reconvened to address the Administration's concerns. The legislation was not passed by Congress that year, and S. 556 was introduced in the next Congress.

During the 108th Congress, the Committee, the NSC and the Administration engaged in extensive negotiations over the reauthorization, but a final bill was not concluded before the 108th Congress ended. Several recommendations developed during these negotiations were incorporated into S. 1057.

OVERVIEW OF INDIAN HEALTH CARE HISTORY

The history of the Federal responsibility for Indian health care is quite extensive and well-documented in numerous sources, including past Senate Reports on prior legislation. See e.g., Senate Report Nos. 94–133, 102–392 and 108–411. The underlying responsibility to provide health care did not originate with the Act; rather, the Act was passed after Congress recognized that a sea-change in administration was needed to ensure improvements were achieved in Indian health status and services.

[2] S. 2526 (106th Congress), S. 212 (107th Congress), S. 556 (108th Congress).

The administration of Indian health had initially been managed in a piecemeal approach, then ultimately coalesced within the IHS, an agency of the DHHS.[3]

Based on that history and in fulfillment of the special obligation to Indian people,[4] Congress passed the Act to provide coordinated programs and meaningful direction in Indian health care administration.

THE PRE-IHCIA INDIAN HEALTH SYSTEM

At the time of passage of the Act in 1976, the information on Indian health painted a stark portrait of existence in Indian communities. The Senate Report accompanying S. 522, the Indian Health Care Improvement Act, which was signed into law as Public Law No. 94–437, indicated that the "vast majority of Indians still live in an environment characterized by inadequate and understaffed health facilities, improper or nonexistent waste disposal and water supply systems, and continuing dangers of deadly or disabling diseases."[5]

Health status. These conclusions were based upon the statistics at the time. For example, the "incidence of tuberculosis for Indians and Alaska Natives [was] 7.3 times higher than the rate for all citizens of the United States. * * * [T]he suicide rate * * * [was] approximately twice as high as in the total U.S. population."[6] Also troubling was the infant mortality rate for Indian babies which was significantly higher than the national average.[7]

Health professionals. Compounding the low health status were the difficulties in recruiting and retaining qualified health professionals—Indian health professionals, in particular—to work in the Indian communities. The available information indicated that out of 500 doctors in the Indian Health Service, only 3 were Indian.[8] Overall, "in 1975, there were only 72 American Indian physicians."[9] Likewise, only half of the number of pharmacists needed were employed in these Indian communities.[10]

Health facilities. The conditions and availability of health facilities did not fare any better. A significant number of the existing facilities were over twenty years old. Many others were "old one-story, wooden buildings with inadequate electricity, ventilation, insulation and fire protection systems, and of such insufficient size as to jeopardize the health and safety of their occupants."[11] The Joint Committee on Accreditation of Hospitals (JCAHO) found that "only 24 of the 51 existing IHS hospitals" met accreditation stand-

[3] The responsibility for Indian health first fell to the War Department in 1803, then to the Interior Department in 1849, before finally being transferred to the Department of Health, Education and Welfare (DHEW), the predecessor of the DHHS, in 1955. The Division of Indian Health within DHEW had initial responsibility for Indian health before eventually being renamed the Indian Health Service. See Task Force on Indian Health in the Final Report to the American Indian Policy Review Commission (Final Report) at 32.

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

[5] S. Rep. No. 94–133, at 36 (1976).

[6] Id.

[7] Id.

[8] Id., at 55.

[9] Headlands Indian Health Careers, Program History, available at *http://www.headlands.ouhsc.edu/history.asp* (Last reviewed December 14, 2005).

[10] S. Rep. No. 94–133, at 42 (1976).

[11] S. Rep. No. 94–133, at 36–37 (1976).

ards and "two-thirds [were] obsolete and that 22 need[ed] complete replacement." [12]

Funding. The funding situation also revealed significant disparities. For example, "[p]er capita expenditures for Indian health purposes [were] 25 percent below per capita expenditures for health care in the average American community." [13]

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

CURRENT INDIAN HEALTH SYSTEM

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

Indian health status. Indian mortality rates from tuberculosis were 400% greater than other U.S. populations.[14] Despite a decrease of 64% over a period spanning 1972 to 1999, Indian infant mortality rates still remained 24% higher than other U.S. populations.[15] Other Indian mortality rates far exceeded the mortality rates of other U.S. populations for causes including alcoholism (638%), diabetes mellitus (291%), unintentional injuries (215%), pneumonia and influenza (67%), gastrointestinal disease (38–40%) and heart disease (20%).

Even during the short period of 1997 to 2001, the overall "prevalence of diabetes increased by 33% in all major regions served by the Indian Health Service." The most alarming increase, however, occurred among the Indian youth ages 15–19, for whom diabetes increased by 106% from 1990–2002.[16]

Recent information on suicide indicates that these rates are also astonishing. In 2005, the Committee held two hearings on the issue of Indian youth suicide. A field hearing was held in Bismarck, N.D. on May 2, 2005, and an oversight hearing was held in Washington, D.C. on June 15, 2005.

According to national data for 2002, suicide was the second leading cause of death for Indians of both sexes in the 15–34 year age range, and the fourth leading cause of death for both sexes in the 10–14 year age range. On the reservations of the Northern Great Plains (States of North and South Dakota, Iowa, Minnesota and Nebraska), the rate of Indian youth suicide is up to 10 times higher than it is elsewhere in the country.

Yet, in terms of services at several Indian health facilities, the demand for mental health care outstripped their capacity.[17] In at

[12] Id., at 37.
[13] Id.
[14] U.S. Department of Health and Human Services, Indian Health Service, 2000–2001 Trends in Indian Health, at 7.
[15] U.S. Department of Health and Human Services, Indian Health Service, 2000–2001 Trends in Indian Health, at 49.
[16] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2006, Justification of Estimates for Appropriations Committees, at IHS–81.
[17] United States Government Accountability Office, Report to the Committee on Indian Affairs, U.S. Senate, Indian Health Service: Health Care Services Are Not Always Available to Native Americans, GAO Report No. GAO–05–789, (August, 2005) at 18.

least one facility, the mental health services would be cut by 20% in FY 2005 because funding had been depleted.[18]

Another alarming and growing problem arising in Indian communities is the use of methamphetamines. According to the National Survey on Drug Use and Health, the use rate during a 2002–2004 survey period among Indians, aged 12 and older, is higher than nearly every other population.[19]

Health facilities. According to the most recent data, 413 facilities exist within the Indian health system with an average age of 30 years.[20] Approximately 49 of those facilities are hospitals ranging in capacity from 4 to 156 beds, but only 19 of the hospitals have operating rooms.[21]

Besides hospitals, "there were 231 health centers * * * offering primary care and some ancillary services such as pharmacy, laboratory and X-ray".[22] Also, the 133 health stations in the Indian health system provided primary services.[23]

According to the IHS Health Facilities Construction Priority System, the estimated unfunded total cost to meet the need was nearly $1.5 billion as of FY 2005.[24] In addition, the backlog for the maintenance and improvement needs of current facilities was estimated at $482,956,000.[25] However, on the bright side, "[f]ully 100 percent of IHS hospitals and health clinics met accreditation standards in FY 2004."[26]

In addition, since the Indian Sanitation Facilities and Services Act, Public Law 86–121, codified at 42 U.S.C. 2004, was passed in 1959, "over 265,000 Indian homes have been provided sanitation facilities" which served to reduce "[t]he gastroenteric and post-neonatal death rates among the Indian people * * * primarily because of the increased prevalence of safe drinking water supplies and sanitary waste disposal systems."[27]

The IHS noted that "in 1955, more than 80% of American Indians and Alaska Natives were living in homes without essential sanitation facilities."[28] The gastrointestinal death rate was "15.4 per 100,000 population, * * * 4.3 times higher than that for all other races in the United States."[29] But by 1995, that death rate was reduced to 1.7 per 100,000, although it is still 38–40% higher than the rate for all races in the United States.[30]

In FY 2004, approximately $139 million was available for sanitation facilities construction, of which nearly $93 million came from Indian Health Service funds and more than $46.5 million came

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[18] GAO Report No. GAO–05–789, at 18.

[19] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, The NSDUH Report, September 16, 2005, *http://oas.samhsa.gov/2k5/meth/meth.htm*, (Last reviewed on December 2, 2005).

[20] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2006, Justification of Estimates for Appropriations Committees, at IHS–5.

[21] GAO Report No. GAO–05–789, at 9.

[22] Id.

[23] Id.

[24] U.S. Department of Health and Human Services, Indian Health Service, Health Care Facilities FY 2007 Planned Construction Budget (February 11, 2005).

[25] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2006, Justification of Estimates for Appropriations Committees, at IHF–4.

[26] Id., at IHS–5.

[27] U.S. Department of Health and Human Services, Indian Health Service. The Sanitation Facilities Construction Program of the Indian Health Service, Public Law 86–121, Annual Report for 2004, at 1.

[28] Id., at 20.

[29] Id.

[30] Id.

from other Federal agencies and non-Federal sources.[31] The Indian Health Service estimated that in FY 2004 sanitation facilities were provided to a total of 24,928 homes.[32] However, the total estimated costs to address the sanitation deficiencies in existing homes was nearly $1.9 billion, with nearly 150,000 Indian homes still needing sanitation facilities, 36,000 of which did not have potable water.[33]

Health professionals. The number of Indian health professionals has increased since the Act was signed into law. According to the latest Census information, there were over 1,300 Indian physicians and surgeons and over 10,000 Indian registered nurses.[34] These numbers suggest that the incentives in the Act have assisted in increasing these numbers.

However, vacancy rates for key health professionals indicate that a substantial need still exists for qualified health professionals in the Indian health system. The vacancy rates for health professions with the greatest shortfalls consist of Dentists (24%), Certified Registered Nurse Anesthetists (33%), Medical Imaging (including x-rays, ultrasounds, CT scans etc.) (20%), Nurses (14%) Pharmacists and Physicians (both 11%).[35]

Types and level of services. The IHS and tribal and urban Indian health programs provide an array of basic medical, dental and vision services. For example, the personal health services including inpatient care, and routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc.[36]

Even though basic services may be available, access to those services is not assured. In its study on the availability of health services to Indians, the Government Accountability Office (GAO) found that Indian patients often had to wait more than 30 days—in some cases 2 to 6 months—between setting the appointment for services and receiving the services, a time frame "in excess of standards and goals identified in other federally operated health service delivery systems."[37]

Moreover, "[t]he most frequent gaps were for services aimed at the diagnosis and treatment of medical conditions that caused discomfort, pain, or some degree of disability but that were not emergent or acutely urgent."[38] For example, in some cases, adult Indian patients "could wait as long as 120 days to get approval for eyeglasses."[39]

According to one tribal official interviewed by the GAO, these situations create an environment in which Indian patients become de-

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[31] U.S. Department of Health and Human Services, Indian Health Service. The sanitation Facilities Construction Program of the Indian Health Service, Public Law 86–121, Annual Report for 2004, at 5.

[32] Id.

[33] U.S. Department of Health and Human Services, Indian Health Service, Justification of Estimates for Appropriations Committees for Fiscal Year 2006, p. IHF–9 and U.S. Department of Health and Human Services, Indian Health Service, The Sanitation Facilities Construction Program of the Indian Health Service, Public Law 86–121, Annual Report for 2003.

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

[35] Hearings on Interior, Environment and Related Agencies Appropriations for 2006 Before the U.S. House of Representatives, Committee on Appropriations, 109th Cong., 1st Sess., April 14, 2005, at 278–279.

[36] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2006, Justification of Estimates for Appropriations Committees, at IHS–3.

[37] GAO Report No. GAO–05–789, at 15.

[38] Id., at 19.

[39] Id.

moralized and may wait until their condition becomes "an emergency that required a higher level of treatment."[40] The GAO also noted that gaps in care were common.

The Committee is deeply concerned with the GAO's findings and its conclusions that the disturbing result of these gaps are "diagnosis or treatment delays that exacerbate[ ] the severity of a patient's condition and create[ ] a need for more intensive treatment."[41] The Committee is further concerned that these gaps are increasing health care costs and diminishing the potential for prevention efforts.

The Committee appreciates the Administration's efforts in promoting prevention as a key to reducing health care costs, but believes greater effort is needed to reduce gaps in health services to Indians. Improvements are needed in all areas of the Indian health care system to ameliorate problems and delays in service delivery. The improvements outlined in S. 1057 for programs and policies, the Bi-partisan Commission study on health service delivery, and other new provisions in S. 1057 are designed to help address these problems.

THE INDIAN HEALTH CARE IMPROVEMENT ACT

In passing the Act, Congress set forth ambitious goals for improving the health of Indians, including encouraging their participation in "the planning and management" of health services. 25 U.S.C. 1601(b). The Act "would provide the direction and financial resources to overcome the inadequacies in the existing Federal Indian health care program." Senate Report No. 94–133, at 13.

These goals built upon the foundation laid in President Nixon's 1970 "Special Message to the Congress on Indian Affairs".[42] In his Special Message, President Nixon declared that "[t]he time ha[d] come to break decisively with the past and to create the conditions for a new era in which the Indian future is determined by Indians acts and Indian decisions."[43]

Breaking decisively with the past meant a radical change in health care delivery, beginning with the administration of the programs and policy-making. Placing administrative and decision-making authority in the hands of Indian tribes, rather than solely in the agency's hands, was a fundamental and logical approach in health care delivery. Such a modification took several years to overcome difficulties in achieving tribal participation in the administration of these programs.[44]

Today, nearly half of the IHS budget is administered through tribal contracts or compacts under the Indian Self-Determination and Education Assistance Act of 1976 (ISDEAA), U.S.C. 450 et seq. This not only reflects Congressional policy of promoting tribal self-

[40] Id., at 16.
[41] GAO Report No. GAO–05–789, at 21.
[42] President's Special Message to Congress on Indian Affairs, 213 Pub. Papers 564 (July 8, 1970).
[43] Id., at 565.
[44] See e.g., U.S. General Accounting Office, now, U.S. Government Accountability Office, Report to the Chairman, Select Committee on Indian Affairs, U.S. Senate, Indian Health Service, Contracting under the Indian Self-Determination Act, GAO Report No. GAO/HRD–86–99, September, 1986.

determination, but generates a higher level of cooperation between the Indian health providers.[45]

GENERAL PRINCIPLES IN THE REAUTHORIZATION

During the reauthorization process, a critical assessment of the Act was undertaken by the Committee and the Indian health community and several basic principles evolved. As a general matter, the history of Indian health and the interplay between the ISDEAA and the Act must be kept in mind when developing Indian health policy.

Self-determination. Since self-determination was declared to be the new direction in Federal Indian policy, tribal participation has significantly contributed to improving services for Indian people.[46] Meaningful participation by tribes in administering programs through contracting or compacting has been a principal means of implementing the self-determination policy.

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

Such involvement means appreciable engagement between the agency and Indian tribes. Numerous tools have successfully increased that involvement. For example, negotiated rulemaking has been found to be useful in several initiatives such as education, housing and self-governance.[47]

The Committee has received testimony from tribal participants in negotiated rulemaking that "true understanding among Tribes and with IHS is achieved"[48] through that process. That true understanding is consistent with the Committee's desire to foster consensus-building and reduce obstacles that negatively impact service delivery.

The Administration has expressed concerns about the time and resource constraints involved in negotiated rulemaking. The Committee strongly supports fiscal accountability, but believes that the long-term benefits of negotiated rulemaking exceed the short-term costs.

The Committee believes that the Indian tribal and urban health providers—as first responders in the health system—should be directly involved in developing health programs and the regulations that govern them. Tribal involvement in rulemaking not only leads to a more informed rule, but it fosters tribal support. Negotiated rulemaking can save costs to all parties in the long run. By building a higher level of consensus in the regulations, the IHS lowers

[45] U.S. Department of Health and Human Services, Indian Health Service, Fiscal Year 2006, Justification of Estimates for Appropriations Committees.

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

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

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

the potential for legal challenges to the rules and associated litigation costs. The Committee favors consensus-building over litigation and encourages this long-term view.

Besides negotiated rulemaking, the Committee has favored consultation with tribes as another tool to increase tribal participation, but has generally left the manner or method of consultation to the discretion of the Secretary.

For example, the ISDEAA simply requires an annual consultation on the budget. However, the Secretary has in the past implemented a rigorous regional and national schedule for budget consultation.[49]

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

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

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

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

The Committee understands that, in the past, the Indian tribes had been foreclosed from implementing programs that the agency did not actually implement either under the Act or the Snyder Act,

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[49] See e.g., *http://www.hhs.gov/iga/tribal/0506_budget_session_transcript.doc,* (Last reviewed December 12, 2005), and *http://www.hhs.gov/iga/tribal/9707.html,* (Last reviewed December 9, 2005), but see *http://www.npaihb.org/legis/IHS%20Budget/Budget_Intro_Page.htm,* (Last reviewed December 9, 2005).

[50] U.S. Department of Health and Human Services, Department Tribal Consultation Policy, January, 2005, available at *http://www.hhs.gov/ofta/docs/FnlCnsltPlcywl.pdf.* (Last reviewed December 15, 2005).

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

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

[53] Id., at 596.

25 U.S.C. 13. Simple program authorizations under the Act and the Snyder Act were deemed insufficient to allow the Indian tribes to administer the programs even under the redesign provisions of the ISDEAA.

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

In the past, the Committee has been apprehensive about eliminating certain mandates such as those requiring studies. In reviewing the studies conducted and annual reporting information, it appears that quite a few studies mandated by the Act were not completed. These studies were intended to provide insight into the accomplishments and challenges in Indian health and assist the Committee in seeking new approaches to service delivery. The Committee is troubled that the health status of Indians reflects many of the same problems it did in 1976 and that several mandates in current law have been disregarded.

Consequently, the Committee has included in S. 1057, a Bi-partisan Commission to thoroughly review opportunities for improvement. During the 108th Congress, the bill to reauthorize the Act, S. 556, contained provisions wherein the Bi-partisan Commission would study the potential of funding Indian health as an entitlement. Based on the Administration's recommendations offered during the 108th Congress, the Committee modified the Commission's objectives in S. 1057.

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

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

KEY PROVISIONS

Several key improvements and provisions of S. 1057 are particularly noteworthy:

Non-Eligibles. Congress has recognized that "without a proper health status, the Indian people will be unable to fully avail themselves of the many economic, educational, and social programs already directed to them. * * *" Senate Report No. 94–133, at 23. Providing services to Indian people improves the health of Indians in a direct manner.

However, protecting the health of Indians requires attention to issues other than direct services to Indians. In the 1800s, services such as vaccinations were provided to Indians located near forts to protect the health of soldiers.[54] Now the tables are turned. Individuals not otherwise eligible for Indian health care may receive a limited scope of health services under the Act to protect the health of Indians.

Serving non-eligibles for these purposes comports with the Administration's goals of promoting healthy "Indian * * * communities" and "including new approaches to delivering care".[55] Serving non-eligibles has been a policy of the Act for many years and it reflects a logical and reasonable approach to protect Indian health.

For example, the Act provides that services may be provided to a non-eligible pregnant woman carrying an Indian's child. 25 U.S.C. 1680c(c)(3) (Section 807(d)(3) of S. 1057). In addition, services may be provided to prevent the outbreak of communicable diseases such as tuberculosis. 25 U.S.C. 1680c(c)(2) (Section 807(d)(2) of S. 1057).

In including these "non-eligible individuals" in the service delivery, Congress has set forth considerations for the IHS and Indian tribes to address prior to providing the services—the "two-part determination". This two-part determination consists of determining that

> (i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and
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> (ii) there is no reasonable alternative health facility or services, within or without the service area of such service unit, available to meet the health needs of such individuals. 25 U.S.C. 1680c(b)(1)(A).

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

Where services are directly provided by the IHS (direct services), the Indian tribe(s) served by the Service Unit and the IHS jointly make the two-part determination. 25 U.S.C. 1680c(b)(1)(A). Section 807 of S. 1057 provides that, for programs administered by an Indian tribe pursuant to a contract or compact under the ISDEAA, the Indian tribe is authorized to provide services to non-eligibles, but "shall take into account" the two-part determination.

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

However, Section 807 does provide some guidance on how the parties may determine whether there will be no diminution of services. For example, the non-eligibles receiving services "shall be lia-

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[54] See American Indian Policy Review Commission, Task Force Six, Final Report to the Commission, Vol. 6.

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

ble for payment of such health services under a schedule of charges prescribed by the Secretary. * * *" 25 U.S.C. 1680c(b)(2)(A).

In addition, health services may be provided to indigent non-eligibles if there is a reimbursement agreement with the State or local governments. These provisions, however, do not limit the ability of either the IHS or Indian tribes to include additional considerations in determining whether services would be decreased. Other budgetary factors, delays in services, appointment waiting times,[56] etc. are all other considerations that may be appropriate, depending on the particular circumstances.

Likewise, when assessing reasonable alternatives, the IHS and Indian tribes may be confronted by factors such as remote locations, distances to other health facilities and other unique difficulties, which render other health care alternatives unavailable. Questions surrounding what is available should be placed in the context of the following policy considerations. First, services under this Act are for the ultimate protection of Indian health. Second, the IHS and tribal health programs are the payors of last resort which means, in this situation, that all other avenues of obtaining health services should be exhausted prior to seeking assistance from either IHS or the tribal health programs.

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

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

Evaluations were left in S. 1057 to the IHS and Indian tribes based on their individual circumstances and, if appropriate, could be developed more fully through negotiated rule-making or consultation.

Third Party Reimbursements. Funding from sources other than IHS was identified as a factor which affected the availability of health care services for Indians.[57] Those funding sources include third-party reimbursements from Medicaid and Medicare. In some cases, these reimbursements constitute up to 50% of the medical care budget for a particular Indian health program.[58]

With more resources, the Indian health care system could provide more services and the Committee strongly encourages IHS and the Indian tribes to seek additional resources to supplement the

[56] See GAO Report No. GAO–05–789.
[57] GAO Report No. GAO–05–789, at 4.
[58] Id., at 5.

appropriated sums provided annually.[59] The GAO noted that "[f]acilities with higher reimbursements had additional funds with which they could hire staff, purchase equipment and supplies, and renovate their buildings."[60] In one case, 31 percent of a facility's clinical providers and other staff was funded by third party reimbursements.[61]

S. 1057 provides for an increase in access to Medicaid by removing barriers through waivers of premiums and cost-sharing at Indian health facilities and by codifying agency regulations or practices which recognize the unique nature of and special circumstances applying to Indian property, particularly trust and restricted property.[62] Likewise, S. 1057 provides other means of removing barriers to obtaining third-party reimbursements, such as the process for seeking waivers of sanctions, which promotes favorable state-tribal relations.

Health Professions. Difficulties in recruiting and retaining qualified health professionals have long been recognized as a significant factor impairing Indians' access to health care services.[63] Noting that many Indian communities are often in remote locations and lack adequate housing and educational and recreational opportunities for employees and their families,[64] the GAO reported that some critical positions such as for pharmacists and dentists remained vacant for several years in some locations.[65]

The provisions in Title I address the health professional shortage in Indian communities. Congress specifically included these provisions in 1976 because the existing programs to improve manpower capabilities were woefully inadequate or completely unsuitable for Indian health providers and communities.[66]

The programs existing in 1976 did "not link the recipients [of scholarships] directly to the Indian Health Service," were "not designed to recruit and support Indians," and were too limited in the "category of health professionals" supported by these programs.[67]

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

These programs specifically target the needs of the Indian health system. For example, the scholarship priorities are developed through a year-long consultation process wherein the IHS sends the program information and request for priority to each tribal

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[59] S. 1057 adds amendments to the ISDEAA which authorize the Native American Health and Wellness Foundation to promote the mission of IHS through such means as receiving donations which supplement, not offset, appropriations. Offsetting in Indian health care programs is generally prohibited by law. See 25 USC § 1641(a).

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

[61] Id.

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

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

[64] Id.

[65] Id.

[66] Senate Report No. 94–133, at 55–57.

[67] Id., at 55–56.

leader and the tribal education and health programs. The comprehensive list is developed based on the IHS and tribal health professional projected needs, vacancies and available positions. By focusing on the specific needs of Indian communities, the Committee believes that this approach has significantly improved Indian health.

Just as targeting the specific needs of the Indian health system became the hallmark of the health professional policy, a holistic approach also became a key policy component in increasing the number of Indian health professionals. The Committee strongly encourages the Secretary to evaluate all opportunities to improve the chances of success for Indian health professionals, including obtaining the licenses or certifications necessary for providing health care services. The Committee has been made aware of the need to increase the number of licensed health professionals in the Indian health system and included provisions in S. 1057 to address that need. S. 1057 provides for portability of current licenses for tribal health professionals consistent with other Federal health licensing provisions. In addition, S. 1057 authorizes programs to enhance and facilitate enrollment in and completion of courses of study in health professions.

The Committee believes that the Title I programs should fully equip the individuals with the tools needed to transition into the health profession, including successfully completing all courses of study and passing the required licensing or board examinations. In addition, the Committee expects that the IHS would also ensure that scholarship recipients are provided every opportunity to fulfill their service obligations, including technical assistance in understanding their obligations.

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

The incentives fostered by scholarships, loan repayments, and bonuses are multiplied when combined with professional development programs for health professionals which the Committee believes to be essential components of recruitment and retention programs in the Indian health system. S. 1057 establishes several professional development programs in Title I such as opportunities for advanced training and research, tribal cultural orientation, training in the administration and planning of tribal health programs and tribal demonstration projects for innovative recruitment, placement and retention programs, which may include professional development programs.

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

In addition, the Committee took a long-term view of health professions in S. 1057. The most dire placement needs are in the direct care positions, such as doctors, nurses, and pharmacists. In the long-term, Indian health professionals are also needed in educational positions to bolster recruitment and improve the new Indian health professionals' chances of success.

The Committee has been informed that an appreciable need exists at the tribal colleges and universities to increase the number of Indian instructors in the nursing programs.[68] The Committee recognizes that Indian instructors often have personal knowledge of the health disparities in Indian communities and a deep commitment to serve these communities for the long-term. Indian educators increase the likelihood of success for Indian students and bring to the classroom the unique cultural competence required in the Indian health field.

With that in mind, the Committee included provisions in Title I of S. 1057 wherein a scholarship recipient may fulfill his or her service obligation (required in exchange for the scholarship) by teaching in a tribal college or university nursing or other health related program, provided the Secretary determines that the health services to Indians will not be decreased. In addition, the Secretary may, prior to waiving any service obligation or repayment of a scholarship, consider placement of a scholarship recipient in a teaching capacity in a tribal college or university nursing or related health program. Other provisions for nursing grants were added to extend a preference in grant awards to tribal college and university nursing programs.

Prior to including these provisions, the Committee considered the likelihood that inexperienced, new graduates might be placed in teaching positions. One tribal college President indicated that "these are clinically seasoned, mature [Bachelor of Science-Nursing] prepared nurses returning to school for educational and career mobility."[69] Teaching positions available for these individuals would include lab coordinators and clinical instructors. This tribal college President also indicated that "new [Registered Nurse] graduates of associate or generic baccalaureate programs would not be qualified to teach. * * *"[70]

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

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

Home Health Care. Current law authorized a feasibility study to be conducted on hospice care services. However, the IHS never con-

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

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

[70] Id.

ducted that study and now, thirteen years later, to conduct such a study would greatly delay what have already been demonstrated to be much needed services.

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

Currently, home health care, long-term care and hospice care are not readily available to most Native communities. Indians must travel long distances only to be placed in facilities that are far from home, culturally unfamiliar, and not conducive to their well-being. Having culturally-appropriate facilities close to Indian communities will not only promote the patient's well-being, but will enable family members to more easily visit the patient.

Section 213 of S. 1057 authorizes the Secretary to fund other services which meet the policy objectives set forth in section 3 of the legislation. A partial list of such other services includes hospice care, assisted living, long-term health care, home- and community-based services, public health functions, and traditional health care practices.

Concerns have been raised regarding the economic feasibility of facilities providing these types of services, if access is limited to just Indians. Therefore, subject to the "two-part determination" under Section 807 of the bill, the IHS, Indian tribes, or tribal organizations may provide the types of care authorized in Section 213 to persons otherwise ineligible for the health care benefits of the IHS, provided that such persons furnish reimbursement of reasonable charges for such services. The inclusion of these individuals may be necessary in some circumstances to achieve the minimum patient base needed to make the venture economically feasible and to realize the cost efficiencies of providing these services.

With regard to the services authorized by Section 213, the Department of Justice informally expressed concerns with a subset of the home- and community-based services, specifically "chore services". These concerns primarily focus on potential liability for the Federal government that may arise under the Federal Tort Claims Act from: (1) services provided in a setting other than an IHS or tribal facility that are not directly associated with the medical condition being treated, (2) whether the providers will be adequately trained, and (3) family members' support being included as a standard service.

To address these concerns the Committee struck the words "homemaker" and "chore services" from the definitions in the substitute amendment adopted in Committee. The substitute amendment further clarified the "Personal care services" definition to specify that ancillary tasks, when performed, must be associated with support services related to activities of daily living. Last, the substitute amendment makes clear that home- and community-based services do not include services provided by an individual

who is legally responsible for the provision of such services, such as a family member or legal guardian.

Traditional Health Care. The 1928 Merriam Report[71] generated several initiatives to improve health conditions for Native Americans. One reform was the active solicitation of traditional Indian healers to participate in federal health services to Indians—an abrupt change from the prior assimilationist policies promoted by the Federal Government.

Several provisions in the Act reflected those reforms as well.[72] In particular, the Community Health Representatives in the Act were required to "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." 25 U.S.C. 1616(b)(6).

The Committee is aware that Indian tribes have long sought to promote traditional healing in the framework of the Indian health system, but that concerns have been raised regarding inclusion of traditional healing in the IHCIA.

One concern involves the possible legal liability to the Federal Government in connection with the traditional practices. Under the ISDEAA, Federal Tort Claim Act (FTCA) coverage applies when Indian tribes or tribal organizations administer programs or services pursuant to a contract or compact. If traditional health practices were services provided under an ISDEAA contract or compact, such practices would be covered by the FTCA.

Other concerns have been raised regarding whether the Federal Government or courts should be scrutinizing tribal traditions in the defense against claims arising under the FTCA. To address these concerns, the Committee encourages the Secretary and Indian tribes to thoroughly examine the traditional healing provisions through the implementation plan under Section 803 of S. 1057, or through consultation, particularly on how the traditional practices and healers fit within the FTCA framework.

Behavioral Health. S. 1057 has a strong focus on behavioral health. Title VII takes a comprehensive and integrative approach to behavioral health, providing both prevention and treatment programs for Indian children, youth, women and elders. The bill also emphasizes the interconnectedness of services related to alcohol and substance abuse, child welfare, suicide prevention and social services. Particular programs are authorized for Indian youth, Indian women, those affected by fetal alcohol disorder in Indian communities, and both the victims and perpetrators of child sexual abuse in Indian households.

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

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

[72] Other federal agencies also appear to be consider the value of traditional healing in assisting Indian people recover from various maladies such as post-traumatic stress disorders. See e.g., *www.helenair.com/articles/2005/11/30/montana/a06113005__01.txt,* (Last reviewed November 30, 2005).

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

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

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

In response to this tragedy, a number of resources were provided to the Red Lake reservation, including services by such Federal agencies as the IHS, SAMHSA and Office of Juvenile Justice and Delinquency Prevention, as well as by state and tribal agencies.

The Committee held two hearings specifically on the issue of Indian youth suicide, one in Bismarck, North Dakota on May 2, 2005, and the other in Washington, DC, on June 15, 2005, to discuss the kinds of resources and services being provided to Indian youth who have expressed suicidal thoughts or attempted suicide, and to explore what more might be done.

Based on the information developed through hearings, the Committee added provisions to Title VII of S. 1057 which address youth suicide as part of the behavioral health program provisions. Other provisions added in Title I encourage more Indian people to enter into the psychology profession by increasing the number of grants for the program commonly referred to as In-Psych (Indians into the Psychology) from 3 to 9 and by authorizing a specific level of funding.

The provisions also add a significant cultural component to the suicide programs. They authorize the Secretary to award grants for telemental health demonstration projects to provide counseling to Indian youth and health providers, training for Indian community leaders, and the development of culturally-relevant materials.

The Committee is aware that suicide prevention for Indian youth is a long-term effort that must address many multi-factorial causes. Questions such as whether the loss of cultural identity contributes to the youth suicide problem remain unanswered. Consequently, S. 1057 makes suicide a priority for the IHS research agenda, particularly the identification of various factors that either protect the tribal community or make that community at risk for suicides, and the role the loss of tribal identity plays in suicidal behavior.

Urban Indians. Providing for urban Indian health has been a part of Federal policy for nearly 40 years. Congress began funding

urban Indian clinics in 1967 when $321,000 was provided for an Indian clinic in Rapid City, South Dakota.[73]

Congress specifically included urban Indian health programs as part of the Indian health care system in the Act in 1976, recognizing that the Federal obligation for health care extended to these individuals, to correct disparities in health levels for Indians living in urban areas first as pilot programs and then permanently in the Indian health care system. See Senate Report Nos. 94–133, 100–508 and 108–411.

The policies and status of Indians and Indian tribes under Federal laws, treaties and judicial decisions provide ample support for continuing and improving programs for urban Indians. Under this varied history, the Federal government had dealt with Indian tribes in a variety of ways: some by treaty, others not by treaty. For some Indian tribes, the Federal Government had ignored completely. Some Indian tribes were legislatively blocked from some administrative programs, yet were allowed to exercise treaty rights. Some Indian tribes were "terminated", yet later "restored".

Courts have long held with great favor that Congress has the broad power to legislate for the benefit of Indians, even if located off the reservation, and to define who is an Indian, even if they may not be an enrolled member of a federally-recognized Indian tribe, and for what purposes they may be provided services.[74]

For example, Congress has enacted laws which define Indians in different ways for different purposes. See e.g., Indian Arts and Crafts Act, Pub.L. 101–644, 25 USC 305; No Child Left Behind Act, Pub.L. 107–110, 25 USC 7491; and the American Indian Probate Reform Act of 2004, Pub.L. 108–374. Even the criminal statutes under Title 18 of the U.S. Code regarding crimes on Indian reservations do not define who is an Indian.

In other cases, Congress did not define Indians, nor place geographical limitations on the service areas in which they may be served. The Snyder Act, 25 USC 13, authorizes permanent funding for health care for "the Indians throughout the United States". This statute does not confine the services to Indians who are members of current Federally-recognized tribes or to those living only on reservations. The Snyder Act has never been repealed nor otherwise limited in this respect.

Under this Act, Congress has provided a more inclusive definition of urban Indian than mere membership in a federally-recognized Indian tribe, including members of "terminated" tribes, that is, groups that once had a political government relationship with the United States.

Termination was another failed Federal Indian policy designed to end the government-to-government relationship with Indian tribes and assimilate their members into the larger society. However in

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

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

remedying the devastating effect of termination, Congress saw fit to continue the health services in the Act to those individuals. See *Menominee Tribe* v. *U.S.,* 391 U.S. 404 (1968). Likewise, by including members of state-recognized tribes, Congress recognized that several Indian tribes had treaty relations with individual states before the Federal government was established, often referred to as "state-recognized tribes".

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

Further, in adopting S. 1057, the Committee is of the opinion that the Congress was on firm constitutional footing based on longstanding precedent. Indeed, the U.S. Supreme Court has held that "it is not meant * * * that Congress may bring a community or body of people within the range of this power by arbitrarily calling them an Indian tribe, but only that in respect of distinctly Indian communities the questions, whether, *to what extent* and for what time they shall be recognized and dealt with as dependent tribes requiring the guardianship and protection of the United States are to be determined by Congress, and not by the courts." *U.S.* v. *Sandoval,* 231 U.S. 28, 46 (1913) (emphasis added). Accordingly, the Act extends health benefits to members of these groups (terminated tribes and state-recognized tribes) without extending Federal recognition to them for all purposes.

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

> First, Indians were provided an opportunity to work and share in the Nation's prosperity in industries prior to and during World War II; second, thousands of Indian men and women served in the Armed Forces away from their reservation, traditional communities or Alaska Native villages; third, formal government relocation programs moved many Indian families from low employment, rural areas to urban areas where "employment opportunities" were considered more readily available; and fourth, countless numbers of Indians attempting to escape depressed conditions on their reservations voluntarily relocated.[75]

The comprehensive approach of this Act is needed to more fully implement the federal responsibility for Indian health care and, even more so today, to address health disparities facing the Indians that had moved from the reservations as a result of the relocation policies. Relocating Indians from reservations to urban areas is the Federal policy and program first begun in 1931.[76] "Relocation complemented other termination programs designed to promote rapid assimilation. Once relocated, Indians were cut off from the special

[75] Senate Report 94–133, page 131.
[76] Felix Cohen, Handbook of Federal Indian Law (1982 ed.), at 169.

federal services that had been available to them as reservation residents." [77]

Congress has previously recognized that the establishment of urban Indian health programs was necessary to rectify the errors of failed Federal Indian policies such as relocation. See Senate Report No. 94–133 at 138. The Committee further found that Title V "represent[ed] a Federal policy commitment to provide the essential authorities and financial resources to permit urban Indian organizations to develop needed health services and to strengthen relationships with existing community health and medical care programs." Senate Report No. 94–133 at 140.

The justifications for that policy are still valid today. The most recent statistics indicate that urban Indians suffer health disparities as do Indians located on reservations. For example, the mortality rates are higher due to accidents (38% higher than other populations), chronic liver disease and cirrhosis (126% higher), diabetes (54% higher), alcoholism (178% higher), and sudden infant death syndrome (157% higher).[78]

The Committee believes that continuation of services to urban Indians, recognized by S. 1057, makes sense from both policy and fiscal perspectives. The Committee has received testimony that these urban Indian health programs improve health services for Indians located in the urban centers in a highly cost-effective manner.

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

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

For example, the South Dakota Urban Indian Health Center operates 3 clinics and experiences over 17,500 patient encounters per year under the Title V program. This center provides such services as a foot care home visit program whereby Community Health Representatives conduct home visits to assess diabetic patients (or those at risk for diabetes). These home visits are a critical part of chronic disease management, particularly in avoiding amputations due to diabetes.

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

The Native Americans for Community Action in Flagstaff, Arizona provides immunizations, mental health and youth substance abuse prevention services among several other primary care services for urban Indians. The Committee has received testimony suggesting that the patients at this urban Indian health center would either have to travel 100 or more miles to visit an IHS clinic on

[77] Id.

[78] The Health Status of Urban American Indians and Alaska Natives, Urban Indian Health Institute, March 16, 2004, available at *www.uihi.org* (Last reviewed March 16, 2006).

the reservation or wait two or three weeks for an appointment at the local Community Health Center. Either alternative would impose significantly more burdens on the patient, and the testimony further suggests that most patients would simply avoid the care altogether.

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

The health program operated by the Nevada Urban Indians, Inc. in Reno, Nevada provides, among other things, immunization and diabetes education programs and experienced over 9,000 patient encounters in 2005. The Native American Rehabilitation Association of the Northwest, Inc. in Portland, Oregon experiences nearly 9,300 patient encounters per year, including 1,040 for mental health care and 3,400 for alcohol and drug treatment. The N.A.T.I.V.E. Project in Spokane, Washington provides a community wellness program and community outreach services for diabetes screening and health education for a community of approximately 12,000 urban Indians.

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

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

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

The urban Indian health programs provide services for the uninsured Indians who might not be able to obtain care elsewhere. With poverty rates of urban Indians hovering at 25% (compared to 14% for the general population), and nearly half living below 200% of the Federal poverty level (compared to 30% for the general popu-

lation)[79], it is no surprise that many urban Indians are uninsured. The Committee has received testimony that in Boston, Massachusetts, 87% of the Boston Indian Center's clients have no health insurance and nearly two out of three urban Indians in Arizona have no insurance.

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

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

According to Oral Health in America: A Report of the Surgeon General, the incidence rates for periodontal disease among Indians is 2½ times that of the general public.[80] In Alaska Native communities, it is not uncommon for the children to require extraction of all of their baby teeth due to pervasive caries. Nor is it uncommon for the nutritional status of Alaska Native elders to be compromised by their inability to consume healthy foods due to dental pain or missing teeth.

This situation is exacerbated by a chronic shortage of dentists. Alaska Tribal health programs are currently experiencing a persistent 25 percent vacancy rate among dentists, with an annual 30 percent turnover rate.[81] Even if the number of dentists in the IHS/tribal system were doubled, it would take 10 years to address the unmet need for dental services.[82] A recent independent evaluation of the DHAT Program in Alaska reports that "five full-time paid dentist positions in the Yukon-Kuskokwim Delta have remained vacant for six years despite a salary/benefits package starting at $177,000."[83]

At its joint hearing on S. 1057 on July 14, 2005, with the Senate Health, Education, Labor and Pensions Committee, the Committee examined issues surrounding the Dental Health Aide Therapist (DHAT) program currently operated under the Community Health Aide/Practitioner (CHAP) program in Alaska Native communities. The Committee received testimony regarding the crisis in oral health care in Alaska Native communities and how the DHAT program was a result of Alaska Native leaders and health providers searching for a means of addressing it. The Committee believes

[79] The Health Status of Urban American Indians and Alaska Natives, Urban Indian Health Institute, March 16, 2004.

[80] U.S. Department of Health and Human Services, U.S. Public Health Service, National Institute of Dental and Craniofacial Research, National Institutes of Health, Oral Health in America: A Report of the Surgeon General (2000) at 77.

[81] Indian Health, Hearing Before the Senate Comm. on Indian Affairs, 109th Cong., 1st Sess., S. Hrg. 109–26, at 168 (April 13, 2005) (statement of Sally H. Smith, Chairman, National Indian Health Board).

[82] S. Hrg. 109–162, at 784 (statement of Dr. Mary Willard, Yukon-Kuskokwim Health Corporation).

[83] Fiset, Louis. "A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives." August, 2005.

that the use of Alaska Natives trained through the DHAT program to serve as dental health aide therapists in Alaska is a necessary response to this access to care crisis.[84]

At the July 14 joint hearing, Dr. Willard, who serves as a dentist for the Yukon-Kuskokwim Health Corporation in Bethel, Alaska, testified before the Committee that the CHAP program has been used in Alaska for 30 years and that the dental health aides are part of the often-remote Native communities.[85] She further testified that DHATs must meet the same dental standards and quality assessments that IHS uses for dentists, and that their skills are equal.

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

Despite strong concerns expressed by the American Dental Association about the quality of care that would be provided by the DHATs, the Committee has received letters indicating strong support of the DHAT Program in Alaska from the State of Alaska's Department of Health and Human Services, the Alaska Native Health Board, the Alaska Native Tribal Health Consortium, the American Dental Hygienists' Association, and others.[86]

The Committee wants to ensure that Alaska Natives receive the best feasible care and appreciates the concerns for patient safety regarding the use of DHATs to perform surgical dental procedures (extractions, pulpotomies and diagnosis and treatment of caries). However, the difficult policy decisions lie in balancing perceived risks to patient safety against the alternative reality of their receiving no care at all.

Consequently, the Committee has determined to limit the DHAT program to Alaska and require a study of the program. The study will be conducted by a panel of neutral experts, including clinicians with experience in providing care to remote populations and clinicians who can measure and evaluate oral and medical complications, community practitioners from Alaska, economists with experience in dental delivery, oral epidemiologists, and Alaskan Natives with experience in the health delivery system.

In developing the study parameters, the Secretary must consult with appropriate professional organizations, among other parties. The Committee expects that the American Dental Association will be specifically included in that consultation given their concerns and expertise in these matters.

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[84] Because no U.S. dental school provides mid-level dental training, DHATs are trained at the University of Otago, New Zealand, under a two-year program. The Committee has been informed that the DHAT Program is operated with wide success in Canada and 40 other countries. See World Oral Health Country/Area Profile Programme, World Health Organization Collaborating Center.

[85] S. Hrg. 109–162, at 363–363 (statement of Dr. Mary Willard, Yukon-Kuskokwim Health Corporation).

[86] See also Id., at 716 et seq. (statement of Don Kashaveroff, President, Seldovia Village Tribe).

Furthermore, the Committee believes that the study should compare the care provided by the DHATs with care provided by other dental delivery systems, such as the "Integrated Dental Health Program for Alaska Native Populations" model developed by Drs. Howard Bailit, Tryfon Beazoglou, Amid Ismail, and Thomas Kovaleski. During the term of this study, the Secretary should engage in appropriate oversight and take actions necessary to ensure that patient health and safety is not compromised.

SECTION-BY-SECTION ANALYSIS

A significant portion of current law has been carried forward by S. 1057 and reorganized in the various titles according to subject matter. S. 1057 also adds several new provisions to current law which may (1) amend current law, such as turning a demonstration project into a permanent program, (2) simply clarify or make small additions, such as including tribal organizations in various sections, or (3) introduce brand new programs to the Indian health care system, such as hospice care.

The following section-by-section analysis will, where relevant, identify whether current law has been changed followed by an explanation of the current law to be reauthorized by S. 1057. In addition, the codified section in current law will also be noted to provide ease of reference.

Section 1. Short title. This Act may be cited as the "Indian Health Care Improvement Act Amendments of 2005".

Section 2(a). Indian Health Care Improvement Act Amended. This section begins the provisions of the Act ending with Section 816. The following section numbers of this analysis will reflect the section numbers of the Act.

Section 1. Short title; table of contents

This Act may be cited as the "Indian Health Care Improvement Act". Section 1 also contains the table of contents.

Section 2. Findings

This section maintains current law.

Current law: Section 1601 of current law (25 U.S.C. 1601) sets out Congressional findings for the Act which indicate that the health levels of Indians are below that of the rest of the U.S. population and that the provision of health care is consonant with the Federal relationship and responsibility to Indian people.

Section 3. Declaration of national Indian health policy

This section amends current law by (1) replacing the enumerated list of health level objectives with the goals contained in the Healthy People 2010 national health agenda; and (2) adding new language to (a) add trust to the responsibilities being fulfilled by the national policy, (b) allow Indians to set their priorities according to their needs, (c) increase the health profession degrees awarded to Indians so the levels of Indian health professionals in each Service Area is at least the level of the general population, (4) require consultation consistent with Indian self-determination, and (5) provide funding to Indian tribal programs and facilities consistent with levels of IHS programs and facilities.

Current law: In Section 1602, Congress declares that the national policy, in fulfillment of special responsibilities and legal obligation to Indians, is to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect the policy. In addition, the policy is to meet an enumerated list of health status objectives for Indians such as reducing coronary heart disease to no more than 100 per 100,000. It is also the intent of Congress that the proportion of degrees awarded in the health professions to Indians be increased to 0.6 percent. The Secretary is also required to report on the progress made in each objective annually.

Section 4. Definitions

This section (Section 1603 in current law) maintains current law and adds several new definitions to reflect current practices, significant updates and coordination in health services to Indians, as follows: accredited and accessible, Area Office, Assistant Secretary, behavioral health, community college, contract health service, Department, Indian health program, junior or community college, reservation, telehealth, telemedicine, Traditional Health Care Practices, tribal college or university, and Tribal Health Program.

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

Section 101. Purpose

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

Current law: Under Section 1611, the purpose of Title I is to increase the number of Indian health professionals and to assure an adequate supply of health professionals to provide health services to Indians.

Section 102. Health professions recruitment program for Indians

This section maintains current law.

Current law: Section 1612 authorizes funding for recruitment programs, to include identifying Indians with potential for entering health professions, publicizing funding sources, and establishing programs to facilitate enrollment in applicable courses of study. This section also addresses funding applications and amount of funding to be provided, as well as outlining the eligibility for these programs.

Section 103. Health professions preparatory scholarship program for Indians

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

Current law. Section 1613 authorizes scholarships to Indians for compensatory preprofessional education as well as pregraduate education leading to a baccalaureate degree in a preparatory field

for a health profession. The compensatory preprofessions scholarships are awarded for up to two years on a full or part-time basis and pregraduate scholarships are for up to four years (S. 1057 adds 2-year extensions). This section specifies certain conditions on these scholarships which include the types of costs that may be covered and prohibits denial of a scholarship based solely on scholastic achievement if the applicant has already been admitted or maintains good standing at an accredited institution or if the applicant is eligible for assistance under another Federal program.

Section 104. Indian Health Professions Scholarships

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

Current law. Section 1613a authorizes scholarships, designated as Indian Health Scholarships, to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Scholarship recipients are then required to fulfill a service obligation by either working for an IHS, tribal or urban Indian health program or in private practice located in a health professional shortage area with the length not specified in statute. The section further sets forth how the funding for these scholarships is to be allocated and addresses all the requirements of the active duty service obligation incurred as a result of the scholarship, including breach of contract situations.

Section 105. American Indians Into Psychology Program

This section maintains current law and adds new language which (1) sets the number of colleges or universities that may receive grants from at least 3 to 9 and (2) establishes a maximum grant amount of $300,000, for a total of $2.7 million for each of FY 2006 through 2015.

Current law: Section 1621p authorizes grants to at least 3 colleges and universities for developing and maintaining Indian psychology career recruitment programs, including one to develop and maintain the Quentin N. Burdick American Indians Into Psychology Program at the University of North Dakota. This section directs the Secretary to issue regulations for competitive funding and specifies conditions of the grants and active duty service requirements.

Section 106. Scholarship programs for Indian tribes

This section maintains current law and adds new language which (1) amends the source of funds for the scholarship costs by allowing 20% to be from any source instead of only non-federal sources, (2) requires that licensing and educational requirements for all health professions, instead of only the doctor and nursing professions, be met, and (3) adds Title XXI of the Social Security Act to the non-discriminatory provisions.

Current law: Section 1616m authorizes the Secretary to make funds available to Tribal Health Programs for the purpose of educating Indians to serve as health professionals in Indian commu-

nities. This section specifies the requirements for receiving such funds; the course of study; contract conditions; specific parameters for a breach of contract; the relationship of a scholarship under this section to the Social Security Act; and conditions of continuance of funding are all specified in this section. The recipient cannot discriminate against patients who receive assistance under Titles XVIII and XIX of the Social Security Act. The recipients shall be required to fulfill service obligations and use the scholarship for tuition and reasonable education or living expenses.

Section 107. Indian health service extern programs

This section maintains current law and adds provisions (1) extending the extern program to tribal or urban Indian health providers (on a discretionary basis) or other DHHS agencies (as available) instead of only the IHS, (2) instead of entitling the externs to employment, gives them a preference for employment with the IHS, and allowing an extern program for high school programs.

Current law: Section 1614 gives preference for employment in the Service (and as added by S. 1057, a Tribal Health Program, Urban Indian Organization or other agencies within the Department), to any recipient of a scholarship pursuant to section 1613a or 1616m. The section specifies that such employment does not count toward any active duty service obligation. It specifies the timing and length of employment and exempts the program from any competitive personnel system or agency personnel limitation.

Section 108. Continuing education allowances

This section maintains current law, except for the deletion of the set-aside for postdoctoral training, and adds language which extends the continuing education allowances to tribal and urban Indian health providers, not just the IHS, and includes all health professionals.

Current law: To encourage health professionals to join the IHS and continue working in rural or remote areas where significant numbers of Indians reside, Section 1615 permits the Secretary to provide allowances to health professionals employed by the IHS to enable them to take leave of their duty stations for a period of time each year for professional consultation and refresher training courses. Section 108 also authorizes a set-aside of not more than $1 million for postdoctoral training programs.

Section 109. Community Health Representative Program

This section maintains current law and adds language which formally identifies the health paraprofessionals as Community Health Representatives (CHRs) and extends the use of CHRs to tribal and urban Indian health programs.

Current law: Section 1616 authorizes the CHR Program for training and using Indians as CHRs. This section specifies the duties of the Service regarding this program, including providing supervision, an evaluation system and a high standard of training for CHRs to ensure that they provide quality health services to Indian communities served by this program. This program may also promote traditional health care practices consistent with IHS standards for health care.

Section 110. Indian Health Service Loan Repayment Program

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

Current law: Section 1616a establishes the Indian Health Service Loan Repayment Program in order to ensure an adequate supply of trained health professionals needed to maintain accreditation and provide health care services to Indians. The section specifies eligibility for the program which includes individuals with a degree or license in a health profession, in graduate training or about to complete an approved course of study. The application information must clearly explain rights and obligations and be available very early so individuals can timely complete the applications. This section outlines how the priorities for program participants will be established. Recipient contracts are required which set forth the rights and obligations. This section establishes deadlines for decisions on applications (21 days under S. 1057). The loan repayment program includes payment of principal, interest and related expenses of school loans up to $35,000 for each year of obligated service and, in addition to this payment, may include an amount to cover tax liability incurred for this payment. This section also includes a waiver from any employment ceiling; recruitment programs; non-applicability of Section 215 of the Public Health Service Act; assignment of individuals; breach of contract; waiver or suspension of obligation; and the requirement of an annual report to Congress.

Section 111. Scholarship and Loan Repayment Recovery Fund

This section maintains current law and adds provisions expanding the source of funds for this Recovery Fund, in addition to appropriations, to include collections from contract breaches for the scholarships or loan repayment programs and interest. Tribal health programs may also use payments received to provide scholarships, in addition to the current uses of recruitment and employment of health care professionals. The Secretary of DHHS may now determine what amounts are not required to meet withdrawals for the Fund, rather than the Secretary of the Treasury.

Current law: Section 1616a–1 establishes an Indian Health Scholarship and Loan Repayment Recovery Fund within the Treasury of the United States wherein funds collected for breaches of contractual obligations under the IHS or tribal scholarships or under loan repayment programs. The section specifies the use of these funds which includes employment or recruitment of health professionals, the investment of the funds, and the sale of obligations by the Secretary of the Treasury. The Secretary of the Treasury may also invest funds in this Fund which are not necessary to meet withdrawals for the uses specified in this Section.

Section 112. Recruitment activities

This section maintains current law and adds language to allow reimbursement for health professionals seeking positions with tribal and urban Indian health programs, in addition to the IHS.

Current law: Section 1616b permits the Secretary to reimburse certain travel expenses to health professionals seeking positions with the IHS. Potential candidates for contracts under section 110 and their spouses are all eligible for such reimbursement of travel. In addition, this section requires the Secretary to assign one individual in each Area Office to have full-time responsibility for recruitment activities.

Section 113. Indian Recruitment and Retention Program

This section maintains current law and adds language which (1) sets a time limit of three years for demonstration projects funded under this section instead of an open-ended timeframe under current law and (2) clarifies that the Indian organizations eligible to compete are urban Indian organizations.

Current law: Section 1616c requires the Secretary to fund innovative demonstration projects (under S. 1057 for up to 3 years) to enable Indian tribes, tribal and Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs. The section also specifies that any Indian tribe, tribal or Indian organization is eligible to apply for these funds and compete on the same basis as IHS programs which receive grants under this section.

Section 114. Advanced training and research

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

Current law: Section 1616d establishes a demonstration project to enable health professionals who are employed in an Indian Health Program or Urban Indian Organization at the time of application to pursue advanced training or research areas of study, where a need exists. The section also imposes a service obligation for the recipients and requires equal opportunity for participating in the program.

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

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

Current law: Section 1616e authorizes the Quentin N. Burdick American Indians into Nursing Program for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians. The section specifies potential grant recipients and requires that one of them be for the program at the University of North Dakota; how grants may be used; information which must be included in applications for the grant; preferences for grant recipients; establishment and mainte-

nance of a program at the University of North Dakota; and an active duty service obligation.

Section 116. Tribal cultural orientation

This section maintains current law and adds language which (1) ensures that employees in each Service Area obtain cultural orientation, rather than merely establishing a program for cultural orientation, (2) requires the program to include instruction on the relationship of the Indian tribes with the IHS, rather than simply a history of the IHS, and a description of the traditional health care practices of the Indian tribes in the Service Area and (3) requires consultation with affected tribal and urban Indian organizations.

Current law: Section 1616f requires appropriate employees of the Service who serve particular Indian Tribes to receive instruction in the history and culture of the tribes they serve and in the history of the IHS. The section requires the Secretary to develop such a program in consultation with the affected Indian tribes, which shall, to the extent feasible, be implemented through tribal colleges or universities and include instruction in Native American studies.

Section 117. INMED Program

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

Current law: Section 1616g authorizes the Secretary to provide grants to at least 3 colleges and universities to maintain and expand the Indian health careers recruitment program (Indians Into Medicine Program). The Quentin N. Burdick Indian Health Programs at the University of North Dakota is to be one of the authorized grants. This section also specifies requirements for institutional applicants for these grants.

Section 118. Health training programs of community colleges

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

Current law: Section 1616h requires the Secretary to award grants to (under S. 1057, accredited, accessible) community colleges to assist in establishing health profession education leading to a degree or diploma for individuals who desire to practice such profession on or near a reservation or in a tribal clinic. The Secretary is also required to award grants to the colleges that already have these programs. The Secretary must provide technical assistance to encourage community colleges to establish and maintain such pro-

grams. Finally, any program receiving assistance under this section is required to provide advanced training for health professionals.

Section 119. Retention bonus

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

Current law: Section 1616j permits the Secretary to provide retention bonuses for health professions where recruitment or retention is difficult if the individual has completed 3 years of employment and any service obligation from federal scholarships or loan repayment programs. Rates for retention bonuses may cover multiple years, but not exceed an annual rate of $25,000. Refunds shall be required if the health professional does not complete the term of service under any retention agreement, unless the default is not the fault of the individual.

Section 120. Nursing residency program

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

Current law: Section 1616k establishes a program to enable nurses working for an Indian Health Program or Urban Indian Organization to pursue advanced training. The participants are required to enter a service obligation. The program shall include a combination of education and work study leading to either an associate or bachelor's degree in nursing degrees or a Master's degree.

Section 121. Community health aide program

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

Current law: Section 1616e directs the Secretary to develop and operate a Community Health Aide Program in Alaska. Requirements are specified for the Alaska program including the (1) development of training and curriculum combining theory and practical experience, (2) instruction in acute care, health promotion, (3) establishment of a certification Board, and (4) development of systems for continuing education and supervision.

Section 122 Tribal health program administration

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

Current law: Section 1616n requires the Secretary to provide training in the administration and planning of Tribal Health Programs.

Section 123. Health professional chronic shortage demonstration programs

This section amends current law by changing a lone pilot program to address health professional shortages into a national demonstration project.

Current law: Section 1616o authorizes the Secretary to make a grant to the School of Medicine at the University of South Dakota to fund a pilot program on an Indian reservation at one or more service units in South Dakota to address the chronic manpower shortages in the Aberdeen Area of the IHS. The pilot program shall incorporate a program advisory board composed of representatives from the tribes and Indian communities which are served by the program.

Section 124. National health service corps

This section maintains current law and adds urban Indian health programs within the protections against removal of any member of the Corps working in the programs. The section also exempts National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service from full-time equivalent limitations when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

Current law: Section 1680b prohibits the Secretary from removing a member of this Corps from an Indian health program or withdrawing funding to support such member, unless the Secretary ensures that Indians will experience no reduction in services.

Section 125. Substance abuse counselor educational curricula demonstration programs

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

Current law: Section 1665j allows the Secretary to enter into contracts with or make grants to colleges and universities (including tribal) to establish demonstration programs developing curricula for substance abuse counseling. Duration and renewal of the grant are both for periods of one year each. The section also states the criteria for review and approval of the applications, requires the Secretary to provide technical and other assistance to grant recipients, requires the Secretary to submit an annual report to the President for inclusion in the annual report to Congress and defines the term "educational curriculum" and "eligible community college".

Section 126. Behavioral health training and community education programs

This section maintains current law and (1) adds tribal organizations and urban Indian organizations as participants in the pro-

gram, (2) clarifies that the tribal and urban Indian organizations are part of the consultation process, (3) changes the focus from solely on mental health to behavioral health and (4) eliminates the requirement that the staff be assigned primarily to the IHS Service Units.

Current law: Section 1621h(d) requires the Secretary, with the Secretary of the Interior and in consultation with representatives of the Indian Tribes, to conduct a study and compile a list of certain types of staff positions within the Bureau of Indian Affairs, the Service and Indian Tribes, which should include training in any aspect of mental illness, dysfunction, or self-destructive behavior. The Secretary is then required to provide training criteria appropriate for each type of position and ensure that this training is provided. On request of the appropriate Indian entity, the Secretary is required to develop and implement a program of community education on mental illness, as well as technical assistance to tribal entities to obtain and develop community education materials. Within 90 days of enactment of this Act, the Secretary is required to develop a plan to increase mental health services by at least 500 staff positions within 5 years, with at least 200 of such positions devoted to child, adolescent, and family services. Such staff would be assigned primarily to the IHS service unit levels.

Section 127. Authorization of appropriations

Section 127 authorizes appropriations as are necessary to carry out this title for each fiscal year through 2015.

TITLE II—HEALTH SERVICES

Section 201. Indian Health Care Improvement Fund

This section maintains current law and adds provisions clarifying that the Secretary may expend funds either directly or through contracts or compacts under the Indian Self-Determination and Education Assistance Act, as well as provisions regarding the use of telemedicine and Traditional Health Care Practices.

Current law: Section 1621 authorizes the use of funds, designated as the "Indian Health Care Improvement Fund", for the purposes of eliminating the deficiencies in health status and resources for tribes; eliminating backlogs and meeting the needs in health care services; eliminating the inequities in funding for direct care and contract health service programs; and augmenting the ability of the Indian Health Service to meet its various responsibilities. Funding authorized by this section may not be used to offset appropriated funds and must be used to improve the health status and reduce the resource deficiencies of tribes. This section also defines "health status and resource deficiency" and requires that Tribal Health Programs be equally eligible for funds as the IHS. A report is required to be submitted to Congress 3 years after enactment which addresses the current health status and resource deficiency for each Service Unit. Funds appropriated under this section are to be included in the base budget of the IHS for determining appropriations in subsequent years. Finally, nothing in this section is intended to diminish the primary responsibility of the IHS to eliminate backlogs in unmet health care, or to discourage additional efforts of IHS to achieve parity among Tribes.

Section 202. Catastrophic Health Emergency Fund

This section maintains current law and adds language which requires the use of negotiated rulemaking for promulgation of regulations issued for this section.

Current law: Section 1621a establishes the Catastrophic Health Emergency Fund (CHEF) to be administered by the Secretary through the central office of the Indian Health Service in order to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. No part of the CHEF or the administration thereof is to be subject to contract or grant, nor shall these funds be apportioned on an Area Office, Service Unit, or other similar basis. The Secretary is required to promulgate regulations for the administration of these funds. This section prohibits funds appropriated to CHEF from being used to offset or limit other appropriations made to the Indian Health Service. It also requires that all reimbursements to which the Service is entitled from any source by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF be deposited into CHEF.

Section 203. Health promotion and disease prevention services

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

Current law: Section 1621b directs the Secretary to provide health promotion and disease prevention services to Indians in order to meet the Act's health status objectives. An evaluation statement of the resources required to undertake these health promotion and disease prevention activities would be included in a required report to Congress.

Section 204. Diabetes prevention, treatment, and control

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

Current law: Section 1621c requires the Secretary to determine the incidence of this disease and its complications among Indians and the measures needed to prevent, treat and control it. The Secretary is also required to screen Indians for diabetes and for conditions which indicate a high risk for diabetes. The Secretary is required to continue to fund model diabetes projects (and under S. 1057, dialysis programs). To the extent that funding is available, the Secretary is required to work with each Area Office to establish patient registries in Area Offices and ensure that data collected are disseminated to other Area Offices, subject to privacy laws. The

Secretary is also allowed to maintain diabetes control officers in each Area.

Section 205. Shared services for long-term care

This section amends current law by changing a demonstration project into a permanent program and adding new provisions which (1) authorize other services similar in nature to long-term care and construction for facilities for the similar services and (2) encourage the use of existing underused facilities or allow the use of swing beds for long-term or similar care.

Current law: Section 1680l allows the Secretary to enter contracts for 6 demonstration projects to deliver long-term care services to Indians which may also authorize sharing of staff, construction and proportionate allocation of funding between the tribes and IHS. Any nursing facility funded under this section must meet the requirements for such facilities under section 1919 of the Social Security Act. In addition, the Secretary is required to provide necessary technical and other assistance to enable applicants to comply with the provisions of this section.

Section 206. Health services research

This section amends current law by (1) eliminating the specific set-aside of $200,000 for research and replacing it with general authority to fund research for Indian health programs, instead of only the IHS, (2) requiring the Secretary to coordinate, to the extent practical, the resources and activities for Indian health research needs, and (3) authorizing the funding for both clinical and nonclinical research.

Current law: Section 1621g authorizes funding for research to further the performance of the health service responsibilities of the IHS. Indian tribes and tribal organizations contracting under the Indian Self-Determination and Education Assistance Act are to be given equal opportunity to compete for these research funds.

Section 207. Mammography and other cancer screening

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

Current law: Section 1621k requires the Secretary to provide for mammography for Indian women 35 years or older at a frequency determined by the Secretary in consultation with the National Cancer Institute and consistent with appropriate standards to ensure the safety and accuracy of the mammogram under the Social Security Act.

Section 208. Patient travel costs

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

Current law: Section 1631l requires the Secretary to provide funds for the travel costs of patients, for emergency and non-emer-

gency air transport where ground transport is not feasible, associated with receiving health care services.

Section 209. Epidemiology centers

This section amends current law by (1) maintaining the centers in existence on the date of passage of this Act, but still requiring the establishment of centers in the remaining Areas without reducing funds for the existing centers, (2) allowing the funding for any new centers to be administered, but not divisible, by tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act, but no longer by tribal consortia and (3) eliminating the requirements that the Secretary establish the data and formats for reporting and establish the system for monitoring progress toward the health objectives.

Current law: Section 1621m requires the Secretary establish epidemiology centers in each Service Area. Newly established centers may be operated by Tribal Health Programs. The functions of these centers are delineated in this section. The Director of the Centers for Disease Control and Prevention is required to provide technical assistance to the centers and the Secretary is authorized to provide funding to Tribes and Tribal Organizations to conduct epidemiological studies of Indian communities.

Section 210. Comprehensive school health education programs

This section maintains current law and adds language which (1) clarifies the types of purposes for which the funds may be used such as for both regular school and after school programs, for the benefit of Indian and urban Indian children, for oral health programs, for violence prevention and for other health issues as appropriate, (2) includes tribal organizations and urban Indian health organizations as eligible for funding, (3) consolidates the reporting requirements into the application criteria which is now subject to consultation between the Secretary and the Indian tribes, tribal organizations and urban Indian organizations.

Current law: Section 1621n allows the Secretary to provide grants to Indian Tribes for the development of comprehensive school health education programs for children from pre-school through grade 12. The specific purposes for which funds may be used are delineated. Upon request, the Secretary is required to provide technical assistance in the development and dissemination of comprehensive health education plans, materials and information. The Secretary shall establish criteria for review and approval of applications for this funding. For Bureau of Indian Affairs funded schools, the Secretary of the Interior shall develop similar programs.

Section 211. Indian Youth Program

This section maintains current law and adds tribal organizations and urban Indian organizations as participants in the program and consultation and includes urban Indian youth as beneficiaries of program services.

Current law: Section 1621o allows the Secretary to establish and administer programs for innovative mental and physical disease prevention and health promotion and treatment for Indian preadolescent and adolescent youths. Allowable and prohibited uses of

the funds authorized by this section are delineated. The Secretary is required to disseminate information regarding models for delivery of comprehensive health care services to Indian youth; to encourage the implementation of these models; and to provide technical assistance upon request. The Secretary will establish criteria for review and approval of applications under this section.

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

This section amends current law by expanding the communicable diseases from simply tuberculosis to other communicable and infectious diseases, by encouraging the Indian tribes to coordinate with the Centers for Disease Control, by eliminating superfluous provisions which reduce the grant amount for expenses incurred by the federal government or for supplies or equipment furnished to the grant recipient.

Current law: Section 1621q authorizes the Secretary to fund projects specifically for the purpose of preventing, controlling and eliminating tuberculosis. Funding is also authorized for public information and education programs, and skills improvement activities. Funding under this section requires an application or proposal for funding. Entities which receive funding under this section must provide assurances they will coordinate their activities with the Centers for Disease Control and Prevention as well as State and local health agencies. Finally, in carrying out this section, the Secretary may provide technical assistance upon request and shall submit a report to Congress on the use of the funds and the progress made toward prevention, control, and elimination of tuberculosis among Indians.

Section 213. Authority for provision of other services

This section amends current law by making permanent a demonstration project for home- and community-based care. The new provisions also (1) add special requirements for the home- and community-based care, (2) add several definitions, and (3) eliminate the exclusion of cash payments, room and board, construction and nursing facility services.

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

Section 214. Indian women's health care

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

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

Section 215. Environmental and nuclear health hazards

This section maintains current law and adds language which (1) requires ongoing monitoring of trends in health hazards to Indians and other environmental hazards to Indian communities, (2) provides additional considerations for the studies conducted under this section and (3) requires consultation with Indian tribes and tribal organizations in developing plans for addressing the health problems.

Current law: Section 1677 requires the Secretary, in conjunction with other Federal agencies, to conduct studies to determine trends in the health hazards to Indian miners and other Indians as a result of nuclear resource development. Upon completion of such studies, the Secretary shall develop health plans to address the health problems studied. The Secretary is required to submit the study to Congress 18 months after the date of enactment and a report no later than 1 year after the study which includes recommendations for the implementation of the plan and evaluation activities. This section establishes an Intergovernmental Task Force to identify environmental hazards and to take corrective action. The Secretary is to chair this task force, which shall meet at least twice yearly. If an Indian, who is employed in or around any environmental hazard, suffers from a work-related condition, the Indian Health Program which treats him may be reimbursed by the Indian's employer.

Section 216. Arizona as a contract health service delivery area

This section maintains current law and extends the date to 2015, instead of 2000, for the designation as a contract health service delivery area.

Current law: Under Section 1678, the State of Arizona is designated as a contract health service delivery area for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona effective fiscal years 1984 to 2000. The Indian Health Service will not curtail any services as a result of this provision.

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

This section is new.

New provisions: The States of North Dakota and South Dakota are designated as one contract health service delivery area for the purpose of providing contract health care services to members of federally recognized Indian Tribes in North and South Dakota. The Indian Health Service will not curtail any services as a result of this provision.

Section 217. California Contract Health Services Program

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

Current law: Section 1621j requires the Secretary to establish a demonstration project using the California Rural Indian Health

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

Section 218. California as a contract health service delivery area

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

Current law: Section 1680 designates the State of California, excluding certain specified counties, as a contract health service delivery area for providing contract health care services to California Indians.

Section 219. Contract health services for the Trenton service area

This section maintains current law.

Current law: Section 1680e directs the Secretary to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in North Dakota and the counties of Richland, Roosevelt, and Sheridan in Montana. This section does not expand the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for these services that applied on May 1, 1986.

Section 220. Programs operated by Indian tribes and tribal organizations

This section maintains current law, but eliminates language which limits the particular use of funds for which the Indian tribes and tribal organizations can receive funding on the same basis as the IHS.

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

Section 221. Licensing

This section is new.

New provision: Section 221 requires that health care professionals employed by a Tribal Health Program shall, if licensed in

any State, be exempt from the licensing requirements of the State in which the Tribal Health Program provides the services.

Section 222. Notification of provision of emergency contract health services

This section maintains current law.

Current law: Section 1646 allows 30 days (as a condition of payment) for an elderly or disabled Indian to notify the Service of any emergency care or health services received from a non-Service provider or in a non-Service facility.

Section 223. Prompt action on payment of claims

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

Current law: Section 1621s provides a deadline for the Service to respond to notification of a claim by a provider of a contract care service. The section also provides that if the Service fails to respond within the required time, the Service shall accept the claim as valid. The IHS shall pay a completed claim within 30 days after completion of the claim.

Section 224. Liability for payment

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

Current law: Section 1621u provides that a patient who receives authorized contract health care services will not be held liable for any charges or costs associated with those authorized services. In addition, the Secretary is required to notify the provider of such services and the patient who receives them of the same, within a specified time.

Section 225. Office of Indian Men's Health

This section is new.

New provision: Section 225 directs the Secretary to establish the Office of Indian Men's Health, which shall be headed by a Director, to coordinate and promote the health status of Indian men. The Secretary is also required to submit a report to Congress within two years of enactment, describing any activity and finding of the Director.

Section 226. Authorization of appropriations

This section maintains current law, but extends the authorization to 2015 and eliminates the references to specific sections which had a separate authorization period.

Current law: Section 226 authorizes appropriations as necessary to carry out this title, for each fiscal year through 2000, except for certain specific sections.

TITLE III—FACILITIES

Section 301. Consultation; construction and renovation of facilities; reports

This section maintains current law and adds language which (1) expands the accrediting bodies whose standards may be met for

construction, (2) requires an evaluation of the impact of a proposed closure prior to closing, (3) requires the Secretary to establish a health care facility priority system developed through negotiated rule-making which prioritizes certain types of facilities such as outpatient, specialized care facilities, (4) adds specific requirements for the report to be submitted to Congress such as the types of facilities to be included, the method for evaluating the needs, the opportunity for nomination of facilities and consultation, (5) requires the Secretary to consult and cooperate with Indian tribes in finding innovative approaches to meet the facilities needs; and (6) requires a GAO study of the baseline facility needs and requires the Secretary to update this report every 5 years.

Current law: Section 1631 requires consultation with Indian tribes prior to expending construction funds. In addition, it sets forth requirements to be met prior to closing any facility. This section also establishes and defines criteria for closure of health care facilities and sets forth reporting requirements.

Section 302. Sanitation Facilities

This section maintains current law and adds language which (1) establishes priority funding for emergency repairs and operation or maintenance to avoid imminent health threats or to protect the investment in health benefits gained through the sanitation facilities, (2) prohibits the use of IHS funding for new homes constructed using Department of Housing and Urban Development funds, (3) allows the Secretary to accept funds from all federal sources and may place those funds in ISDEAA agreements for sanitation facilities construction, (4) authorizes the Secretary to allows certain funding to be used to fund tribal loans or matching or cost participation requirements to construct sanitation facilities, (5) requires the Secretary enter into interagency agreements for financial assistance, (6) requires standards for planning, design and construction of sanitation facilities to be developed through negotiated rule-making, (7) requires consultation with Indian tribes in developing the 10-year plan for sanitation facilities, (8) establishes an Indian tribe's primary responsibility for collecting user fees and the Secretary's responsibility in assisting tribes when the facility is threatened with imminent failure, (9) clarifies the information required to be in the annual report and, (10) sets forth the definitions of the different levels of deficiencies.

Current law: Section 1632 provides the findings, certain duties for sanitation, authorized uses of sanitation funding and facilities, and reporting requirements, and establishes the deficiency levels for those facilities. This section requires training or technical assistance in the operation and maintenance of sanitation facilities. The Secretary is also required to submit a report to Congress on the status of sanitation facilities backlog and a 10-year plan for addressing it.

Section 303. Preference to Indians and Indian firms

This section maintains current law and adds new language to clarify rates of pay requirements and other wage requirements similar to local rates as determined by the Indian tribes.

Current law: Section 1633 authorizes the Secretary to use Indian preference for certain construction activities.

Section 304. Expenditure of nonservice funds for renovation

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

Current law: Section 1634 authorizes the Secretary to accept any expansion or renovation funded with non-Service funds in accordance with certain criteria. The Secretary is required to maintain a separate priority list for these facilities.

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

This section maintains current law and adds language which requires the funding to be used for the portion of costs which benefits the eligible population, but exempts from the specific eligibility requirements applicants whose principal health administration offices are located where there is no road system providing direct access to inpatient hospitals.

Current law: Section 1636 establishes criteria for small ambulatory care facilities, including use of funds, grant application requirement priorities, and conditions for reversion of facilities.

Section 306. Indian health care delivery demonstration project

This section maintains current law and adds language which (1) requires consultation, (2) permits the use of IHS funds to match other funds, and (3) authorizes regulations to be developed through negotiated rule-making.

Current law: Section 1637 authorizes the Secretary to establish demonstration projects to test alternative health care delivery systems through the construction and renovation of hospitals, health centers, health stations and other facilities. Section 1637 establishes criteria for the projects such as the need for such facility, number of Indians to be served, the economic viability of the project, and the administrative and financial capability of Indian tribes or Tribal Organizations to administer the project. This section also requires technical assistance and use of the same criteria in evaluating tribal and IHS facilities.

Section 307. Land transfer

This section amends current law by changing a specific authorization into a general authorization whereby Federal agencies may transfer, at no cost, land and improvements to the IHS for the provision of health care services, and the Secretary is authorized to accept the land.

Current law: Section 1638 provides specific authorization for transferring 5 acres of land at the Chemawa Indian School to the IHS.

Section 308. Leases, contracts and other agreements

This section maintains current law and adds tribal organizations as eligible lessors.

Current law: Section 1674 authorizes the Secretary to enter into leases, contracts or other agreements with Indian Tribes for the delivery of health services at those facilities. The leases may also include provisions for construction, renovation and compensation.

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

This section is new.

New provisions: Section 309 authorizes a study, using consultation, to determine the feasibility of a loan or loan guarantee fund for Indian health care facilities construction. A number of study requirements are delineated such as the maximum principal amount and term of the loan that should be offered, amount attributable for planning, appropriate security for the loan, and legislative or regulatory changes needed.

Section 310. Tribal leasing

This section is new.

New provision: Section 310 authorizes a tribal health program to lease permanent structures without prior approval in appropriation Acts.

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

This section maintains current law and adds (1) tribal organizations to the eligible participants and those tribes that have begun, but not completed the process of acquisition or construction of a health care facility, (2) requires the criteria to be developed through negotiated rule-making, (3) requires negotiation for the continued operation of the facility at the end of the 10-year lease, (4) authorizes recovery in a proportional amount from the IHS if the IHS ceases to use the facility within the 10-year lease period, and (5) includes staff quarters in the definition of the health facilities under this section.

Current law: Section 1680h(e) authorizes the Secretary to enter joint ventures with Indian Tribes, and provide staffing, equipment and supplies for the operation of the facility under a no-cost 10-year lease with the Indian Tribes in exchange for the tribal construction of the facility, in accordance with certain criteria.

Section 312. Location of facilities

This section maintains current law and adds language which (1) allows an Indian owner to request that the IHS locate facilities on his or her lands within tribal jurisdiction, subject to the priority for location being given to the Indian tribe and (2) adds, as part of the Indian lands for consideration under this section, all lands in Alaska owned by any Alaska Native village, or regional corporation under the Alaska Native Claims Settlement Act, or land allotted to an Alaska Native.

Current law: Section 1680n sets forth certain priorities in locating health care facilities on Indian lands to address unemployment conditions in the economically depressed Indian communities, if requested by the Indian tribe with jurisdiction over the Indian lands. Section 1680n also defines "Indian lands".

Section 313. Maintenance and improvement of health care facilities

This section is new.

New provisions: Section 313 requires reporting of backlogs in maintenance and improvements for facilities and authorizes the use of funds to construct a replacement facility if the costs of renovation would exceed a maximum threshold cost to be developed through negotiated rule-making.

Section 314. Tribal management of federally-owned quarters

This section is new.

New provisions: Section 314 authorizes Tribal Health Programs operating a health care facility and federally-owned quarters pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act to establish reasonable rental rates for the federally-owned quarters and directly collect the rent. These quarters shall remain eligible for improvement and repair funds as other federally-owned quarters. The Tribal Health Programs operating the quarters are required to provide at least 60 days notice before changing the rental rate.

Section 315. Applicability of Buy American Act requirement

This section maintains current law, but exempts Indian tribes and tribal organizations from the requirements of the Buy American Act and eliminates a reporting requirement for purchases from FY 1993 to FY 1994.

Current law: Section 1638b requires application of the Buy American Act for all procurement.

Section 316. Other funding for facilities

This section is new.

New provisions: Section 316 authorizes the Secretary to accept funding from other sources for the construction of health care facilities and to transfer such funds to Indian tribes. The Secretary may also enter into interagency agreements for the planning, design and construction of health care facilities.

Section 317. Authorization of appropriations

This section maintains current law (found in Section 1638a), but extends the authorization for appropriations through fiscal year 2015.

TITLE IV—ACCESS TO HEALTH SERVICES

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

This section maintains current law and adds (1) tribal organizations and urban Indian organizations, in addition to tribes and the IHS for whom reimbursements would not be considered in determining appropriations, and (2) expands the authorized uses of the reimbursements from improvements only to hospitals or skilled facilities to also include programs and the excess used to reduce health deficiencies, subject to consultation by the Indian tribes. However, this provision authorizing the Secretary to determine the uses shall not apply when the Indian tribes elect to receive reimbursements directly.

Current law: Sections 1641 and 1642 require that any Medicare or Medicaid payments received by the IHS or Indian tribes shall not be considered in determining appropriations for health care services, and that Indians without Medicare or Medicaid are given equal consideration as those Indians are who are covered by these programs. Section 1645 established a program under which tribes could elect to directly bill and be reimbursed health care services provided under Medicare, Medicaid or other third parties. Specifications are made as to how funds collected from Medicare or Medicaid are to be used.

Section 402. Grants to and contracts with the service, Indian tribes, tribal organizations, and urban Indian organizations

This section maintains current law and adds provisions which outline the agreements between the Secretary and the tribes, tribal or urban Indian organizations to improve the enrollment of Indians in the Social Security Act programs.

Current law: Section 402 requires the Secretary to make grants or enter into contracts with Tribes and Tribal Organizations to improve enrollment and participation in Medicare, Medicaid or SCHIP programs, such as paying premiums. In doing so, the Secretary shall place conditions as deemed necessary to effect the purpose of such funding. Additional agreements may be made in order to improve the receipt and processing of applications for enrollment of Indians under Social Security Act programs and to facilitate cooperation between States, the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations.

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

This section maintains current law and adds language (1) to enable urban Indian organizations to seek recovery from third parties, (2) to require reasonable efforts be taken to provide notice to the patient either before or during the pendency of the action, (3) to limit the IHS right of recovery against a tribal self- insured plan absent written consent from the tribe, (4) to include awards of reasonable attorneys fees and costs of litigation, (5) to prohibit denial of reimbursement on the basis of a different format or form.

Current law: Section 403 allows an Indian Tribe or Tribal Organization to recover payment from third parties for health services provided to the same extent that an individual, or any nongovernmental provider of health services, would be eligible to receive damages, reimbursement, or indemnification. This right of recovery is extended against any State under certain conditions. Certain State or local laws are deemed nonapplicable to prevent or hinder this right of recovery. This section has no effect on private rights of action. Enforcement measures for the right of recovery are all specified in this section.

Section 404. Crediting of reimbursements

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

Current law: Section 404 authorizes the retention of the reimbursements received from third parties and specifies the use of those amounts collected. This section also disallows any offset or

limitation of amount obligated to any Service Unit, Indian Tribe or Tribal or Urban Indian Organization because of the receipt of reimbursements under this section.

Section 405. Purchasing health care coverage

This section is new.

New provisions: Section 405 allows funding to be used for purchasing health insurance for Indians or to be used for a tribal self-insurance plan and eliminates the study previously required to determine the feasibility of allowing Indian tribes to purchase managed care coverage for their members and the report to Congress on the study.

Section 406. Sharing arrangements with Federal agencies

This section amends current law by (1) authorizing the Secretary to enter agreements for sharing of medical facilities with the Departments of Veterans Affairs and Defense, instead of merely examining the feasibility of entering the agreements, (2) requiring consultation with Indian tribes prior to entering the agreements, (3) require reimbursement to the IHS, tribes, or tribal organizations by the VA where VA eligible beneficiaries receive care from the IHS, tribes or tribal organizations, (4) eliminating the specific cross-utilization of services in Utah only (expanding it generally), and (5) authorizing the Director of IHS to enter into interagency agreements to assist in achieving parity in services for Indians.

Current law: Section 406 authorizes the Secretary to examine the feasibility of entering agreements to share medical facilities and services with the Departments of Veterans Affairs and Defense. The Secretary shall not take action which would impair priority access to or quality of care for Indians at IHS or priority of veterans to care by the Veterans' Administration.

Section 407. Payor of last resort

This section is new.

New provision: Section 407 codifies long-standing policy and specifies that Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to eligible persons.

Section 408. Nondiscrimination in qualifications for reimbursement for services

This section is new.

New provision: Section 408 codifies regulations under Title 42 of the Code of Federal Regulations and deems entities that are operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization to be licensed or recognized under State or local law to furnish such services, for purposes of receiving payment or reimbursement from any federally funded health care program so long as these entities meet all applicable standards for licensure.

Section 409. Consultation

This section is new.

New provision: Section 409 codifies the Centers for Medicaid and Medicare Services charter which recognized the Tribal Technical

Advisory Group established to assist the Secretary in identifying and addressing issues affecting Indians in health care programs under the Social Security Act. It also encourages a State to establish a process to seek advice on a regular basis from designees of Indian Health Programs and Urban Indian Organizations.

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

This section is new.

New provision: Section 410 allows the Secretary to enter arrangements with individual States to allow SCHIP funds for Indians to be provided to Indian Health Programs for providing child health assistance to targeted low-income Indian children, consistent with the purposes of SCHIP.

Section 411. Social Security Act sanctions

This section is new.

New provision: Section 411 allows Indian Health Programs to request a waiver of a sanction imposed against a health care provider in the event the State does not act upon a tribal request to the State to seek the waiver. A safe harbor clause from anti-kickback sanctions is included in this section for referrals, transactions or exchanges between and among Indian Health Care Programs.

Section 412. Cost sharing

This section is new.

New provisions: Section 412 addresses coinsurance, copayments, and deductibles, and exempts Indians from such cost sharing. Section 412 provides an exemption from premium payments for Indians eligible for Medicaid and SCHIP programs. Section 412 also excludes certain trust, restricted, cultural or subsistence Indian property from the Medicaid eligibility determinations or Medicaid estate recovery.

Section 413. Treatment under Medicaid managed care

This section is new.

New provisions: Section 413 specifies actions to be taken for payment for services furnished to Indians in Medicaid managed care programs. This section also allows Medicaid managed care programs to be offered by Indian Health Programs and provides the requirements for these programs.

Section 414. Navajo Nation Medicaid Agency feasibility study

This section is new.

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

Section 415. Authorization of appropriations

This section maintains current law and extends the authorization for appropriations to fiscal year 2015.

Current law: Section 415 authorizes appropriations of such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this title.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Section 501. Purpose

This section maintains current law and adds language to maintain and make health services available, in addition to being accessible to urban Indians.

Current law: Section 1651 sets forth the purpose of the title which is to establish programs in urban center to make health care accessible to urban Indians.

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

This section maintains current law.

Current law: Section 1652 sets forth the authority of the Secretary to enter contracts with or make grants to Urban Indian Organizations including prescribing the criteria for selecting urban Indian organizations and making recommendations for improving health programs for urban Indians.

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

This section maintains current law.

Current law: Section 1653 sets forth the standards, criteria and uses of funds for contracts and grants for health care services. The grants require that the urban Indian organization estimate the service population, health care needs and status of the urban Indians, provide basic health education and make recommendations for improving health programs. The grants may be made to provide outreach, educational, outpatient behavioral health services, develop innovative service delivery models, health promotion and immunization services.

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

This section maintains current law.

Current law: Section 1654 authorizes the Secretary to enter into contracts under the Snyder Act, 25 U.S.C. 13, to urban Indian organizations who does not have a contract under section 1654. Section 1654 sets forth the standards, criteria and uses of funds for contracts and grants to determine unmet health care needs of urban Indians.

Section 505. Evaluations; renewals

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

Current law: Section 1655 authorizes the Secretary to develop evaluation and renewal standards for the various contracts and grants. The Secretary shall also evaluate the urban Indian programs through onsite annual evaluations.

Section 506. Other contract and grant requirements

This section maintains current law and adds provisions which would allow lump sum payments unless the urban Indian organiza-

tion is not capable of administering the payments in their entirety and allows the funding to be carried forward.

Current law: Section 1656 sets forth other specific contract and grant requirements such as payment methods, procurement and amendments.

Section 507. Reports and records

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

Current law: Section 1657 sets forth certain reporting and recordkeeping requirements for Urban Indian Organizations.

Section 508. Limitation on contract authority

This section maintains current law and adds language which includes authority to award grants.

Current law: Section 1658 limits contracts to the amount of appropriations.

Section 509. Facilities

This section maintains current law and adds provisions which would allow for leasing, purchasing, renovating, constructing and expanding, in addition to repairing, facilities and authorizes a study for a revolving loan fund to construct facilities.

Current law: Section 1659 sets forth the various requirements governing the funding for urban health care facilities and authorizes the Secretary to make funds available to contractors or grant recipients to make minor renovations to the urban health facilities to meet or maintain compliance with the requirements of the Joint Commission on Accrediting Health Care Organizations.

Section 510. Division of urban Indian health

This section maintains current law, but changes the Branch of Urban Indian programs into an Office within the IHS.

Current law: Section 1660 establishes a Branch of Urban Indian Health within the IHS.

Section 511. Grants for alcohol and substance abuse related services

This section maintains current law.

Current law: Section 1660a authorizes the Secretary to make grants for alcohol and substance abuse services to urban Indian organizations. Section 511 also establishes criteria for alcohol and substance abuse grants.

Section 512. Treatment of certain demonstration projects

This section maintains provisions which makes permanent certain demonstration projects in Oklahoma and requires them to meet the requirements of Title V, but will be treated as service units, and the funding shall not be subject to the ISDEAA.

Section 513. Urban NIAAA transferred programs

This section maintains current law, but changes the date of the transfer from September 30, 2001 to September 30, 2008.

Current law: Section 1660c authorizes the Secretary to transfer to Urban Indian Organizations alcohol programs that had been previously transferred to the Secretary.

Section 514. Consultation with urban Indian organizations

This section is new.

New provision: Section 514 establishes consultation requirements with Urban Indian Organizations including a definition of consultation.

Section 515. Federal Tort Claim Act coverage

This section is new.

New provision: Section 515 authorizes Urban Indian Organizations to be deemed an executive agency for Federal Tort Claim Act coverage.

Section 516. Urban youth treatment center demonstration

This section is new.

New provision: Section 516 authorizes the Secretary to fund at least 2 Indian youth treatment centers in certain states where urban centers are located.

Section 517. Use of Federal Government facilities and sources of supply

This section is new.

New provisions: Section 517 authorizes the Urban Indian Organizations to receive donations of Federal excess property and, for purposes of 40 CFR 501, and deems them to be executive agencies for access to the Federal sources of supply.

Section 518. Grants for diabetes prevention, treatment and control

This section is new.

New provisions: Section 518 authorizes the Secretary to make grants for diabetes prevention, treatment and control. Section 518 sets forth requirements and criteria for diabetes grants, such as the size and location of the urban Indian population, the need and performance standards.

Section 519. Community health representatives

This section is new.

New provision: Section 519 authorizes the Secretary to contract with the urban Indian organizations to provide community health representatives.

Section 520. Effective date

This section is new.

New provision: Section 520 establishes that the effective date for the amendments made by this Act begins on the date of enactment regardless of whether the Secretary has issued regulations.

Section 521. Eligibility for services

This section is new.

New provision: Section 521 establishes that urban Indians are the ultimate beneficiaries of the services under this title.

Section 522. Authorization of appropriations

This section maintains current law and extends the authorization to fiscal year 2015.

Current law: Section 522 authorizes appropriations through fiscal year 2015.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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

This section amends current law by changing the position of the Director into an Assistant Secretary.

Current law: Section 1661 establishes the Indian Health Service within the Public Health Service of the Department, and the position of Director of the Indian Health Service who shall be confirmed by the Senate with a term of four years. The Director shall administer the Indian Health Service and the Director's duties and responsibilities are outlined in this section, including managing funds, entering contracts, all functions relating to the management of hospitals and facilities.

Section 602. Automated management information system

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

Current law: Section 1662 requires the Secretary to establish an automated management information system for the Service and each Tribal Health Program. It requires that patients have access to their own health records.

Section 603. Authorization of appropriations

This section maintains current law and extends the authorization to fiscal year 2015.

Current law: Section 1663 authorizes appropriated funds in sums that may be necessary to carry out this title, for each fiscal year through fiscal year 2000.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

Section 701. Behavioral health prevention and treatment services

This section maintains current law and adds language which (1) authorizes the Secretary, Indian tribes, tribal organizations, and urban Indian organizations to develop programs which emphasize collaboration for behavioral health, (2) requires technical assistance to Indian tribes, tribal and urban Indian organizations, (3) requires a continuum of care for behavioral health to the extent feasible including acute hospitalization, detoxification, and emergency shelter.

Current law: Section 1621h and Section 1665 state the purposes of the section; requires the Secretary to encourage the development of plans for delivery of Indian mental Health Services; directs the Secretary to provide comprehensive mental health care programs;

facilitates the governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization to establish community mental health plans; requires the Secretary to coordinate mental health planning; and directs the Secretary to assess the need, availability and cost for inpatient mental health care for Indians.

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

This section maintains current law and adds language which requires the Secretary to update existing Memoranda of Agreement and adds tribal organizations and to consult with Indian tribes, tribal and urban Indian organizations in developing the Memoranda which shall be published in the Federal Register.

Current law: Section 1621h(b) requires the Secretary to develop and enter memoranda of agreement with the Secretary of the Interior to, among other things, make a comprehensive assessment, coordination, and annual review of all the behavioral health care needs and services available or unavailable to Indians. Specific provisions that are required in this memorandum are delineated.

Section 703. Comprehensive Behavioral Health Prevention and Treatment Program

This section amends current law by changing the alcohol and substance abuse focus to comprehensive behavioral health and adds more specific types of treatment such as residential and intensive outpatient treatment and by requiring consent of Indian tribes to be served before the Secretary enters contracts with private or other public health providers to provide the services under this section.

Current law: Section 1665a requires the Secretary to provide a program of comprehensive behavioral health, prevention, treatment, and aftercare. The Secretary may provide these services through Contract Health Services.

Section 704. Mental Health Technician Program

This section maintains current law and adds the use and promotion of traditional health care practices.

Current law: Section 1621h(g) establishes a mental health technician program within the Service, requiring high-standard paraprofessional training in mental health care, supervision and evaluation of technicians.

Section 705. Licensing requirement for mental health care workers

This section maintains current law.

Current law: Section 1621h(l) requires that any person employed as a psychologist, social worker, or marriage and family therapist, be licensed to provide those services or be supervised by one who is licensed.

Section 706. Indian women treatment programs

This section maintains current law and adds language which requires the implementation of this section to be consistent with section 701, recognizes the behavioral health focus and requires consultation with Indian tribes and tribal organizations in establishing criteria for applications.

Current law: Section 1665b authorizes funding to develop and implement a program of prevention, intervention, treatment, and relapse prevention services for alcohol and substance abuse, specifically addressing the cultural, historical, social, and childcare needs of Indian women. How funds are to be used is specified in this section, including the development of community training, counseling and prevention models.

Section 707. Indian Youth Program

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

Current law: Section 1665c requires the development and implementation of a program for detoxification and rehabilitation of Indian youth. It also establishes alcohol and substance abuse treatment centers or facilities for Indian youth. Additional provisions addressed in this section are: intermediate adolescent behavioral health services; use of Federally owned structures; rehabilitation and aftercare services; inclusion of family in youth treatment programs; and a study for the feasibility of multi-drug abuse programs.

Section 708. Indian Youth Telemental Health Demonstration Project

This section is new.

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

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

This section amends current law by requiring the establishment in each Area at least one inpatient mental health facility and determining that California shall be considered two Areas.

Current law: Section 1621h(i) states within one year after enactment, the Secretary shall make an assessment of the need for inpatient mental health care facilities, including the conversion of under utilized hospital beds into psychiatric units to meet the needs.

Section 710. Training and community education

This section maintains current law and adds language which authorizes the Indian tribes and tribal organizations to develop training and community education programs, defines community based training, adds child sexual abuse to the types of training authorized and recognizes the behavioral health focus.

Current law: Section 1621h(d) requires that the Secretary, in cooperation with the Secretary of the Interior, provide either directly or through funding, a program of community education in the area of behavioral health. Specifics of instruction are delineated. This section also requires the Secretary to develop and provide community-based training models.

Section 711. Behavioral Health Program

This section maintains current law and adds the tribal organizations as eligible recipients for funding under this section.

Current law: Section 1621h allows for the development of innovative community-based behavioral health programs; suggests criteria to be used for funding such programs; and requires that the same criteria as used in evaluating other funding proposals be used for programs under this section.

Section 712. Fetal alcohol disorder programs

This section maintains current law and adds language (1) requiring these programs to be implemented consistent with section 701, (2) consolidating fetal alcohol syndrome and fetal alcohol effects into fetal alcohol disorders (FAD), (3) authorizing appropriate psychological services, the development of early childhood intervention projects, supportive services, (4) including the National Institute for Child Health and Human Development and the Centers for Disease Control and Prevention in the national task force on FAD.

Current law: Section 1665g authorizes the Secretary to establish fetal alcohol syndrome and effects programs, to include the development and provision of services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities. In addition a Fetal Alcohol Task Force is established to advise the Secretary. Funding is to be made available for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat or provide rehabilitation and aftercare for Indians affected by this disorder. Urban Indians are included and 10% of the funding is set aside for urban programs.

Section 713. Child sexual abuse and prevention treatment programs

This section amends current law by (1) turning two specific demonstration projects into permanent programs, (2) authorizing services for Indian child victims of sexual abuse and perpetrators of child sexual abuse who are members of an Indian household, and (3) including authorized uses of funds such as developing community education, identifying and providing treatment to victims, developing culturally-sensitive prevention models and diagnostic tools, providing treatment to the perpetrators.

Current law: Section 1680i establishes demonstration projects for Child Sexual Abuse and Prevention Treatment Programs through the Hopi Tribe and Sioux Tribes of the Fort Peck Reservation. The Secretary may establish other demonstration projects, but must have an equal number of projects for the Areas.

Section 714. Behavioral health research

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

Current law: Section 1621h provides for funding for research on the incidence and prevalence of behavioral health problems among Indians. Research priorities are specified such as the interrelationship of mental disorders with alcoholism, suicide, homicide, and the incidence of family violence.

Section 715. Definitions

This section is new.

New provisions: Section 715 provides definitions for the following terms used in this title: assessment; alcohol-related neurodevelopmental disorders or ARND; behavioral health aftercare; dual diagnosis; fetal alcohol disorders; fetal alcohol syndrome or FAS; partial FAS; rehabilitation; and substance abuse.

Section 716. Authorization of appropriations

This section maintains current law and extends the authorization to fiscal year 2015 and eliminates the exceptions for sections that had specific terms of authorization.

Current law: Section 1621w authorizes such sums as may be necessary to carry out this section, for each fiscal year through fiscal year 2000, except for section 703, 706, 708, 710 and 711.

TITLE VIII—MISCELLANEOUS

Section 801. Reports

This section maintains current law and adds provisions which either establish new reporting requirements or consolidates the information required in other sections in one organized list such as (1) requiring as part of the annual reports to Congress (a) comparisons of appropriations provided and required for parity in health services, (b) services provided under ISDEAA agreements, (c) information on the loan repayments, infectious diseases, environmental hazards, status of health care and sanitation facilities, sharing of services between the IHS and other federal agencies, and urban Indian programs.

Current law: Section 1671 requires annual reports which outline the progress made in meeting health objectives, whether new national programs are needed, steps taken to consult with Indian tribes, separate statements for funding requested and obligated and other reporting requirements under this Act.

Section 802. Regulations

This section is new.

New provision: Section 802 sets forth the various requirements for regulations, including negotiated rule-making, for certain titles under this Act. Proposed regulations are required to be published in the Federal Register no later than 270 days after enactment. This section authorizes a negotiated rule-making committee consisting of Indian tribes, tribal and urban Indian organizations.

Section 803. Plan of implementation

This new section requires a plan of implementation of this Act to be submitted to Congress.

Section 804. Availability of funds

This section maintains current law.

Current law: Section 1675 authorizes funding to remain available until expended.

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

This section maintains current law.

Current law: Section 1676 recognizes that any limitation contained in DHHS appropriations on the use of federal funds for abortions shall apply for that period with respect to use of IHS funds.

Section 806. Eligibility of California Indians

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

Current law: Section 1679 requires that until other federal law provides otherwise, Indians located in California shall be eligible for health services from under this Act, including members of federally-recognized tribes, descendants of Indians residing in California as of June 1, 1852, Indians holding trust interests in certain types of land, and Indians listed on the plans for asset distribution in California.

Section 807. Health services for ineligible persons

This section maintains current law and adds language to include compacts, in addition to contracts, under the ISDEAA.

Current law: Section 1680c authorizes services for certain ineligible persons under limited circumstances, including spouses or children of eligible Indians, non-Indian women carrying Indian babies, persons in need of emergency stabilization or prevention of communicable diseases, and outlines criteria for providing services such as requiring reimbursement and tribal approval.

Section 808. Reallocation of base services

This section maintains current law.

Current law: Section 1680g limits the reallocation of base funding upon certain requirements, such as reporting to Congress on the proposed changes and likely effects, the Secretary must fulfill.

Section 809. Results of demonstration projects

This section maintains current law.

Current law: Section 1680m requires that results of demonstration projects be made available to Indian tribes.

Section 810. Provision of services in Montana

This section is new.

Current law: Section 810 requires that services and benefits for Indians in Montana be provided consistent with the court decision *McNabb* v. *Bowen,* 829 F.2d 787 (9th Cir. 1987), but that this requirement shall not be construed as the sense of the Congress for Indians in any other state.

Section 811. Moratorium

This section authorizes the Service to provide certain services according to eligibility criteria in effect on a certain date.

Section 812. Tribal employment

This section is new.

New provision: Section 812 recognizes the governmental purposes of health care by treating Indian tribes or tribal organizations not as an employer for certain purposes.

Section 813. Severability provisions

This section retains remaining provisions if others are stricken by any court.

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

This section is new.

New provisions: Section 814 establishes a bi-partisan commission to study the delivery of health care services to Indians and sets forth (1) duties, such as holding hearings, consulting with Indian tribes, making recommendations and findings which have evaluated the needs, services available, costs and mechanisms for funding, (2) membership made up of 25 members, 10 from Congress, 12 chosen by Congressional Members from each IHS Area and shall be members of federally-recognized tribes, 3 chosen by the Assistant Secretary for Indian Health, and (3) reporting requirements. This section (1) authorizes appointment of a Director and staff for the Commission, (2) establishes their compensation, and (3) authorizes details of federal employees, use of mails, technical assistance and administrative support services. This section authorizes $4 million for the Commission.

Section 815. Appropriations; availability

This section maintains current law subjects new spending authority to the availability of appropriations.

Section 816. Authorization of appropriations.

This section maintains current law and extends the authorization to fiscal year 2015.

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

OTHER SECTIONS OF THE BILL

Section 2(b). Indian Health Care Improvement Act amended.

Section 2 of the bill is new.

New provision: Section 2(b) also includes provisions amending other laws for the references to the "Director of Indian Health Service" which would be changed to "Assistant Secretary for Indian Health".

Section 3. Soboba sanitation facilities. Section 3 of the bill retains current law.

Current law: Section 3 authorizes sanitation facilities to the Soboba Band of Mission Indians, pursuant to the Act of December 17, 1970 (84 Stat. 1465).

Section 4. Amendments to the Medicaid and State Children's Health Insurance Programs. Section 4 of the bill sets forth conforming amendments to the Social Security Act for Medicaid and State Children's Health Insurance Programs which authorize reimbursement to Indian Health Programs for medical assistance provided.

Section 5. Native American Health and Wellness Foundation. Section 5 is new and sets forth amendments to the Indian Self-Determination and Education Assistance Act to establish a Native American Health and Wellness Foundation in the following sections 801 to 803.

Section 801. Definitions

This section sets forth definitions for the Foundation, the Foundation Board of Directors and establishment Committee.

Section 802. Native American Health and Wellness Foundation

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

Section 803. Administrative services and support

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

LEGISLATIVE HISTORY

LEGISLATIVE ACTION

During the 109th Congress,[87] Senator McCain introduced S. 1057, the Indian Health Care Improvement Act Amendments of 2005, on May 17, 2005, for himself and Senator Dorgan. The bill was referred to the Committee on Indian Affairs and reported favorably with amendments on October 27, 2005.

On June 7, 2005, Senator Johnson was added as a cosponsor. On July 14, 2005, Senators Kennedy and Bingaman were added as cosponsors. On October 24, 2005, Senators Cantwell and Murray were added as cosponsors.

LEGISLATIVE HEARINGS

The Committee has held nine hearings since the 106th Congress on the reauthorization of the Act.

During the 109th Congress, on July 14, 2005, the Committee held a joint hearing with the Senate Committee on Health, Education, Labor and Pensions to reauthorize the IHCIA. The hearing addressed the need for reauthorization and several key issues, including negotiated rulemaking, Federal Tort Claim Act coverage and the DHAT program. The witnesses included DHHS, members of the National Steering Committee, tribal leaders and health providers and the American Dental Association.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTES

In an open business session on October 27, 2005, the Committee considered a substitute amendment proposed by Senator McCain and other amendments offered by Senators Dorgan, Crapo, Coburn, and McCain. The Committee adopted the amendment offered by Senator McCain by unanimous consent.

The Committee adopted by voice vote the amendments offered by Senators Dorgan and Crapo. The Committee, by roll call vote, rejected the amendment offered by Senator Coburn. Then, by a unanimous vote, the Committee ordered the substitute amendment, as amended, favorably reported to the full Senate with the recommendation that the bill do pass.

REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires that each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee has concluded that S. 1057 will not require the promulgation of regulations so the regulatory and paperwork impact should be minimal.

EXECUTIVE COMMUNICATIONS

The Committee has not received any formal communication on S. 1057 from the Administration other than the written testimony from the Department of Health and Human Services submitted at

[87] Senate Report No. 108–411 provides a detailed chronology of the legislative activity that has occurred since the 106th Congress.

the Joint Hearing on S. 1057 on July 14, 2005, which is attached hereto as an Exhibit.

STATEMENT OF DR. CHARLES W. GRIM, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairmen and Members of the Committees:

I am honored to testify before you today on the important issue of reauthorization of the Indian Health Care Improvement Act (IHCIA). Accompanying me today are Robert McSwain, Deputy Directory, Craig Vanderwagen, M.D., Acting Chief Medical Officer, and Gary Hartz, Director, Office of Environmental Health and Engineering.

This landmark legislation forms the backbone of the system through which Federal health programs serve American Indians/Alaska Natives and encourages participation of eligible American Indians/Alaska Natives in these and other programs.

The IHS has the responsibility for the delivery of health services to more than 1.8 million Federally-recognized American Indians/Alaska Natives through a system of IHS, tribal, and urban (I/T/U) health programs based on judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians/Alaska Natives to the highest levels, 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 responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major statutes are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L. 67–85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94–437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the Federal government programs that deliver health services to Indian people, but it also provides additional guidance in several areas. The IHCIA contains specific language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services; the construction, replacement, and repair of health care facilities; access to health services; and, the provision of health services for urban Indian people.

DHHS ACTIVITIES

Since enactment of the IHCIA in 1976, statutory authority has substantially expanded programs and activities to keep pace with changes in healthcare services and administration. Federal funding for the IHCIA has contributed billions of dollars to improve the health status of American Indians/Alaska Natives. And, much progress has been made, particularly in the areas of infant and maternal mortality.

The Department under this Administration's leadership reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide for a consistent HHS policy when working with the more than 560 Federally recognized Tribes. This Council gives the IHS Director a highly visible role within the Department on Indian policy, where he serves as vice chairperson of the Council.

The Department has also recently completed work ushering through a revised HHS Tribal consultation policy and involving Tribal leaders in the process. This new policy further emphasizes the unique government-to-government relationship between Indian Tribes and the Federal government and assists in improving services to the Indian community through better communications. Consultation may take place at many different levels. To ensure the active participation of Tribes in the development of its budget request, an HHS-wide budget consultation session is held annually. This meeting provides Tribes with an opportunity to meet directly with leadership from all Department agencies and identify their priorities for upcoming program requests. Last year, Tribes identified inflation and population growth as their top budget priorities and IHS's FY 2006 budget request included an increase of $80 million for these items. Both the House and the Senate have included these increases in FY 2006 appropriations action, and we appreciate their efforts in this regard.

Through the Centers for Medicare & Medicaid Services (CMS), a Technical Tribal Advisory Group was established which provides Tribes with a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. And, the IHS has been vigilant about improving outcomes of Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to, or struggling with, this potentially disabling disease.

It is clear the Department has not been a passive observer of the health needs of eligible American Indians/Alaska Natives. Yet, we recognize that health disparities among this population do exist and are among some of the highest in the Nation for certain diseases (e.g., alcoholism, tuberculosis, diabetes, and injuries), and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

The IHCIA was enacted to provide basic primary and preventive services in recognition of the Federal government's unique relationship with members of Federally recognized Tribes. Members of Federally recognized Tribes are also eligible for other Federal health programs (such as Medicare, Medicaid and SCHIP), on the same basis as other Americans, and many also receive health care through employer-sponsored or other healthcare coverage.

It is within the context of current law and programs, that we turn our attention to S. 1057.

S. 1057

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. Improving access to healthcare for all eligible American Indians and Alaska Natives is critical to the Department and a priority for all of those involved in the administration of these important programs. We, therefore, commend your interest and will note positive provisions in S. 1057. However, we will also note concern on provisions which may negatively impact our ability to provide needed access to services by establishing program mandates and burdensome requirements that may divert resources from important services. We hope to work with you to address these issues.

The Department brings a keen awareness of the health care needs of Indian country and is supportive of reauthorization of the IHCIA. We support provisions that increase the flexibility of the Department to work with Tribes, to increase the availability of health care, including new approaches to delivering care, and to expand the range of options of health services available to eligible American Indians and Alaska Natives. Accordingly, I commend Congress for including in S. 1057 various changes that respond to concerns raised in previous proposals. Some of these changes go a long way toward improving the ability of the Secretary to effectively manage the program within current budgetary resources.

Moreover, I would like to note our particular interest in other provisions of S. 1057.

In the area of behavioral health, title VII of S. 1057 provides for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes language in Sections 704, 706, 711(b) and 712 that requires the establishment or expansion of specific additional services. The Department should be given the flexibility to provide for all Behavioral Health Programs in a manner that supports the local control and priorities of Tribes, and to address their specific needs within IHS overall budgetary levels.

PROVISIONS RELATED TO MEDICARE AND MEDICAID

In general, we believe the provisions of the bill that relate to the Medicaid and State Children's Health Insur-

ance (SCHIP) programs should be considered by the authorizing committees and in a framework consistent with the FY 2006 Budget Resolution and the Reconciliation process. As part of the larger Resolution and Reconciliation process, a Medicaid Commission was established to examine many aspects of that program. The Commission is charged with advising the Secretary on ways to modernize the Medicaid program so that it can provide high-quality health care to its beneficiaries in a financially sustainable way. Tribes are represented on the Commission through Secretary Leavitt's recent appointment of the Chair of the Centers for Medicaid and Medicaid Services Tribal Technical Advisory Group.

REPORTING REQUIREMENTS

S. 1057 includes new requirements for reporting to Congress within the President's Budget. The IHS and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance. However, we recommend striking language that provides additional specificity about what should be included in the President's budget request.

INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

Currently, the scholarship program regularly consults with the I/T/U's to determine the priorities. Each year, the program sends letters to all tribal chairmen, tribal health directors, urban program directors, IHS clinical directors, and IHS headquarters offices. Through this communication, scholarship program staff will update the relevant parties regarding the health professions for which awards were made in the current year and ask for their recommendations for the professions for which awards should be made in the coming year. Recommendations are aggregated and reviewed with the Office of Public Health and the Office of Management Support to determine which professions will be funded for the coming year.

New section 104(a)(2) proposes to allocate the program funding by formula to the twelve IHS areas. If allocation by formula is authorized Indian, students will not be given an opportunity to apply for a scholarship if their area does not receive adequate allocation and if their profession is not considered a priority in their area; e.g., dental hygienist, physical therapist, medical technology. This would even impact a medical student who has identified general surgery or general psychiatry as a specialty. They will not receive the scholarship, because it is not a priority or there are no positions available for these disciplines/specialties.

We are concerned that the large areas will receive the greatest amount of appropriated funds, leaving the smaller areas with amounts sufficient to fund only a small portion of their health professional needs. If an area chooses to allocate the funds among the tribes within the area, funds available to many will be insufficient to support even one student.

We recommend retaining the provision in current law which would maintain the national focus of the scholarship program to more appropriately meet the health professions needs of Indian country.

DIABETES EVALUATION AND COORDINATION

The bill has eliminated the current requirement for an evaluation of the 20 model diabetes programs for effectiveness and for each Area to employ at least one diabetes control officer, commonly now known as the Area Diabetes Consultant/Coordinator, to coordinate and manage on a full-time basis activities within the Area Office for the prevention, treatment, and control of diabetes. Area Diabetes Consultants/Coordinators are critical to the ability of the Service to provide support to the local Indian health programs as they implement the Special Diabetes for Indians Program formula and competitive grants programs. The evaluation provision for the model diabetes programs also is important to ensure that this program's effectiveness is assessed to make sure it maintains a productive role in the context of the implementation of the Special Diabetes for Indians Program at the local level. Both the National Diabetes Program and the Tribal Leaders Diabetes Committee (TLDC) have advocated for Area Diabetes Consultant/Coordinators.

We recommend that the requirement to employ at least one diabetes control officer in each of the 12 areas, as well as the requirement to evaluate the effectiveness of services provided through model diabetes projects established under this section, be retained.

HEALTH CARE FACILITIES

Sanitation facilities construction is conducted in 38 States with Federally recognized Tribes who take ownership of the facilities to operate and maintain them once completed. There are 49 hospitals, 247 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to Indian people.

HEALTH CARE FACILITIES NEEDS ASSESSMENT AND REPORT

New section 301(d)91) authorizes Government Accountability Office (GAO) to complete a report, after consultation with Tribes, on the needs for health care facilities construction, including renovation and expansion needs. However, efforts are currently underway to develop a complete description of need similar to what would be required by the bill. The plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource

intensive means for acquiring and updating the information that would be required in these reports.

We recommend the deletion of the reference to the Government Accountability Office undertaking the report because it would be redundant of and a setback for IHS's current efforts to develop an improved facilities construction methodology. This would allow the IHS to complete its new priority construction methodology which will address the future federal and tribal health facility needs.

RETROACTIVE FUNDING OF JOINT VENTURE CONSTRUCTION PROJECTS

New section 311(a)(1) would permit a tribe that has "begun or substantially completed" the process of acquisition of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. An agreement implies that all parties have participated in the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient or ineffective to operate and recommend that it be deleted.

SANITATION FACILITIES DEFICIENCY DEFINITIONS

New section 302(h)(4) provides definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country, which are ambiguous. As proposed deficiency level III could be interpreted to mean all methods of service delivery (including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home) are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two.

In addition, the definition for deficiency level V and deficiency level IV, through phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas, level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law as more appropriate for distinguishing the various levels of deficiencies which determine the allocation of existing resources.

THRESHOLD CRITERIA FOR SMALL AMBULATORY PROGRAM

New Section 305(b)(1) amends current law to set two minimum thresholds—one for number of patient visits and another for the number of eligible Indians. In order to be eligible under the criteria of S. 1057, a facility must provide at least 150 patient visits annually in a service area with no fewer than 1500 eligible Indians. Aside from the fact that these are both minimum thresholds and so somewhat contradictory, the new makes implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource Patient Management System (RPNS). Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term "eligible Indians" refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity. In order to make the language clear and equitable, the provision should provide one minimum threshold that can be validated.

NEW NEGOTIATED RULEMAKING AND CONSULTATION REQUIREMENTS

We are concerned about the remaining requirements for negotiated rulemaking and increased requirements for consultation in the bill because of the high cost and staff time associated with this approach. We are committed to our on-going consultation with Tribes and urban Indian organizations under current Executive Orders, as well as promulgating regulations where necessary to carry out IHCIA using the procedures required by Chapter V of title 6, United States Code (commonly known as the Administrative Procedures Act).

We have other objections to S. 1057, including, for example: new requirements using "shall" instead of "may" in provisions that will create budget pressures on current program activity; expansion of the scope of Federal Torts Claim Coverage for service provided to otherwise ineligible non-Indians; expansion of authorities for Urban Indian Organizations; elimination of the term "grant" and replacement with the term "funding"; and new provisions that contemplate the Secretary exercising authority through the Service, Tribes and Tribal Organizations which is not tied to agreements entered into under the Indian Self-Determination and Education Assistance Act (ISDEAA). The Administration may also have additional views on this legislation.

I reiterate our commitment to working with you to reauthorize of the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. I hope to work with this Committee and other Committees of the Congress, the National Tribal Steering Committee, and other representatives of Indian country to develop a bill that all stakeholders in these important programs can support. Again, I appreciate the opportunity to appear before

you today to discuss this important legislative proposal. I will be pleased to try to answer any questions that you may have. Thank you.

COST ESTIMATES

The Committee has not yet received the final cost estimate from the Congressional Budget Office.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that the enactment of S. 1057 will result in the following changes in existing law (existing law proposed to be omitted enclosed in black brackets, new language to be added in italic, and existing law in which no change is proposed shown in roman):

UNITED STATES CODE ANNOTATED

TITLE 25. INDIANS

CHAPTER 18—INDIAN HEALTH CARE

GENERAL PROVISIONS

Sec.
1. Short title; table of contents
1601. [Congressional f]Findings.
1602. Declaration of *National Indian* health [objectives] *policy*.
1603. Definitions.

[SUBCHAPTER] *TITLE* I—INDIAN HEALTH, *HUMAN RESOURCES, AND DEVELOPMENT* [PROFESSIONAL PERSONNEL]

1611. [Congressional statement of p]*P*urpose.
1612. Health [p]*P*rofessions [r]*R*ecruitment [p]*P*rogram for Indians.
1613. Health [p]*P*rofessions [p]*P*reparatory [s]*S*cholarship [p]*P*rogram for Indians.
1613a. Indian health professions scholarships.
105. American Indians into Psychology program.
106. Scholarship programs for Indian Tribes.
1614. Indian health service extern programs.
1615. Continuing education allowances.
1616. Community Health Representative Program.
1616a. Indian Health Service Loan Repayment Program.
1616a–1. Scholarship and [L]*l*oan [R]*r*epayment [R]*r*ecovery [F]*f*und.
1616b. Recruitment activities.
1616c. [Tribal] *Indian* recruitment and retention program.
1616d. Advanced training and research.
1616e. *Quentin N. Burdick American Indians into* [N]*n*ursing program.
[1616e–1. Nursing school clinics.]
1616f. Tribal *cultural orientation* [culture and history.]
1616g. INMED Program.
1616h. Health training programs of community colleges.
[1616i. Additional incentives for health professionals.]
1616j. Retention bonus.
1616k. Nursing residency program.
1616*l*. Community Health Aide Program.
[1616m. Matching grants to tribes for scholarship programs.]

1616n. Tribal health program administration.
123. Health professional chronic shortage demonstration programs.
124. National Health Service Corps.
125. Substance abuse counselor education curricula demonstration programs.
126. Behavioral health training and community education programs.
[1616*o*. University of South Dakota pilot program.]
1616p. Authorization of appropriations.

[SUBCHAPTER] *TITLE* II—HEALTH SERVICES

1621. Indian Health Care Improvement Fund.
1621a. Catastrophic [h]*H*ealth [e]*E*mergency [f]*F*und.
1621b. Health promotion and disease prevention services.
1621c. Diabetes prevention, treatment, and control.
205. Shared services for long-term care.
[1621d. Hospice care feasibility study.]
[1621e. Reimbursement from certain third parties of costs of health services.]
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GENERAL PROVISIONS

§1601. [Congressional f]*F*indings

[The] Congress makes the following findings:

[(a)] *(1)* Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to the American Indian people.

[(b)] *(2)* A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

[(c)] *(3)* Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

[(d)] *(4)* Despite such services, the unmet health needs of [the American] Indian*s* [people] are severe and the health status of the Indians is far below that of the general population of the United States.

§1602. Declaration of [health objectives] *National Indian Health Policy*

[(a) The] Congress [hereby] declares that it is the policy of this Nation, in fulfillment of its special *trust* responsibilities and legal obligations to [the American] Indian*s*.—[people,]

(1) to assure the highest possible health status for Indians [and urban Indians] and to provide all resources necessary to effect that policy[.]*;*

[(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians and urban Indians by the year 2000:]

[(1) Reduce coronary heart disease deaths to a level of no more than 100 per 100,000.]

[(2) Reduce the prevalence of overweight individuals to no more than 30 percent.]

[(3) Reduce the prevalence of anemia to less than 10 percent among children aged 1 through 5.]

[(4) Reduce the level of cancer deaths to a rate of no more than 130 per 100,000.]

[(5) Reduce the level of lung cancer deaths to a rate of no more than 42 per 100,000.]

[(6) Reduce the level of chronic obstructive pulmonary disease related deaths to a rate of no more than 25 per 100,000.]

[(7) Reduce deaths among men caused by alcohol-related motor vehicle crashes to no more than 44.8 per 100,000.]

[(8) Reduce cirrhosis deaths to no more than 13 per 100,000.]

[(9) Reduce drug-related deaths to no more than 3 per 100,000.]

[(10) Reduce pregnancies among girls aged 17 and younger to no more than 50 per 1,000 adolescents.]

[(11) Reduce suicide among men to no more than 12.8 per 100,000.]

[(12) Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17.]

[(13) Reduce to less than 10 percent the prevalence of mental disorders among children and adolescents.]

[(14) Reduce the incidence of child abuse or neglect to less than 25.2 per 1,000 children under age 18.]

[(15) Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples.]

[(16) Increase years of healthy life to at least 65 years.]

[(17) Reduce deaths caused by unintentional injuries to no more than 66.1 per 100,000.]

[(18) Reduce deaths caused by motor vehicle crashes to no more than 39.2 per 100,000.]

[(19) Among children aged 6 months through 5 years, reduce the prevalence of blood lead levels exceeding 15 ug/dl and reduce to zero the prevalence of blood lead levels exceeding 25 ug/dl.]

[(20) Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 45 percent among children aged 6 through 8 and no more than 60 percent among adolescents aged 15.]

[(21) Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6 through 8 and no more than 40 percent among adolescents aged 15.]

[(22) Reduce to no more than 20 percent the proportion of individuals aged 65 and older who have lost all of their natural teeth.]

[(23) Increase to at least 45 percent the proportion of individuals aged 35 to 44 who have never lost a permanent tooth due to dental caries or periodontal disease.]

[(24) Reduce destructive periodontal disease to a prevalence of no more than 15 percent among individuals aged 35 to 44.]

[(25) Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth.]

[(26) Reduce the prevalence of gingivitis among individuals aged 35 to 44 to no more than 50 percent.]

[(27) Reduce the infant mortality rate to no more than 8.5 per 1,000 live births.]

[(28) Reduce the fetal death rate (20 or more weeks of gestation) to no more than 4 per 1,000 live births plus fetal deaths.]

[(29) Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births.]

[(30) Reduce the incidence of fetal alcohol syndrome to no more than 2 per 1,000 live births.]

[(31) Reduce stroke deaths to no more than 20 per 100,000.]

[(32) Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) to attain an incidence of no more than 13 per 100,000.]

[(33) Reduce breast cancer deaths to no more than 20.6 per 100,000 women.]

[(34) Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women.]

[(35) Reduce colorectal cancer death to no more than 13.2 per 100,000.]

[(36) Reduce to no more than 11 percent the proportion of individuals who experience a limitation in major activity due to chronic conditions.]

[(37) Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000.]

[(38) Reduce significant visual impairment to a prevalence of no more than 30 per 1,000.]

[(39) Reduce diabetes-related deaths to no more than 48 per 100,000.]

[(40) Reduce diabetes to an incidence of no more than 2.5 per 1,000 and a prevalence of no more than 62 per 1,000.]

[(41) Reduce the most severe complications of diabetes as follows:]

[(A) End-stage renal disease, 1.9 per 1,000.]

[(B) Blindness, 1.4 per 1,000.]

[(C) Lower extremity amputation, 4.9 per 1,000.]

[(D) Perinatal mortality, 2 percent.]

[(E) Major congenital malformations, 4 percent.]

[(42) Confine annual incidence of diagnosed AIDS cases to no more than 1,000 cases.]

[(43) Confine the prevalence of HIV infection to no more than 100 per 100,000.]

[(44) Reduce gonorrhea to an incidence of no more than 225 cases per 100,000.]

[(45) Reduce chlamydia trachomatis infections, as measured by a decrease in the incidence of nongonococcal urethritis to no more than 170 cases per 100,000.]

[(46) Reduce primary and secondary syphilis to an incidence to no more than 10 cases per 100,000.]

[(47) Reduce the incidence of pelvic inflammatory disease, as measured by a reduction in hospitalization for pelvic inflammatory disease to no more than 250 per 100,000 women aged 15 through 44.]

[(48) Reduce viral hepatitis B infection to no more than 40 per 100,000 cases.]

[(49) Reduce indigenous cases of vaccine-preventable diseases as follows:]

[(A) Diphtheria among individuals aged 25 and younger, 0.]

[(B) Tetanus among individuals aged 25 and younger, 0.]

[(C) Polio (wild-type virus), 0.]

[(D) Measles, 0.]

[(E) Rubella, 0.]

[(F) Congenital Rubella Syndrome, 0.]

[(G) Mumps, 500.]

[(H) Pertussis, 1,000.]

[(50) Reduce epidemic-related pneumonia and influenza deaths among individuals aged 65 and older to no more than 7.3 per 100,000.]

[(51) Reduce the number of new carriers of viral hepatitis B among Alaska Natives to no more than 1 case.]

[(52) Reduce tuberculosis to an incidence of no more than 5 cases per 100,000.]

[(53) Reduce bacterial meningitis to no more than 8 cases per 100,000.]

[(54) Reduce infectious diarrhea by at least 25 percent among children.]

[(55) Reduce acute middle ear infections among children aged 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children.]

[(56) Reduce cigarette smoking to a prevalence of no more than 20 percent.]

[(57) Reduce smokeless tobacco use by youth to a prevalence of no more than 10 percent.]

[(58) Increase to at least 65 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay.]

[(59) Increase to at least 75 percent the proportion of mothers who breast feed their babies in the early postSE 1)partum period, and to at least 50 percent the proportion who continue breast feeding until their babies are 5 to 6 months old.]

[(60) Increase to at least 90 percent the proportion of pregnant women who receive prenatal care in the first trimester of pregnancy.]

[(61) Increase to at least 70 percent the proportion of individuals who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the United States Preventive Services Task Force.]

[(c) It is the intent of the Congress that the Nation increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to Indians to 0.6 percent.]

[(d) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the progress made in each area of the Service toward meeting each of the objectives described in subsection (b) of this section.]

(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 successor objectives;

(3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

(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 Service Area is raised to at least the level of that of the general population;

(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

(6) to provide funding for programs and facilities operated by Indian Tribes and Tribal Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

§ 1603. Definitions

For purposes of this **[**chapter**]** *Act***[—]***:*

(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

(2) The term 'Area Office' means an administrative entity including a program office, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

(3) The term 'Assistant Secretary' means the Assistant Secretary of Indian Health.

(4) The term 'behavioral health' means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. This definition can include the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

(5) The term 'California Indians' means those Indians who are eligible for health services of the Service pursuant to section 806.

(6) The term 'community college' means—

(A) a tribal college or university, or

(B) a junior or community college.

(7) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

(8) The term 'Department' means, unless otherwise designated, the Department of Health and Human Services.

(9) The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

(A) controlling—

(i) development of diabetes;
(ii) high blood pressure;
(iii) infectious agents;
(iv) injuries;
(v) occupational hazards and disabilities;
(vi) sexually transmittable diseases; and
(vii) toxic agents; and

(B) providing—
(i) fluoridation of water; and
(ii) immunizations.

(10) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, and any other health profession.

(11) The term 'health promotion' means—

(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

(B) encouraging adequate and appropriate diet, exercise, and sleep;

(C) promoting education and work in conformity with physical and mental capacity;

(D) making available 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 Health Care Practices; and

(G) providing 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) immunization and other prevention of communicable diseases, including HIV/AIDS;
(vii) environmental health;
(viii) exercise and physical fitness;
(ix) avoidance of fetal alcohol disorders;
(x) first aid and CPR education;
(xi) human growth and development;
(xii) injury prevention and personal safety;
(xiii) behavioral health;
(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;
(xv) personal health and wellness practices;

(xvi) personal capacity building;

(xvii) prenatal, pregnancy, and infant care;

(xviii) psychological well-being;

(xix) reproductive health and family planning;

(xx) safe and adequate water;

(xxi) safe housing relating to the elimination, reduction, and prevention of contaminants that create unhealthy housing conditions;

(xxii) safe work environments;

(xxiii) stress control;

(xxiv) substance abuse;

(xxv) sanitary facilities;

(xxvi) sudden infant death syndrome prevention;

(xxvii) tobacco use cessation and reduction;

(xxviii) violence prevention; and

(xxix) such other activities identified by the Service, a Tribal Health Program, or an Urban Indian Organization, to promote achievement of any of the objectives described in section 3(2).

(12) The term 'Indian', unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 806, except that, for the purpose of section 102 and 104, the term also means any individual who—

(A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or

(ii) is a descendant, in the first or second degree, or any such member;

(B) is an Eskimo or Aleut or other Alaska 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.

(13) The term 'Indian Health Program' means—

(A) any health program administered directly by the Service;

(B) any Tribal Health Program; or

(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47), (commonly known as the 'Buy Indian Act').

(14) The term 'Indian Tribe' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(15) The term 'junior or community college' has the meaning given the term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

(16) The term 'reservation' means any federally recognized Indian Tribe's reservation, Pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (25 U.S.C. 1601 et seq.).

[(a)**]***(17) The term* **[**"**]**'Secretary**[**"**]**' , unless otherwise designated, means the Secretary of Health and Human Services.

[(b)**]***(18) The term* **[**"**]**'Service**[**"**]**' means the Indian Health Service.

[(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (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.**]**

[(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C.A. §1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.**]**

[(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.**]**

(19) The term 'Service Area' means the geographical area served by each Area Office.

(20) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

(21) The term 'telehealth' has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

(22) The term 'telemedicine' means a telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

(23) The term '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 embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony.

(24) The term 'tribal college or university' has the meaning given the term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059c(b)(3)).

(25) The term 'Tribal Health Program' means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(26) The term 'Tribal Organization' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(27) The term 'Urban Center' means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary.

[(f) "**]** *(28) The term* 'Urban Indian**["]**' means any individual who resides in an **[**u**]***U*rban **[**c**]***C*enter **[**, as defined in subsection (g) of this section,**]** and who meets **[**one**]** *1* or more of the **[**four**]** *following* criteria: **[**in subsection (c)(1) through (4) of this section.**]**

(A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

(B) The individual is an Eskimo, Aleut, or other Alaska Native.

(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

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

(29) The term 'Urban Indian Organization' means a nonprofit corporate body that (A) is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) provides for the participation of all interested Indian groups and individuals; and (D) is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

[(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV of this chapter, as determined by the Secretary.**]**

[(h) "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 maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.**]**

[(i) "Area office" means an administrative entity including a program office, within the Indian Health Service through which serv-

ices and funds are provided to the service units within a defined geographic area.]

[(j) "Service unit" means—]

[(1) an administrative entity within the Indian Health Service, or]

[(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],]

[through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.]

[(k) "Health promotion" includes—]

[(1) cessation of tobacco smoking,]

[(2) reduction in the misuse of alcohol and drugs,]

[(3) improvement of nutrition,]

[(4) improvement in physical fitness,]

[(5) family planning,]

[(6) control of stress, and]

[(7) pregnancy and infant care (including prevention of fetal alcohol syndrome).]

[(l) "Disease prevention" includes—]

[(1) immunizations,]

[(2) control of high blood pressure,]

[(3) control of sexually transmittable diseases,]

[(4) prevention and control of diabetes,]

[(5) control of toxic agents,]

[(6) occupational safety and health,]

[(7) accident prevention,]

[(8) fluoridation of water, and]

[(9) control of infectious agents.]

[(m) "Service area" means the geographical area served by each area office.]

[(n) "Health profession" means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.]

[(*o*) "Substance abuse" includes inhalant abuse.]

[(p) "FAE" means fetal alcohol effect.]

[(q) "FAS" means fetal alcohol syndrome.]

[SUBCHAPTER] *TITLE I*—INDIAN HEALTH, *HUMAN RESOURCES, AND DEVELOPMENT* [PROFESSIONAL PERSONNEL]

§ 1611. [Congressional statement of p]*P*urpose

The purpose of this [subchapter] *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 [adequate] *optimum* supply of health professionals to the *Indian Health Programs* [Service, Indian tribes, tribal organizations,] and

[u]*U*rban Indian [o]*O*rganizations involved in the provision of health care to Indian*s* [people].

§ 1612. Health *P*[p]rofessions *R*[r]ecruitment *P*[p]rogram for Indians

(a) [GRANTS FOR EDUCATION AND TRAINING] *IN GENERAL*.—The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities, *Tribal Health Programs*, *or Urban Indian Organizations* [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) [of this subsection] or who are undertaking training necessary to qualify them to enroll in any such course of study; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1) [of this subsection].

(b) [APPLICATION FOR GRANT; SUBMITTAL AND APPROVAL; PREFERENCE; PAYMENT] *FUNDING*.—

(1) *APPLICATION.—The Secretary shall not make a grant under this section* [No grant may be made under this section] unless an application [therefor] has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe *pursuant to this Act*. The Secretary shall give a preference to applications submitted by Tribal Health Programs or *Urban Indian Organizations* [Indian tribes or tribal organizations].

(2) *AMOUNT OF GRANTS; PAYMENT*.—The amount of a [any] grant under this section shall be determined by the Secretary. Payments pursuant to [grants under] this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as [the Secretary finds necessary.] *provided for in regulations issued pursuant to this Act. To the extent not otherwise prohibited by law, funding commitments shall be for 3 years, as provided in regulations issued pursuant to this Act.*

§ 1613. Health *P*[p]rofessions *P*[p]reparatory *S*[s]cholarship *P*[p]rogram for Indians

(a) [REQUIREMENTS] *SCHOLARSHIPS AUTHORIZED*.—The Secretary, acting through the Service, shall *provide scholarship* [make scholarship] grants to Indians who—

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

(2) have demonstrated the *potential* [capability] to successfully complete courses of study in the health professions.

(b) PURPOSES.—[AND DURATION OF GRANTS; PREPROFESSIONAL AND PREGRADUATE EDUCATION] Scholarship *grants provided* [grants made] pursuant to this section shall be for the following purposes:

(1) Compensatory preprofessional education of any *recipient* [grantee], such scholarship not to exceed [two] *2* years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary *pursuant to regulations issued under this Act*).

(2) Pregraduate education of any *recipient* [grantee] 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 Secretary)]. *An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved.*

(c) [COVERED EXPENSES] *OTHER CONDITIONS*.—Scholarships [grants made] under this section—

(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a *recipient* [grantee] while attending school[.]*;*

(2) shall not be denied solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; and

(3) shall not be denied solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

[(d) BASIS FOR DENIAL OF ASSISTANCE]

[The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.]

[(e) ELIGIBILITY FOR ASSISTANCE UNDER OTHER FEDERAL PROGRAMS]

[The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.]

§ 1613a. Indian *H*[h]ealth *P*[p]rofessions *S*[s]cholarships

(a) *IN* GENERAL.— [AUTHORITY]

(1) AUTHORITY.—[In order to provide health professionals to Indians, Indian tribes, tribal organizations, and urban Indian organizations, t]*T*he Secretary, acting through the Service [and in accordance with this section], shall make scholarship grants to Indians who are enrolled full or part time in [appropriately] accredited schools [and] pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section *338A of the Public Health Services Act (42 U.S.C.*

254*l)* [of Title 42], except as provided in subsection (b) of this section.

(2) DETERMINATIONS BY SECRETARY.—The Secretary, acting through the Service, shall determine—

(A) who shall receive scholarship grants under subsection (a); and

(B) the distribution of the scholarships among health professionals on the basis of the relative needs of Indians for additional service in the health professions.

(3) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Assistant Secretary and shall not be delegated in a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(b) [RECIPIENTS; A]*ACTIVE D*[D]*UTY S*[S]*ERVICE O*[O]BLIGATION.—

[(1) The Secretary, acting through the Service, shall determine who shall receive scholarships under subsection (a) of this section and shall determine the distribution of such scholarships among such health professions on the basis of the relative needs of Indians for additional service in such health professions.]

[(2) An individual shall be eligible for a scholarship under subsection (a) of this section in any year in which such individual is enrolled full or part time in a course of study referred to in subsection (a) of this section.]

(1)[(3)(A)] *OBLIGATION MET.*—The [A]*a*ctive duty service obligation under a written contract with the Secretary under this section [of Title 42] that an [individual] *Indian* has entered into [under that section] shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice *on an equivalent year-for-year obligation,* by service *in 1 or more of the following:*[—]

(A)[(i) i]*I*n *an* [the] Indian Health *Program*. [Service;]

[(ii) in a program conducted under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.];]

(B)[(iii) i]*I*n a program assisted under *title V* [subchapter IV] of this *Act.* [chapter;]

(C)[(iv) i]*I*n the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.[; or]

(D) In a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, the health service provided to Indians would not decrease.

(2)[(B)] *OBLIGATION DEFERRED.*—At the request of any individual who has entered into a contract referred to in *paragraph (1)* [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:

(A)[(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 *sub*section.

(B)[(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).

(C)[(iii)] The active duty service obligation will be served in the health profession of that individual[,] in a manner consistent with *paragraph (1)* [clauses (i) through (v) of subparagraph (A)].

(D)[(C)] *A recipient of a*[n Indian Health S]scholarship *under this section* may, at the election of the recipient, meet the active duty service obligation described in *paragraph (1)* [subparagraph (A)] by service in a program specified *under* [in] that *paragraph* [subparagraph] that—

(i) is located on the reservation of the *Indian T*[t]ribe in which the recipient is enrolled; or

(ii) serves the *Indian T*[t]ribe in which the recipient is enrolled.

(3)[(D)] *PRIORITY WHEN MAKING ASSIGNMENTS*.—Subject to *paragraph (2)* [subparagraph (C)], the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in *paragraph (1)* [subparagraph (A)], shall give priority to assigning individuals to service in those programs specified in *paragraph (1)* [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.

(c)[(4)] *PART-TIME STUDENTS*.—In the case of an individual receiving a scholarship under this section who is enrolled part time in an approved course of study—

(1)[(A)] such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the *Area Office* [Secretary];

(2)[(B)] the period of obligated service described in *subsection (b)(1)* [paragraph (3)(A)] shall be equal to the greater of—

(A)[(i)] the part-time equivalent of *1*[one] year for each year for which the individual was provided a scholarship (as determined by the *Area Office* [Secretary]); or

(B)[(ii) two] *2* years; and

(3)[(C)] the amount of the monthly stipend specified in section *338A(g)(1)(B) of the Public Health Service Act (42 U.S.C.* 254*l*(g)(1)(B)*)* [of Title 42] shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

(d) BREACH OF CONTRACT.—

(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005 if that individual—

[(5)(A) An individual who has, on or after October 29, 1992, entered into a written contract with the Secretary under this section and who—**]**

*(A)***[**(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)**[**,**]***;*

*(B)***[**(ii)**]** is dismissed from such educational institution for disciplinary reasons**[**,**]***;*

*(C)***[**(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

*(D)***[**(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, on his behalf, under the contract**]**.

*(2)***[**(B)**]** *OTHER BREACHES.*—If for any reason not specified in *paragraph (1)* **[**subparagraph (A)**]** an individual breaches *a* **[**his**]** written contract by failing either to begin such individual's service obligation *required* under *such contract* **[**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* **[**1616a of this title**]** in the manner provided for in such subsection.

*(3)***[**(C)**]** *CANCELLATION UPON DEATH OF RECIPIENT.*—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.

*(4)***[**(D)**]** *WAIVERS AND SUSPENSIONS.*—

(A) IN GENERAL.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, *in consultation with the affected Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations,* determines that—

(i) it is not possible for the recipient to meet that obligation or make that payment;

(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

(B) FACTORS FOR CONSIDERATION.—Before waiving or suspending an obligation of service or payment under subparagraph (A), the Secretary may take into consideration whether the obligation may be satisfied in a teaching capacity at a tribal college or university nursing program under subsection (b)(1)(D).

(5)[(E)] *EXTREME HARDSHIP.*—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

(6)[(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 [T]*t*itle 11, *United States Code,* unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

[(c) PLACEMENT OFFICE]

[The Secretary shall, acting through the Service, establish a Placement Office to develop and implement a national policy for the placement, to available vacancies within the Service, of Indian Health Scholarship recipients required to meet the active duty service obligation prescribed under section 254m of Title 42 without regard to any competitive personnel system, agency personnel limitation, or Indian preference policy.]

§ 105. American Indians into Psychology Program

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

(b) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide a grant authorized under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

(1) provides outreach and recruitment for the health professions to Indian communities including elementary, secondary, and accredited and accessible community colleges that will be served by the program;

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

(3) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

(4) provides stipends to undergraduate and graduate students to pursue a career in psychology;

(5) develops affiliation agreements with tribal colleges and universities, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and

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

(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—

(1) in an Indian Health Program;

(2) in a program assisted under title V of this Act; or

(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,700,000 for each of fiscal years 2006 through 2015.

§ 106. Scholarship programs for Indian tribes

(a) IN GENERAL.—

(1) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants available to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

(3) APPLICATION.—An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(b) REQUIREMENTS.—

(1) IN GENERAL.—A Tribal Health Program receiving a grant under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

(B) 20 percent of such costs may be paid from any other source of funds.

(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in 1 of the health professions contemplated by this Act.

(d) CONTRACT.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship. Such contract shall—

(1) obligate such recipient to provide service in an Indian Health Program or Urban Indian Organization, in the same Service Area where the Tribal Health Program providing the scholarship is located, for—

(A) a number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

(B) such greater period of time as the recipient and the Tribal Health Program may agree;

(2) provide that the amount of the scholarship—

(A) may only be expended for—

(i) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), with such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled; and not to exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

(3) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

(4) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

(e) BREACH OF CONTRACT.—

(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

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

(B) is dismissed from such educational institution for disciplinary reasons;

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

(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX or title XXI of such Act; and

(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal Health Program has not complied with the requirements of this section.

§ 1614. Indian *H*[h]ealth *S*[s]ervice *E*[e]xtern *P*[p]rograms

(a) EMPLOYMENT *PREFERENCE.*—[OF SCHOLARSHIP GRANTEES DURING NONACADEMIC PERIODS] *Any individual who receives a scholarship pursuant to section 104 or 106 shall be given preference*

for employment in the Service, or may be employed by a Tribal Health Program or an Urban Indian Organization, or other agencies of the Department as available, during any nonacademic period of the year.

(*b*) *NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.*—

[Any individual who receives a scholarship grant pursuant to section 1613a of this title shall be entitled to employment in the Service 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 [grant].

(*c*) *TIMING; LENGTH OF EMPLOYMENT.*—

[(b) EMPLOYMENT OF MEDICAL AND OTHER STUDENTS DURING NONACADEMIC PERIODS]

Any individual enrolled in a *program, including a high school program, authorized under section 102(a)* [course of study in the health professions] may be employed by the Service *or by a Tribal Health Program or an Urban Indian Organization* during any nonacademic period of the year. Any such employment shall not exceed [*120*] [one hundred and twenty] days during any calendar year.

(*d*) *NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.*—

[(c) EMPLOYMENT WITHOUT REGARD TO COMPETITIVE PERSONNEL SYSTEM OR AGENCY PERSONNEL LIMITATION; COMPENSATION]

Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department [of Health and Human Services].

§ 1615. Continuing *E*[e]ducation *A*[a]llowances

[(a) DISCRETIONARY AUTHORITY; SCOPE OF ACTIVITIES]

In order to encourage *health professionals, including community health representatives and emergency medical technicians,* [physicians, dentists, nurses, and other health professionals] to join or continue in *an Indian Health Program or an Urban Indian Organization* [the Service] and to provide their services in the rural and remote areas where a significant portion of [the] Indians [people] reside[s], the Secretary, acting through the Service, may provide allowances to health professionals employed in *an Indian Health Program or an Urban Indian Organization* [the Service] to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

[(b) LIMITATION]

[Of amounts appropriated under the authority of this subchapter for each fiscal year to be used to carry out this section, not more than $1,000,000 may be used to establish postdoctoral training programs for health professionals.]

§ 1616. Community Health Representative Program

(a) *IN GENERAL.*—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) *(commonly*[, popularly] known as the (Snyder Act), the Secretary*, acting through the Service,* shall maintain a Community Health Representative Program under which *Indian Health Programs* [the Service]—

(1) provide[s] for the training of Indians as *community health representatives;* [health paraprofessionals,] and

(2) use[s] such *community health representatives* [paraprofessionals] in the provision of health care, health promotion, and disease prevention services to Indian communities.

(b) *DUTIES.*—The [Secretary, acting through the] Community Health Representative Program of the Service, shall—

(1) provide a high standard of training for [paraprofessionals to C]*c*ommunity [H]*h*ealth [R]*r*epresentatives to ensure that the [C]*c*ommunity [H]*h*ealth [R]*r*epresentatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by [such] *the* Program[,]*;*

(2) in order to provide such training, develop and maintain a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care[,]*;* and

(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty[,]*;*

(3) maintain a system which identifies the needs of [C]*c*ommunity [H]*h*ealth [R]*r*epresentatives for continuing education in health care, health promotion, and disease prevention, and *develop* [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 [t]*T*raditional [h]*H*ealth [c]*C*are [p]*P*ractices of the Indian [t]*T*ribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

§ 1616a. Indian Health Service Loan Repayment Program

(a) ESTABLISHMENT.—

[(1)] The Secretary, acting through the Service, shall establish *and administer* a program to be known as the [Indian Health] Service Loan Repayment Program (hereinafter referred to as the "Loan Repayment Program") in order to *ensure* [assure] an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian [h]*H*ealth [p]*P*rograms and Urban Indian Organizations.

[(2) For the purposes of this section—]

[(A) the term "Indian health program" means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—]

[(i) directly by the Service;]

[(ii) by any Indian tribe or tribal or Indian organization pursuant to a contract under—]

[(I) the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], or]

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

[(iii) by an urban Indian organization pursuant to subchapter IV of this chapter; and]

[(B) the term "State" has the same meaning given such term in section 254d(i)(4) of Title 42.]

(b) *ELIGIBLE INDIVIDUALS*.—[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 *under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(c)(i))* [, 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 [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* without a service obligation; and

(3) submit to the Secretary an application for a contract described in subsection *(e)* [(f) of this section].

(c) APPLICATION [AND CONTRACT FORMS].—

(1) *INFORMATION TO BE INCLUDED WITH FORMS*.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection *(l)* [of this section] in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve

Corps of the Public Health Service or a civilian employee of the [Indian Health] Service to enable the individual to make a decision on an informed basis.

(2) *CLEAR LANGUAGE*.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

(3) *TIMELY AVAILABILITY OF FORMS*.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

(d) *PRIORITIES*.—[VACANCIES; PRIORITY]

(1) *LIST*.—Consistent with *subsection (k)* [paragraph (3)], the Secretary[, acting through the Service and in accordance with subsection (k), of this section,] shall annually—

(A) identify the positions in each Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* for which there is a need or a vacancy[,]*;* and

(B) rank those positions in order of priority.

(2) *APPROVALS*.—*Notwithstanding* [Consistent with] 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) a*fter making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—*

(i) individuals recruited through the efforts of *an* Indian *Health Program or Urban Indian Organization; and* [tribes or tribal or Indian organizations.]

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

[(3)(A) Subject to subparagraph (B), of the total amounts appropriated for each of the fiscal years 1993, 1994, and 1995 for loan repayment contracts under this section, the Secretary shall provide that—]

[(i) not less than 25 percent be provided to applicants who are nurses, nurse practitioners, or nurse midwives; and]

[(ii) not less than 10 percent be provided to applicants who are mental health professionals (other than applicants described in clause (i)).]

[(B) The requirements specified in clause (i) or clause (ii) of subparagraph (A) shall not apply if the Secretary does not receive the number of applications from the individuals described in clause (i) or clause (ii), respectively, necessary to meet such requirements.]

(e) *RECIPIENT CONTRACTS*.—[APPROVAL]

(1) *CONTRACT REQUIRED*.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary

and the individual entering into a written contract described in *paragraph (2)* [subsection (f) of this section].

(2) *CONTENTS OF CONTRACT*.—[The Secretary shall provide written notice to an individual promptly on—]

[(A) the Secretary's approving, under paragraph (1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or]

[(B) the Secretary's disapproving an individual's participation in such Program.]

[(f) CONTRACT TERMS]

The written contract referred to in this section between the Secretary and an individual shall contain—

(A)[(1)] an agreement under which—

(i)[(A)] subject to *sub*paragraph *(C)*[(3)], the Secretary agrees—

(I)[(i)] to pay loans on behalf of the individual in accordance with the provisions of this section[,]*;* and

(II)[(ii)] to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a *Tribal Health Program or Urban Indian Organization* [tribe or Indian organization] as provided in *clause (ii)(III);* [subparagraph (B)(iii),] and

(ii)[(B)] subject to *sub*paragraph *(C)*[(3)], the individual agrees—

(I)[(i)] to accept loan payments on behalf of the individual;

(II)[(ii)] in the case of an individual described in subsection (b)(1)—

(aa)[(I)] to maintain enrollment in a course of study or training described in subsection (b)(1)(A) [of this section] until the individual completes the course of study or training[,]*;* and

(bb)[(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); *and*

(III)[(iii)] to serve for a time period (hereinafter in this section referred to as the ["] 'period of obligated service'["]) equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* to which the individual may be assigned by the Secretary;

(B)[(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 *subparagraph (A)(ii)(III)* [paragraph (1)(B)(iii)];

(C)[(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;

(D)[(4)] a statement of the damages to which the United States is entitled under subsection (*l*) [of this section] for the individual's breach of the contract; and

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

(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

(2) the Secretary's disapproving an individual's participation in such Program.

(g) *PAYMENTS.*—[LOAN REPAYMENT PURPOSES; MAXIMUM AMOUNT; TAX LIABILITY REIMBURSEMENT; SCHEDULE OF PAYMENTS]

(1) *IN GENERAL.*—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

(A) tuition expenses;

(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

(C) reasonable living expenses as determined by the Secretary.

(2)[(A)] *AMOUNT.*—For each year of obligated service that an individual contracts to serve under subsection *(e)*,[(f) of this section] 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, whichever is more*, [254*l*–1(g)(2)(A) of Title 42)] 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—

(A)[(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;

(B)[(ii)] provides an incentive to serve in Indian [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations* with the greatest shortages of health professionals; and

(C)[(iii)] provides an incentive with respect to the health professional involved remaining in an Indian

[h]*H*ealth [p]*P*rogram *or Urban Indian Organization* with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

(3)[(B)]*TIMING.*—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

(4)[(3)] *REIMBURSEMENTS FOR TAX LIABILITY.*—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual, the Secretary—

(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

(5)[(4)] *PAYMENT SCHEDULE.*—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

(h) *EMPLOYMENT CEILING.*—[EFFECT ON EMPLOYMENT CEILING OF DEPARTMENT OF HEALTH AND HUMAN SERVICES] Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section[, while undergoing academic training,] shall not be counted against any employment ceiling affecting the Department [of Health and Human Services] *while those individuals are undergoing academic training*.

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

(j) *APPLICABILITY OF LAW.*—[PROHIBITION OF ASSIGNMENT TO OTHER GOVERNMENT DEPARTMENTS] Section *214 of the Public Health Service Act (42 U.S.C. 215)* [215 of Title 42] shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

(k) *ASSIGNMENT OF INDIVIDUALS.*—[STAFF NEEDS OF HEALTH PROGRAMS ADMINISTERED BY INDIAN TRIBES] The Secretary, in assigning individuals to serve in Indian [h]*H*ealth [p]*P*rograms *or Urban Indian Organizations* pursuant to contracts entered into under this section, shall—

(1) ensure that the staffing needs of *Tribal* [Indian h]*H*ealth [p]*P*rograms *and Urban Indian Organizations* [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 [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations* that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

(*l*) *BREACH OF CONTRACT.*—[VOLUNTARY TERMINATION OF STUDY OR DISMISSAL FROM EDUCATIONAL INSTITUTION; COLLECTION OF DAMAGES]

(1) *SPECIFIC BREACHES.*—An individual who has entered into a written contract with the Secretary under this section and *has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract if that individual* [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 *or she* is enrolled (such level determined by the educational institution under regulations of the Secretary);

(ii) voluntarily terminates such enrollment; or

(iii) is dismissed from such educational institution before completion of such course of study; or

(B) is enrolled in a graduate training program[,] *and* fails to complete such training program[, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii) of this section,].

[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) *OTHER BREACHES; FORMULA FOR AMOUNT OWED.*—If, for any reason not specified in paragraph (1), an individual breaches his *or her* written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection *(e)(2)* [(f) of this section], the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: $A=3Z(t-s/t)$ in which—

(A) ["]'A'["] is the amount the United States is entitled to recover;

(B) ["]'Z'["] is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer 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) [of this section]; and

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

(3) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deduc-

tions in [M]*m*edicare payments pursuant to section *1892 of the Social Security Act* [1395ccc of Title 42].

(4)[(3)(A)] *TIME PERIOD FOR REPAYMENT.*—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach or such longer period beginning on such date as shall be specified by the Secretary.

(5) *RECOVERY OF DELINQUENCY.*—

(A)[(B)] *IN GENERAL.*—If damages described in *paragraph (4)* [subparagraph (A)] are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

(i) *use* [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.

(B)[(C)] *REPORT.*—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of [T]*t*itle 31, *United States Code*, shall apply to any such contract to the extent not inconsistent with this subsection.

(m) *WAIVER OR SUSPENSION OF OBLIGATION.*—[CANCELLATION OR WAIVER OF OBLIGATIONS; BANKRUPTCY DISCHARGE]

[(1) Any obligation of an individual under the Loan Repayment program for service or payment of damages shall be canceled upon the death of the individual.]

(1)[(2)] *IN GENERAL.*—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

(3) *HARDSHIP WAIVER.*—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

(4) *BANKRUPTCY.*—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under [T]*t*itle 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

(n) [ANNUAL R]*R*EPORT.—The Secretary shall submit to the President, for inclusion in *the* [each] report required to be submitted to [the] Congress under section *801* [1671 of this title], a

report concerning the previous fiscal year which sets forth *by Service Area the following:*[—]

(1) *A list of* the health professional positions maintained by *Indian Health Programs and Urban Indian Organizations* [the Service or by tribal or Indian organizations] for which recruitment or retention is difficult[;].

(2) [t]*T*he number of Loan Repayment Program applications filed with respect to each type of health profession[;].

(3) [t]*T*he number of contracts described in subsection *(e)* [(f) of this section] that are entered into with respect to each health profession[;].

(4) [t]*T*he amount of loan payments made under this section, in total and by health profession[;].

(5) [t]*T*he number of scholarship*s* [grants] that are provided under section*s 104 and 106* [1613a of this title] with respect to each health profession[;].

(6) [t]*T*he amount of scholarship*s* [grants] provided under section *104 and 106* [1613a of this title], in total and by health profession[;].

(7) [t]*T*he number of providers of health care that will be needed by Indian [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations*, by location and profession, during the *3* [three] fiscal years beginning after the date the report is filed[; and].

(8) [t]*T*he measures the Secretary plans to take to fill the health professional positions maintained by *Indian Health Programs or Urban Indian Organizations* [the Service or by tribes or tribal or Indian organizations] for which recruitment or retention is difficult.

§1616a–1. Scholarship and Loan Repayment Recovery Fund

(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereinafter in this section referred to as the 'LRRF' ["Fund"]). The *LRRF* [Fund] shall consist of such amounts as may be *collected from individuals* [appropriated to the Fund] under *section 104(d), section 106(e), and section 110(l) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF* [subsection (b) of this section]. *All* [A]*a*mounts *collected,* appropriated, *or earned relative to the LRRF* [for the Fund] shall remain available until expended.

[(b) AUTHORIZATION OF APPROPRIATIONS]

[For each fiscal year, there is authorized to be appropriated to the Fund an amount equal to the sum of—]

[(1) the amount collected during the preceding fiscal year by the Federal Government pursuant to—]

[(A) the liability of individuals under subparagraph (A) or (B) of section 1613a(b)(5) of this title for the breach of contracts entered into under section 1613a of this title; and]

[(B) the liability of individuals under section 1616a(*l*) of this title for the breach of contracts entered into under section 1616a of this title; and]

[(2) the aggregate amount of interest accruing during the preceding fiscal year on obligations held in the Fund pursuant

to subsection (d) of this section and the amount of proceeds from the sale or redemption of such obligations during such fiscal year.]

(b) [(c)] USE OF FUNDS.—

(1) BY SECRETARY.—Amounts in the LRRF [Fund and available pursuant to appropriation Acts] may be expended by the Secretary, acting through the Service, to make payments to an Indian *Health Program*—[tribe or tribal organization administering a health care program pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]—]

(A) to which a scholarship recipient under section *104 and 106* [1613a of this title] or a loan repayment program participant under section *110* [1616a of this title] has been assigned to meet the obligated service requirements pursuant to *such* sections; and

(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section *104, 106, or 110.* [1613a of this title or section 1616a of this title.]

(2) *BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program* [An Indian tribe or tribal organization] receiving payments pursuant to paragraph (1) may expend the payments to *provide scholarships* or recruit and employ, directly or by contract, health professionals to provide health care services.

(c) [(d)] INVESTMENT OF [EXCESS F]*F*UNDS.—

[(1)] The Secretary of the Treasury shall invest such amounts of the *LRRF,* [Fund as such] *as the* Secretary of Health and Human Services determines are not required to meet current withdrawals from the *LRRF* [Fund]. 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.

(d) SALE OF OBLIGATIONS.—[(2)] Any obligation acquired by the *LRRF* [Fund] may be sold by the Secretary of the Treasury at the market price.

§ 1616b. Recruitment *A*[a]ctivities

(a) *REIMBURSEMENT FOR TRAVEL.*—The Secretary, *acting through the Service,* may reimburse health professionals seeking positions *with Indian Health Programs or Urban Indian Organizations* [in the Service], including individuals considering entering into a contract under section *110* [1616a of this title], 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) *RECRUITMENT PERSONNEL.*—The Secretary, acting through the Service, shall assign 1 individual in each [a] *A*rea [o] *O*ffice to be responsible on a full-time basis for recruitment activities.

§ 1616c. *Indian* [Tribal r]*R*ecruitment and *R*[r]etention *P*[p]rogram

(a) *IN GENERAL*.—[PROJECTS FUNDED ON COMPETITIVE BASIS] The Secretary, acting through the Service, shall fund, *on a competitive basis, innovative demonstration projects for a period not to exceed 3 years to enable Tribal Health Programs and Urban Indian Organizations to recruit, place, and retain health professionals to meet their staffing needs.* [, on a competitive basis, projects to enable Indian tribes and tribal and Indian organization to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 1616a(a)(2) of this title).]

(b) *ELIGIBLE ENTITIES; APPLICATION*.—[ELIGIBILITY] [(1)] Any *Tribal Health Program or Urban Indian Organization* [Indian tribe or tribal or Indian organization] may submit an application for funding of a project pursuant to this section.

[(2) Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be given an equal opportunity with programs that are administered directly by the Service to compete for, and receive, grants under subsection (a) of this section for such projects.]

§ 1616d. Advanced *T*[t]raining and *R*[r]esearch

(a) *DEMONSTRATION* [ESTABLISHMENT OF P]*PROGRAM*.—The Secretary, acting through the Service, shall establish a *demonstration project* [program] to enable health professionals *who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time* to pursue advanced training or research in areas of study for which the Secretary determines a need exists. [In selecting participants for a program established under this subsection, the Secretary, acting through the Service, shall give priority to applicants who are employed by the Indian Health Service, Indian tribes, tribal organization, and urban Indian organizations, at the time of the submission of the applications.]

(b) *SERVICE OBLIGATION*.—[OBLIGATED SERVICE]An individual who participates in a program under subsection (a) [of this section], where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* [(as defined in section 1616a(a)(2) of this title)] for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after *the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005,* [October 29, 1992,] the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (*l*) of section *110* [1616a of this title] in the manner provided for in such subsection.

(c) *EQUAL OPPORTUNITY FOR PARTICIPATION*.—[ELIGIBILITY] Health professionals from *Tribal Health Programs and Urban Indian Organizations* [Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act [25

U.S.C.A. § 450f et seq.]] shall be given an equal opportunity to participate in the program under subsection (a) [of this section].

[§ 1616e. Nursing program]

[(a) GRANTS]

[The Secretary, acting through the Service, shall provide grants to—]

[(1) public or private schools of nursing,]

[(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 2397h(2) of Title 20), and]

[(3) nurse midwife programs, and nurse practitioner programs, that are provided by any public or private institution,]

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

[(b) PURPOSES]

[Grants provided under subsection (a) of this section may be used to—]

[(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or nurse practitioners,]

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

[(3) provide a program that encourages nurses, nurse midwives, and nurse practitioners 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 nurse practitioners, or]

[(5) provide any program that is designed to achieve the purpose described in subsection (a) of this section.]

[(c) APPLICATION]

[Each application for a grant under subsection (a) of this section shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.]

[(d) PREFERENCE]

[In providing grants under subsection (a) of this section, the Secretary shall extend a preference to—]

[(1) programs that provide a preference to Indians,]

[(2) programs that train nurse midwives or nurse practitioners,]

[(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 2624(a) of this title.]

§ *115.* [(e)] Quentin N. Burdick American Indians Into Nursing Program

(a) GRANTS AUTHORIZED.—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver

health care services to Indians, the Secretary, acting through the Service, shall provide grants to the following:

(1) Public or private schools of nursing.

(2) Tribal colleges or universities.

(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for one or more of the following:

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

(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

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

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

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

(c) APPLICATIONS.—Each application for funding 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 FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

(1) Programs that provide a preference to Indians.

(2) Programs that train nurse midwives or advanced practice nurses.

(3) Programs that are interdisciplinary.

(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

(e) *QUENTIN N. BURDICK PROGRAM GRANT.*—The Secretary shall provide 1 of the grants authorized under subsection (a) [of this section] to establish and maintain a program at the University of North Dakota to be known as the ["]'Quentin N. Burdick American Indians Into Nursing Program'["]. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section *117(b)* [1616g(b) of this title] and the Quentin N. Burdick American Indians Into Psychology Program established under section *105(b)* [1621p(b) of this title].

(f) *ACTIVE DUTY SERVICE O*[O]BLIGATION.—The active duty service obligation prescribed under section *338C of the Public Health Service Act (42 U.S.C.* 254m*)* [of Title 42] shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) [of this section] that is funded by a grant provided under subsection (a) [of this section]. Such obligation shall be met by service—

(1)[(A)] in the [Indian Health] Service;

(2)[(B)] in a program *of an Indian Tribe or Tribal Organization* conducted under *the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) (including programs under agreements with the Bureau of Indian Affairs)* [a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]];

(3)[(C)] in a program assisted under *title V* [subchapter IV] of this *Act* [chapter]; or

(4)[(D)] 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.

(5) in a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, health services provided to Indians would not decrease.

[(g) AUTHORIZATION OF APPROPRIATIONS]

[Beginning with fiscal year 1993, of the amounts appropriated under the authority of this subchapter for each fiscal year to be used to carry out this section, not less than $1,000,000 shall be used to provide grants under subsection (a) of this section for the training of nurse midwives, nurse anesthetists, and nurse practitioners.]

[§1616e–1. Nursing school clinics]

[(a) GRANTS]

[In addition to the authority of the Secretary under section 1616e(a)(1) of this title, the Secretary, acting through the Service, is authorized to provide grants to public or private schools of nursing for the purpose of establishing, developing, operating, and administering clinics to address the health care needs of Indians, and to provide primary health care services to Indians who reside on or within 50 miles of Indian country, as defined in section 1151 of Title 18.]

[(b) PURPOSES]

[Grants provided under subsection (a) of this section may be used to—]

[(1) establish clinics, to be run and staffed by the faculty and students of a grantee school, to provide primary care services in areas in or within 50 miles of Indian country (as defined in section 1151 of Title 18);]

[(2) provide clinical training, program development, faculty enhancement, and student scholarships in a manner that would benefit such clinics; and]

[(3) carry out any other activities determined appropriate by the Secretary.]

[(c) AMOUNT AND CONDITIONS]

[The Secretary may award grants under this section in such amounts and subject to such conditions as the Secretary deems appropriate.]

[(d) DESIGN]

[The clinics established under this section shall be designed to provide nursing students with a structured clinical experience that

is similar in nature to that provided by residency training programs for physicians.]

[(e) REGULATIONS]

[The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.]

[(f) AUTHORIZATION TO USE AMOUNTS]

[Out of amounts appropriated to carry out this subchapter for each of the fiscal years 1993 through 2000 not more than $5,000,000 may be used to carry out this section.]

§1616f. Tribal *Cultural Orientation* [culture and history]

(a) *CULTURAL EDUCATION OF EMPLOYEES*.—[PROGRAM ESTABLISHED] The Secretary, acting through the Service, shall *require that* [establish a program under which] appropriate employees of the Service who serve [particular] Indian [t]*T*ribes *in each Service Area* [shall] receive educational instruction in the history and culture of such *Indian T*[t]ribes *and their relationship to* [in the history of] the Service.

(b) *PROGRAM*.—[TRIBALLY-CONTROLLED COMMUNITY COLLEGES] *In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—*

[To the extent feasible, the program established under subsection (a) of this section shall—]

(1) *be developed in consultation with the affected Indian Tribes, Tribal Organizations, and Urban Indian Organizations;* [be carried out through tribally-controlled community colleges (within the meaning of section 1801(4) of this title) and tribally controlled postsecondary vocational institutions (as defined in section 2397h(2) of Title 20),]

(2) *be carried out through tribal colleges or universities;* [be developed in consultation with the affected tribal government, and]

(3) include instruction in *American Indian* [Native American] studies*; and*[.]

(4) describe the use and place of Traditional Health Care Practices of the Indian Tribes in the Service Area.

§1616g. INMED Program

(a) GRANTS *AUTHORIZED*.—The Secretary, *acting through the Service*, is authorized to provide grants to [at least 3] colleges and universities for the purpose of maintaining and expanding the *Indian* [Native American] health careers recruitment program known as the ["]'Indians into Medicine Program'["] (hereinafter in this section referred to as ["]'INMED'["]) as a means of encouraging Indians to enter the health professions.

(b) *QUENTIN N. BURDICK GRANT*.—[UNIVERSITY OF NORTH DAKOTA] The Secretary shall provide one of the grants authorized under subsection (a) [of this section] to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Programs', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section *105(b)* [1621p(b) of this title] and the Quentin N.

Burdick American Indians Into Nursing Program established under section *115* [1616e of this title].

(c) REGULATIONS.—[; CONTENTS OF RECRUITMENT PROGRAM]

[(1)] The Secretary, *pursuant to this Act,* shall develop regulations *to govern* [for the competitive awarding of the] grants *pursuant to* [provided under] this section.

(d) *REQUIREMENTS.*—[(2)] Applicants for grants provided under this section shall agree to provide a program which—

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

(2) [(B)] incorporates a program advisory board comprised of representatives from the *Indian* tribes and *Indian* communities which will be served by the program[,]*;*

(3) [(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[,]*;*

(4) [(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

(5) [(E)] to the maximum extent feasible, employs qualified Indians in the program.

[(d) REPORT TO CONGRESS]

[By no later than the date that is 3 years after November 23, 1988, the Secretary shall submit a report to the Congress on the program established under this section including recommendations for expansion or changes to the program.]

§ 1616h. Health [t]*T*raining [p]*P*rograms of [c]*C*ommunity [c]*C*olleges

(a) GRANTS *TO ESTABLISH PROGRAMS.*—

(1) *IN GENERAL.*—The Secretary, acting through the Service, shall award grants to *accredited and accessible* community colleges for the purpose of assisting *such* [the] community colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on *or near a* [an Indian] reservation or in *an Indian Health Program* [a tribal clinic].

(2) *AMOUNT OF GRANTS.*—*T*[t]he amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $250,000.

(b) GRANTS FOR MAINTENANCE AND RECRUITING.—[ELIGIBILITY]

(1) *IN GENERAL.*—The Secretary, acting through the Service, shall award grants to *accredited and accessible* community colleges that have established a program described in subsection (a)(1) [of this section] for the purpose of maintaining the program and recruiting students for the program.

(2) *REQUIREMENTS.*—Grants may only be made under this section to a community college which—

(A) is accredited[,]*;*

(B) has *a relationship with* [access to] 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 that train health professionals[,]*;* and

(ii) stipulate certifications necessary to approved internship and field placement opportunities at *Indian Health Programs;* [service unit facilities of the Service or at tribal health facilities,]

(D) has a qualified staff which has the appropriate certifications[, and]*;*

(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1) [of this section.]*; and*

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

(c) [AGREEMENTS AND T]*T*ECHNICAL [*A*]*A*SSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) [of this section] to establish and maintain programs described in subsection (a)(1) [of this section] by—

(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs[,]*;* and

(2) providing technical assistance and support to such colleges.

(d) ADVANCED TRAINING.—

(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

(A)[(1)] has already received a degree or diploma in such health profession[,]*;* and

(B)[(2)] provides clinical services on *or near a* [an Indian] reservation *or for an Indian Health Program*[, at a Service facility, or at a tribal clinic].

(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C) [of this section].

(e) FUNDING PRIORITY.—Where the requirements of subsection (b) are met, funding priority shall be provided to tribal colleges and universities in Service Areas where they exist.

[(e) DEFINITIONS]

[For purposes of this section—]

[(1) The term "community college" means—]

[(A) a tribally controlled community college, or]

[(B) a junior or community college.]

[(2) The term "tribally controlled community college" has the meaning given to such term by section 1801(4) of this title.]

[(3) The term "junior or community college" has the meaning given to such term by section 1058(e) of Title 20.]

[§ 1616i. Additional incentives for health professionals]

[(a) INCENTIVE SPECIAL PAY]

[The Secretary may provide the incentive special pay authorized under section 302(b) of Title 37, to civilian medical officers of the Indian Health Service who are assigned to, and serving in, positions included in the list established under subsection (b)(1) of this section for which recruitment or retention of personnel is difficult.]

[(b) LIST OF POSITIONS; BONUS PAY]

[(1) the Secretary shall establish and update on an annual basis a list of positions of health care professionals employed by, or assigned to, the Service for which recruitment or retention is difficult.]

[(2)(A) The Secretary may pay a bonus to any commissioned officer or civil service employee, other than a commissioned medical officer, dental officer, optometrist, and veterinarian, who is employed in or assigned to, and serving in, a position in the Service included in the list established by the Secretary under paragraph (1).]

[(B) The total amount of bonus payments made by the Secretary under this paragraph to any employee during any 1-year period shall not exceed $2,000.]

[(c) WORK SCHEDULES]

[The Secretary may establish programs to allow the use of flexible work schedules, and compressed work schedules, in accordance with the provisions of subchapter II of chapter 61 of Title 5, for health professionals employed by, or assigned to, the Service.]

§ 1616j. Retention bonus

(a) *BONUS AUTHORIZED.*—[ELIGIBILITY]The Secretary may pay a retention bonus to any *health professional* [physician or nurse] employed by, or assigned to, and serving in, *an Indian Health Program or Urban Indian Organization* [the Service] either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

(1) is assigned to, and serving in, a position [included in the list established under section 1616i(b)(1) of this title] for which recruitment or retention of personnel is difficult[,]*;*

(2) the Secretary determines is needed by *Indian Health Programs and Urban Indian Organizations;* [the Service,]

(3) has—

(A) completed 3 years of employment with *an Indian Health Program or Urban Indian Organization;* [the Service,] 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 *an Indian Health Program or Urban Indian Organization* [the Service] for continued employment for a period of not less than 1 year.

[(b) MINIMUM AWARD PERCENTAGE TO NURSES]

[Beginning with fiscal year 1993, not less than 25 percent of the retention bonuses awarded each year under subsection (a) of the section shall be awarded to nurses.]

(b)[(c)] RATES.—[; MAXIMUM RATE]The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4) [of this section], but in no event shall the annual rate be more than $25,000 per annum.

[(d) TIME OF PAYMENT]

[The retention bonus for the entire period covered by the agreement described in subsection (a)(4) of this section shall be paid at the beginning of the agreed upon term of service.]

[(e) REFUND; INTEREST]

(c) DEFAULT OF RETENTION AGREEMENT.—Any *health professional* [physician or nurse] 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)* [1616a(*l*)(2)(B) of this title].

(d) OTHER RETENTION BONUS.—

[(f) PHYSICIANS AND NURSES EMPLOYED UNDER INDIAN SELF-DETERMINATION ACT]

The Secretary may pay a retention bonus to any *health professional* [physician or nurse] employed by *a Tribal Health Program* [an organization providing health care services to Indians pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et. seq.]] if such *health professional* [physician or nurse] is serving in a position which the Secretary determines is—

(1) a position for which recruitment or retention is difficult; and

(2) necessary for providing health care services to Indians.

§ 1616k. Nursing residency program

(a) ESTABLISHMENT *OF PROGRAM.*—The Secretary, acting through the Service, shall establish a program to enable *Indians who are* licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian *H*[h]ealth *P*[p]rogram *or Urban Indian Organization* [(as defined in section 1616a(a)(2)(A) of this title)], and have done so for a period of not less than *1* [one] year, to pursue advanced training.

[(b) PROGRAM COMPONENTS]

Such program shall include a combination of education and work study in an Indian *H*[h]ealth *P*[p]rogram *or Urban Indian Organization* [(as defined in section 1616a(a)(2)(A) of this title)] 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 *advanced degrees or certification in nursing and public health* [a Master's degree].

(b)[(c)] SERVICE *O*[O]BLIGATION.—[OF PROGRAM PARTICIPANT] An individual who participates in a program under subsection (a) [of this section], where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian *H*[h]ealth *P*[p]rogram *or Urban Indian Organization* for a period of obligated service equal to *the amount of* [at least three times the period of

the] 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* [1616a of this title] in the manner provided for in such subsection.

§1616*l*. Community Health Aide Program

(a) *GENERAL PURPOSES* [MAINTENANCE] OF PROGRAM.—Under the authority of *the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act')* [section 13 of this title], the Secretary, *acting through the Service,* shall *develop and operate* [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) *SPECIFIC PROGRAM REQUIREMENTS.*—[TRAINING; CURRICULUM; CERTIFICATION BOARD]The Secretary, acting through the Community Health Aide Program of the Service, shall—

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

(2) in order to provide such training, develop a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

(C) promotes the achievement of the health status objectives specified in section *3(2)* [1602(b) of this title];

(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.

(c) PROGRAM REVIEW.—

(1) NEUTRAL PANEL.—

(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a neutral panel to carry out the study under paragraph (2).

(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

(2) STUDY.—

(A) IN GENERAL.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

(B) PARAMETERS OF STUDY.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

(C) INCLUSIONS.—The study shall include a determination by the neutral panel with respect to—

(i) the ability of the dental health aide services under this section to address the dental care needs of Alaska Natives;

(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska Tribal Organizations with respect to the adequacy and accuracy of the study.

(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

(A) any determination of the neutral panel under paragraph (2)(C); and

(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

(d) NATIONALIZATION OF PROGRAM.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this section, as the Secretary determines to be appropriate.

(2) EXCEPTION.—The national Community Health Aide Program under paragraph (10) shall not include dental health aide therapist services.

(3) REQUIREMENT.—In establishing a national program under paragraph (1), the Secretary shall not reduce the amount of funds provided for the Community Health Aide Program described in subsections (a) and (b).

[§1616m. Matching grants to tribes for scholarship programs]

[(a) IN GENERAL]

[(1) The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of assisting such tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.]

[(2) Amounts available for grants under paragraph (1) for any fiscal year shall not exceed 5 percent of amounts available for such fiscal year for Indian Health Scholarships under section 1613a of this title.]

[(3) An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as the Secretary determines are necessary to carry out this section.]

[(b) COMPLIANCE WITH REQUIREMENTS]

[(1) An Indian tribe or tribal organization receiving a grant under subsection (a) of this section shall agree to provide scholarships to Indians pursuing education in the health professions in accordance with the requirements of this section.]

[(2) With respect to the costs of providing any scholarship pursuant to paragraph (1)—]

[(A) 80 percent of the costs of the scholarship shall be paid from the grant made under subsection (a) of this section to the Indian tribe or tribal organization; and]

[(B) 20 percent of such costs shall be paid from non-Federal contributions by the Indian tribe or tribal organization through which the scholarship is provided.]

[(3) In determining the amount of non-Federal contributions that have been provided for purposes of subparagraph (B) of paragraph (2), any amounts provided by the Federal Government to the Indian tribe or tribal organization involved or to any other entity shall not be included.]

[(4) Non-Federal contributions required by subparagraph (B) of paragraph (2) may be provided directly by the Indian tribe or tribal organization involved or through donations from public and private entities.]

[(c) COURSE OF STUDY IN HEALTH PROFESSIONS]

[An Indian tribe or tribal organization shall provide scholarships under subsection (b) of this section only to Indians enrolled or accepted for enrollment in the course of study (approved by the Secretary) in one of the health professions described in section 1613a(a) of this title.]

[(d) CONTRACT REQUIREMENTS]

[In providing scholarships under subsection (b) of this section, the Secretary and the Indian tribe or tribal organization shall enter

into a written contract with each recipient of such scholarship. Such contract shall—]

[(1) obligate such recipient to provide service in an Indian health program (as defined in section 1616a(a)(2)(A) of this title), in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—]

[(A) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or]

[(B) such greater period of time as the recipient and the Indian tribe or tribal organization may agree;]

[(2) provide that the amount of such scholarship—]

[(A) may be expended only for—]

[(i) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and]

[(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 254l(g)(1)(B) of Title 42, such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled; and]

[(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);]

[(3) require the recipient of such scholarship to maintain an acceptable level of academic standing (as determined by the educational institution in accordance with regulations issued by the Secretary); and]

[(4) require the recipient of such scholarship to meet the educational and licensure requirements necessary to be a physician, certified nurse practitioner, certified nurse midwife, or physician assistant.]

[(e) BREACH OF CONTRACT]

[(1) an individual who has entered into a written contract with the Secretary and an Indian tribe or tribal organization under subsection (d) of this section and who—]

[(A) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary),]

[(B) is dismissed from such educational institution for disciplinary reasons,]

[(C) voluntarily terminates the training in such an educational institution for which he is provided a scholarship under such contract before the completion of such training, or]

[(D) fails to accept payment, or instructs the educational institution in which he is enrolled not to accept payment,]

[in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract, shall be liable to the United States for the Federal share of the amount which has been paid to him, or on his behalf, under the contract.]

[(2) If for any reason not specified in paragraph (1), an individual breaches his written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (*l*) of section 1616a of this title in the manner provided for in such subsection.]

[(3) The Secretary may carry out this subsection on the basis of information submitted by the tribes or tribal organization involved, or on the basis of information collected through such other means as the Secretary determines to be appropriate.]

[(f) NONDISCRIMINATORY PRACTICE]

[The recipient of a scholarship under subsection (b) of this section shall agree, in providing health care pursuant to the requirements of subsection (d)(1) of this section—]

[(1) not to discriminate against an individual seeking such care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in title XVIII of the Social Security Act [42 U.S.C.A. §1395 et. Seq.] or pursuant to the program established in title XIX of such Act [42 U.S.C.A. §1396 et. seq.]; and]

[(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act [42 U.S.C.A. §1395u(b)(3)(B)(ii)] for all services for which payment may be made under part B of title XVIII of such Act 42 U.S.C.A. §1395j et. seq., and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX of such Act 42 U.S.C.A. §1396 et. seq. to provide service to individuals entitled to medical assistance under the plan.]

[(g) PAYMENTS FOR SUBSEQUENT FISCAL YEARS]

[The Secretary may not make any payments under subsection (a) of this section to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has complied with requirements of this section.]

§1616n. Tribal *H*[h]ealth *P*[p]rogram *A*[a]dministration

The Secretary, *acting through the Service,* shall, by contract or otherwise, provide training for *Indians* [individuals] in the administration and planning of *T*[t]ribal *H*[h]ealth *P*[p]rograms

§ 123. Health Professional Chronic Shortage Demonstration Programs

(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

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

(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region.

(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

§124. National Health Service Corps

(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

(1) remove a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization; or

(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations, has ensured that the Indians receiving services from such member will experience no reduction in services.

(b) EXEMPTION FROM LIMITATIONS.—National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the Service when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

§125. Substance abuse counselor educational curricula demonstration programs

(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 3 years. Such contract or grant may be renewed for an additional 2-year period upon the approval of the Secretary.

(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

(e) ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

(g) DEFINITION.—For the purposes of this section, the term 'educational curriculum' means 1 or more of the following:

(1) Classroom education.

(2) Clinical work experience.

(3) Continuing education workshops.

§126. Behavioral health training and community education programs

(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

(b) POSITIONS.—The positions referred to in subsection (a) are—

(1) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

(A) elementary and secondary education;

(B) social services and family and child welfare;

(C) law enforcement and judicial services; and

(D) alcohol and substance abuse;

(2) staff positions within the Service; and

(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations, (without regard to the funding source) and Urban Indian Organizations.

(c) TRAINING CRITERIA.—

(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or Urban Indian Organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding Traditional Health Care Practices is provided.

(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, or assist the Indian Tribe, Tribal Organization, or Urban Indian Organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

(e) PLAN.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of the enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').

[§1616*o*. University of South Dakota pilot program]

[(a) Establishment]

[The Secretary may make a grant to the School of Medicine of the University of South Dakota (hereafter in this section referred to as "USDSM") to establish a pilot program on an Indian reservation at one or more service units in South Dakota to address the chronic manpower shortage in the Aberdeen Area of the Service.]

[(b) PURPOSES]

[The purposes of the program established pursuant to a grant provided under subsection (a) of this section are—]

[(1) to provide direct clinical and practical experience at the service unit to medical students and residents from USDSM and other medical schools;]

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

[(3) to provide academic and scholarly opportunities for physicians, physician assistants, nurse practitioners, nurse and other allied health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.]

[(c) COMPOSITION; DESIGNATION]

[The pilot program established pursuant to a grant provided under subsection (a) of this section shall—]

[(1) incorporate a program advisory board composed of representatives from the tribes and communities in the area which will be served by the program; and]

[(2) shall be designated as an extension of the USDSM campus and program participants shall be under the direct supervision and instruction of qualified medical staff serving at the service unit who shall be members of the USDSM faculty.]

[(d) COORDINATION WITH OTHER SCHOOLS]

[The USDSM shall coordinate the program established pursuant to a grant provided under subsection (a) of this section with other

medical schools in the region, nursing schools, tribal community colleges, and other health professional schools.]

[(e) DEVELOPMENT OF ADDITIONAL PROFESSIONAL OPPORTUNITIES]

[The USDSM, in cooperation with the Service, shall develop additional professional opportunities for program participants on Indian reservations in order to improve the recruitment and retention of qualified health professionals in the Aberdeen Area of the Service.]

§ 1616p. Authorization of [a]*Appropriations*

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 [2000] to carry out this *title* [subchapter].

TITLE [SUBCHAPTER] II—HEALTH SERVICES

§ 1621. Indian Health Care Improvement Fund

(a) *USE OF FUNDS.*—[APPROVED EXPENDITURES]

The Secretary, *acting through the Service,* is authorized to expend funds, *directly or under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.),* which are appropriated under the authority of this section, [through the Service,] for the purposes of—

(1) eliminating the deficiencies in health status and *health* resources of all Indian [t]*T*ribes[,]*;*

(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, *including the use of telehealth and telemedicine when appropriate;* [and]

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

(5) [(4)] augmenting the ability of the Service to meet the following health service responsibilities[, either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],] with respect to those Indian [t]*T*ribes with the highest levels of health status *deficiencies* and resource deficiencies:

(A) [c]*C*linical care, [(direct and indirect)] including *inpatient care, outpatient care (including audiology,* clinical eye and vision care), *primary care, secondary and tertiary care, and long-term care.*[;]

(B) [p]*P*reventive health, including [screening] mammography *and other cancer screening* in accordance with section *207.* [1621k of this title;]

(C) [d]*D*ental care. [(direct and indirect);]

(D) [m]*M*ental 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* [Indian] practitioners.[;]

(E) [e]*E*mergency medical services.[;]

(F) [t]*T*reatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.[;]

(G) [a]*A*ccident prevention programs.[;]

(H) [h]*H*ome health care.[;]

(I) [c]*C*ommunity health representatives.[; and]

(J) [m]*M*aintenance and repair.

(K) Traditional Health Care Practices.

(b) *NO OFFSET OR LIMITATION.*—[EFFECT ON OTHER APPROPRIATIONS; ALLOCATION TO SERVICE UNITS]

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

(c) ALLOCATION; USE.—[(2)(A)]

(1) IN GENERAL.—Funds appropriated under the authority of this section *shall* [may] be allocated *to Service Units, Indian Tribes, or Tribal Organizations* [on a service unit basis]. The funds allocated to each *Indian Tribe, Tribal Organization, or S*[s]ervice *U*[u]nit under this [sub]paragraph shall be used by the *Indian Tribe, Tribal Organization, or S*[s]ervice *U*[u]nit *under this paragraph* to *improve* [reduce] the health status and *reduce the* resource deficiency of each *Indian* Tribe served by such *S*[s]ervice *U*[u]nit, *Indian Tribe, or Tribal Organization.*

(2) [(B)] *APPORTIONMENT OF ALLOCATED FUNDS.*—The apportionment of funds allocated to a *S*[s]ervice *U*[u]nit, *Indian Tribe, or Tribal Organization* under [sub]paragraph *(1)* [(A)] among the health service responsibilities described in subsection (a)*(5)* [(4) of this section] shall be determined by the Service in consultation with, and with the active participation of, the affected Indian Tribes *and Tribal Organizations.*

(d) [(c)] *PROVISIONS RELATING TO HEALTH STATUS AND R*[R]ESOURCE[S D]*DEFICIENC*[*Y*]*IES* [LEVELS]

For purposes of this section, *the following definitions apply:*[—]

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

(A) the health status objectives set forth in section *3(2)*[1602(b) of this title] are not being achieved; and

(B) the Indian [t]*T*ribe *or Tribal Organization* does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) *AVAILABLE RESOURCES.*—The health resources available to an Indian [t]*T*ribe *or Tribal Organization* include health resources provided by the Service as well as health resources used by the Indian [t]*T*ribe *or Tribal Organization,* including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

(3) *PROCESS FOR REVIEW OF DETERMINATIONS.*—The Secretary shall establish procedures which allow any Indian [t]*T*ribe *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 *Indian T*[t]ribe *or Tribal Organization.*

(e) [(d)] *ELIGIBILITY FOR FUNDS.*—[PROGRAMS ADMINISTERED BY INDIAN TRIBE]

[(1)] *Tribal Health* Programs [administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination 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.

[(2) If any funds allocated to a tribe or service unit under the authority of this section are used for a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.]

(f) [(e)] REPORT [TO CONGRESS].—

By no later than the date that is 3 years after *the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005* [October 29, 1992], the Secretary shall submit to [the] Congress the current health status and resource deficiency report of the Service for each [Indian tribe or s]*S*ervice [u]*U*nit, including newly recognized or acknowledged *Indian T*[t]ribes. Such report shall set out—

(1) the methodology then in use by the Service for determining [t]*T*ribal 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 *or a Tribal Health Program;*

(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service *or a Tribal Health Program;* and

(4) an estimate of—

(A) the amount of health service funds appropriated under the authority of this *Act* [chapter], or any other Act, including the amount of any funds transferred to the Service[,] for the preceding fiscal year which is allocated to each *S*[s]ervice *U*[u]nit, Indian [t]*T*ribe, or *Tribal Organization* [comparable entity];

(B) the number of Indians eligible for health services in each [s]*S*ervice [u]*U*nit or Indian [t]*T*ribe *or Tribal Organization;* and

(C) the number of Indians using the Service resources made available to each [s]*S*ervice [u]*U*nit, [or] Indian [t]*T*ribe *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.*

(g) [(f)] *INCLUSION* [APPROPRIATED FUNDS INCLUDED] IN [B]BASE [B]BUDGET [OF SERVICE].—

Funds appropriated under [authority of] this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(*h*)[(g)] *CLARIFICATION.*—[CONTINUATION OF SERVICE RESPONSIBILITIES FOR BACKLOGS AND PARITY]

Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve *equity* [parity] among Indian[s t]*T*ribes *and Tribal Organizations.*

(*i*)[(h)] *FUNDING DESIGNATION.*— [AUTHORIZATION OF APPROPRIATIONS]

Any funds appropriated under the authority of this section shall be designated as the ["]'Indian Health Care Improvement Fund'["].

§ 1621a. Catastrophic [h]*H*ealth [e]*E*mergency [f]*F*und.

(a) ESTABLISHMENT.—[; ADMINISTRATION; PURPOSE]

[(1)] There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the *'CHEF'* ["Fund"]) consisting of—

(1)[(A)] the amounts deposited under subsection *(f)*[(d) of this section,]*;* and

(2)[(B)] the amounts appropriated to *CHEF* [the Fund] under this section.

(b) ADMINISTRATION.—[(2) The Fund] *CHEF* shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

[(3) The Fund shall not be allocated, apportioned, or delegated on a service unit, area office, or any other basis.]

(c) CONDITIONS ON USE OF FUND.—[(4)] No part of *CHEF* [the Fund] or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination *and Education Assistance* Act (25 U.S.C. 450 et seq.), [[25 U.S.C.A. § 450f et seq.].] *nor shall CHEF funds be allocated, apportioned, or delegated on an Areaffice, Service Unit, or other similar basis.*

(d)[(b)] REGULATIONS.—[; PROCEDURES FOR PAYMENT]

The Secretary shall, through the *negotiated rulemaking process under title VIII, promulgate* [promulgation of] regulations consistent with the provisions of this section to—

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

(2) provide that a [s]*S*ervice [u]*U*nit shall not be eligible for reimbursement for the cost of treatment from *CHEF* [the Fund] until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

(A) *the 2000 level of $19,000* [for 1993, not less than $15,000 or not more than $25,000]; and

(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States

city average) for the 12-month period ending with December of the previous year;

(3) establish a procedure for the reimbursement of the portion of the costs *that exceeds such threshold cost* incurred by—

(A) [s]*S*ervice [u]*U*nits*;* [or facilities of the Service,] or

(B) whenever otherwise authorized by the Service, non-Service facilities or providers[, in rendering treatment that exceeds such threshold cost];

(4) establish a procedure for payment from *CHEF* [the Fund] 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 *CHEF* [the Fund] 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.

(e) NO OFFSET OR LIMITATION.—[(c) EFFECT ON OTHER APPROPRIATIONS]

Amounts appropriated to *CHEF* [the Fund] under this section shall not be used to offset or limit appropriations made to the Service under authority of *the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act')* [section 13 of this title], or any other law.

(f)[(d)] *DEPOSIT OF* REIMBURSEMENT[S TO] FUNDS.—

There shall be deposited into *CHEF* [the Fund] 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 *CHEF* [the Fund].

§1621b. Health [p]*P*romotion and [d]*D*isease [p]*P*revention [s]*S*ervices

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

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

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

[(a) AUTHORIZATION]

(b) PROVISION OF SERVICES.—

The Secretary, acting through the Service *and Tribal Health Programs*, shall provide health promotion and disease prevention services to Indians [so as] to achieve the health status objectives set forth in section *3(2)*[1602(b) of this title].

(c)[(b)] EVALUATION.—[STATEMENT FOR PRESIDENTIAL BUDGET]

The Secretary, *after obtaining input from the affected Tribal Health Programs*, shall submit to the President for inclusion in *the report* [each statement] which is required to be submitted to [the] Congress under section *801*[1671 of this title] an evaluation of—

(1) the health promotion and disease prevention needs of Indians[,]*;*

(2) the health promotion and disease prevention activities which would best meet such needs[,]*;*

(3) the internal capacity of the Service *and Tribal Health Programs* to meet such needs[,]*;* and

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

§1621c. Diabetes [p]*P*revention, [t]*T*reatment, and [c]*C*ontrol

(a) *DETERMINATIONS REGARDING DIABETES.*—[INCIDENCE AND COMPLICATIONS]

The Secretary, *acting through the Service, and* in consultation with [the] *Indian T*[t]ribes *and Tribal Organizations*, shall determine—

(1) by *Indian T*[t]ribe and by Service [u]*U*nit [of the Service], the incidence of, and the types of complications resulting from, diabetes among Indians; and

(2) based on *the determinations made pursuant to* paragraph (1), the measures (including patient education *and effective ongoing monitoring of disease indicators*) each Service [u]*U*nit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among *Indian T*[t]ribes within that Service unit.

(b) *DIABETES* SCREENING.—

To the extent medically indicated and with informed consent, t[T]he Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and, *in consultation with Indian Tribes, Urban Indian Organizations, and appropriate health care providers, establish a cost-effective approach to ensure ongoing monitoring of disease indicators*. Such screening *and monitoring* may be *conducted* [done] by a *Tribal Health Program and may be conducted through appropriate Internet-based health care management programs*. [tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].]

(c) FUNDING FOR DIABETES.—The Secretary shall continue to maintain each model diabetes project in existence on the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian Tribes. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2005 and for projects which are added and funded thereafter.

[(c) MODEL DIABETES PROJECTS]

[(1) The Secretary shall continue to maintain through fiscal year 2000 each model diabetes project in existence October 29, 1992 and located—]

[(A) at the Claremore Indian Hospital in Oklahoma;]

[(B) at the Fort Totten Health Center in North Dakota;]

[(C) at the Sacaton Indian Hospital in Arizona;]

[(D) at the Winnebago Indian Hospital in Nebraska;]

[(E) at the Albuquerque Indian Hospital in New Mexico;]

[(F) at the Perry, Princeton, and Old Town Health Centers in Maine;]

[(G) at the Bellingham Health Center in Washington;]

[(H) at the Fort Berthold Reservation;]

[(I) at the Navajo Reservation;]

[(J) at the Papago Reservation;]

[(K) at the Zuni Reservation; or]

[(L) in the States of Alaska, California, Minnesota, Montana, Oregon, or Utah.]

[(2) The Secretary may establish new model diabetes projects under this section taking into consideration applications received under this section from all service areas, except that the Secretary may not establish a greater number of such projects in one service area than in any other service area until there is an equal number of such projects established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).]

(d) FUNDING FOR DIALYSIS PROGRAMS.—The Secretary is authorized to provide funding through the Service, Indian Tribes, and Tribal Organizations to establish dialysis programs, including funding to purchase dialysis equipment and provide necessary staffing.

[(d) CONTROL OFFICER; REGISTRY OF PATIENTS]

[The Secretary shall—]

[(1) employ in each area office of the Service at least one diabetes control officer who shall coordinate and manage on a full-time basis activities within that area office 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 incidence of diabetes and the complications from diabetes in that area;]

[(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to all other area offices; and]

[(4) evaluate the effectiveness of services provided through model diabetes projects established under this section.]

(e) OTHER DUTIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall, to the extent funding is available—

(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

(B) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

(C) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

(2) DIABETES CONTROL OFFICERS.—

(A) IN GENERAL.—The Secretary may establish and maintain in each Area Office a position of diabetes control offi-

cer to coordinate and manage any activity of that Area office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

(B) CERTAIN ACTIVITIES.—Any Activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

[(e) AUTHORIZATION OF APPROPRIATIONS]

[Funds appropriated under this section in any fiscal year shall be in addition to base resources appropriated to the Service for that year.]

§ 205. Shared services for long-term care

(a) LONG-TERM CARE.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations for, the delivery of long-term care and similar services to Indians. Such agreements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or other similar facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Act) (25 U.S.C. 450 et seq.)) by such Indian Tribe or Tribal Organization.

(b) CONTENTS OF AGREEMENTS.—An 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 Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

[§ 1621d. Hospice care feasibility study]

[(a) DUTY OF SECRETARY]

[The Secretary, acting through the Service and in consultation with representatives of Indian tribes, tribal organizations, Indian Health Service personnel, and hospice providers, shall conduct a study—]

[(1) to assess the feasibility and desirability of furnishing hospice care to terminally ill Indians; and]

[(2) to determine the most efficient and effective means of furnishing such care.]

[(b) FUNCTIONS OF STUDY]

[Such study shall—]

[(1) assess the impact of Indian culture and beliefs concerning death and dying on the provision of hospice care to Indians;]

[(2) estimate the number of Indians for whom hospice care may be appropriate and determine the geographic distribution of such individuals;]

[(3) determine the most appropriate means to facilitate the participation of Indian tribes and tribal organizations in providing hospice care;]

[(4) identify and evaluate various means for providing hospice care, including—]

[(A) the provision of such care by the personnel of a Service hospital pursuant to a hospice program established by the Secretary at such hospital; and]

[(B) the provision of such care by a community-based hospice program under contract to the Service; and]

[(5) identify and assess any difficulties in furnishing such care and the actions needed to resolve such difficulties.]

[(c) REPORT TO CONGRESS]

[Not later than the date which is 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report containing—]

[(1) a detailed description of the study conducted pursuant to this section; and]

[(2) a discussion of the findings and conclusions of such study.]

[(d) DEFINITIONS]

[For the purposes of this section—]

[(1) the term "terminally ill" means any Indian who has a medical prognosis (as certified by a physician) of a life expectancy of six months or less; and]

[(2) the term "hospice program" means any program which satisfies the requirements of section 1395x(dd)(2) of Title 42; and]

[(3) the term "hospice care" means the items and services specified in subparagraphs (A) through (H) of section 1395x(dd)(1) of Title 42.]

§ 206. Health services research

The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs. The Secretary shall also, to the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs. Tribal Health Programs shall be given an

equal opportunity to compete for, and receive, research funds under this section. This funding may be used for both clinical and non-clinical research.

[§ 1621e. Reimbursement from certain third parties of costs of health services]

[(a) RIGHT OF RECOVERY]

[Except as provided in subsection (f) of this section, the United States, an Indian tribe, or a tribal organization shall have the right to recover the reasonable expenses incurred by the Secretary, an Indian tribe, or a tribal organization in providing health services, through the Service, an Indian tribe, or tribal organization, to any individual to the same extent that such individual, or any non-governmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—]

[(1) such services had been provided by a nongovernmental provider, and]

[(2) such individual had been required to pay such expenses and did pay such expenses.]

[(b) RECOVERY AGAINST STATE WITH WORKERS' COMPENSATION LAWS OR NO-FAULT AUTOMOBILE ACCIDENT INSURANCE PROGRAM]

[Subsection (a) of this section shall provide a right of recovery against any State only if the injury, illness, or disability for which health services were provided is covered under—]

[(1) workers' compensation laws, or]

[(2) a no-fault automobile accident insurance plan or program.]

[(c) PROHIBITION OF STATE LAW OR CONTRACT PROVISION IMPEDING RIGHT OF RECOVERY]

[No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or a tribal organization under subsection (a) of this section.]

[(d) RIGHT TO DAMAGES]

[No action taken by the United States, an Indian tribe, or a tribal organization to enforce the right of recovery provided under subsection (a) of this section shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).]

[(e) INTERVENTION OR SEPARATE CIVIL ACTION]

[The United States, an Indian tribe, or a tribal organization may enforce the right of recovery provided under subsection (a) of this section by—]

[(1) intervening or joining in any civil action or proceeding brought—]

[(A) by the individual for whom health services were provided by the Secretary, an Indian tribe, or a tribal organization, or]

[(B) by any representative or heirs of such individual, or]

[(2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, an Indian

tribe, or a tribal organization to institute a separate civil action.]

[(f) RIGHT OF RECOVERY FOR SERVICES WHEN SELF-INSURANCE PLAN PROVIDES COVERAGE]

[The United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.]

§ 207. Mammography and other cancer screening

The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:

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

(2) Other cancer screening meeting accepted and appropriate national standards.

[§ 1621f. Crediting of reimbursements]

[(a) Except as provided in section 1621a(d) of this title, subchapter III–A of this chapter, and section 1680c of this title, all reimbursements received or recovered, under authority of this chapter, Public Law 87–693 (42 U.S.C. 2651, et seq.), or any other provision of law, by reason of the provision of health services by the Service or by a tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.]

[(b) The Service may not offset or limit the amount of funds obligated to any service unit or any entity under contract with the Service because of the receipt of reimbursements under subsection (a) of this section.]

§ 208. Patient travel costs

The Secretary, acting through the Service and Tribal Health Programs, is authorized to 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 a contract or compact under the Indian Self-Determination and Education Act (25 U.S.C. 450 et seq.)) under this Act—

(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

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

[§ 1621g. Health services research]

[Of the amounts appropriated for the Service in any fiscal year, other than amounts made available for the Indian Health Care Improvement Fund, not less than $200,000 shall be available only for research to further the performance of the health service responsibilities of the Service. Indian tribes and tribal organizations contracting with the Service under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be given an equal opportunity to compete for, and receive, research funds under this section.]

§ 209. Epidemiology centers

(a) ADDITIONAL CENTERS.—In addition to those epidemiology centers already established as of the date of enactment of this Act, and without reducing the funding levels for such centers, not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, shall establish an epidemiology center in each Service Area which does not yet have one to carry out the functions described in subsection (b). Any new centers so established may be operated by Tribal Health Programs, but such funding shall not be divisible.

(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each Service Area epidemiology center established under this subsection shall, with respect to such Service Area—

(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the Service Area;

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

(3) 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;

(4) make recommendations for the targeting of services needed by the populations served;

(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

(c) 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.

(d) FUNDING FOR STUDIES.—The Secretary may make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct epidemiological studies of Indian communities.

[§ 1621h. Mental health prevention and treatment services]

[(a) NATIONAL PLAN FOR INDIAN MENTAL HEALTH SERVICES]

[(1) Not later than 120 days after November 28, 1990, the Secretary, acting through the Service, shall develop and publish in the Federal Register a final national plan for Indian Mental Health Services. The plan shall include—]

[(A) an assessment of the scope of the problem of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians, including—]

[(i) the number of Indians served by the Service who are directly or indirectly affected by such illness or behavior, and]

[(ii) an estimate of the financial and human cost attributable to such illness or behavior;]

[(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior; and]

[(C) an estimate of the additional funding needed by the Service to meet its responsibilities under the plan].

[(2) The Secretary shall submit a copy of the national plan to the Congress.]

[(b) MEMORANDUM OF AGREEMENT]

[Not later than 180 days after November 28, 1990, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement under which the Secretaries shall, among other things—]

[(1) determine and define the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;]

[(2) make an assessment of the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;]

[(3) make an initial determination of the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);]

[(4)(A) ensure that Indians, as citizens of the United States and of the States in which they reside, have access to mental health services to which all citizens have access;]

[(B) determine the right of Indians to participate in, and receive the benefit of, such services; and]

[(C) take actions necessary to protect the exercise of such right;]

[(5) delineate the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);]

[(6) provide a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—]

[(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the

various tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) [25 U.S.C.A. §2401 et seq.] with the mental health initiatives pursuant to this chapter, particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and]

[(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;]

[(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to subsection (d) of this section; and]

[(8) provide for an annual review of such agreement by the two Secretaries.]

[(c) COMMUNITY MENTAL HEALTH PLAN]

[(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a community mental health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members.]

[(2) In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the tribe in the development of such plan. Upon the establishment of such a plan and at the request of the tribe, such officials, as directed by the memorandum of agreement developed pursuant to subsection (c), of this section, shall cooperate with the tribe in the implementation of such plan.]

[(3) Two or more Indian tribes may form a coalition for the adoption of resolutions and the establishment and development of a joint community mental health plan under this subsection.]

[(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community mental health plan and to provide administrative support in the implementation of such plan.]

[(d) MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS]

[(1) The Secretary and the Secretary of the Interior, in consultation with representatives of Indian tribes, shall conduct a study and compile a list, of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness or dysfunctional and self-destructive behavior.]

[(2) The positions referred to in paragraph (1) are—]

[(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—]

[(i) elementary and secondary education;]

[(ii) social services and family and child welfare;]

[(iii) law enforcement and judicial services; and]

[(iv) alcohol and substance abuse;]

[(B) staff positions with the Service; and]

[(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes, including positions established in contracts entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].]

[(3)(A) The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraph (2)(A) and ensure that appropriate training has been, or will be, provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to an Indian tribe for the training of, such individual. In the case of positions funded under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], the appropriate Secretary shall ensure that such training costs are included in the contract, if necessary.]

[(B) Funds authorized to be appropriated pursuant to this section may be used to provide training authorized by this paragraph for community education programs described in paragraph (5) if a plan adopted pursuant to subsection (d) of this section identifies individuals or employment categories, other than those identified pursuant to paragraph (1), for which such training or community education is deemed necessary or desirable.]

[(4) Position-specific training criteria described in paragraph (3) shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional Indian healing and treatment practices is provided.]

[(5) The Service shall develop and implement or, upon the request of an Indian tribe, assist such tribe to develop and implement, a program of community education on mental illness and dysfunctional and self-destructive behavior for individuals, as determined in a plan adopted pursuant to subsection (d) of this section. In carrying out this paragraph, the Service shall provide, upon the request of an Indian tribe, technical assistance to the Indian tribe to obtain or develop community education and training materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.]

[(e) STAFFING]

[(1) Within 90 days after November 28, 1990, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within five years after November 28, 1990, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level for services which shall include

outpatient, emergency, aftercare and follow-up, and prevention and education services.]

[(2) The plan developed under paragraph (1) shall be implemented under section 13 of this title.]

[(f) STAFF RECRUITMENT AND RETENTION]

[(1) The Secretary shall provide for the recruitment of the additional personnel required by subsection (f) of this section and the retention of all Service personnel providing mental health services. In carrying out this subsection, the Secretary shall give priority to practitioners providing mental health services to children and adolescents with mental health problems.]

[(2) In carrying out paragraph (1), the Secretary shall develop a program providing for—]

[(A) the payment of bonuses (which shall not be more favorable than those provided for under section 1616i and 1616j of this title) for service in hardship posts;]

[(B) the repayment of loans (for which the provisions of repayment contracts shall not be more favorable than the repayment contracts under section 1616a of this title) for health professions education as a recruitment incentive; and]

[(C) a system of postgraduate rotations as a retention incentive.]

[(3) This subsection shall be carried out in coordination with the recruitment and retention programs under subchapter I of this chapter.]

[(g) MENTAL HEALTH TECHNICIAN PROGRAM]

[(1) Under the authority of section 13 of this title, the Secretary shall establish and maintain a Mental Health Technician program within the Service which—]

[(A) provides for the training of Indians as mental health technicians; and]

[(B) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.]

[(2) In carrying out paragraph (1)(A), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.]

[(3) The Secretary shall supervise and evaluate the mental health technicians in the training program.]

[(4) The Secretary shall ensure that the program established pursuant to this subsection involves the utilization and promotion of the traditional Indian health care and treatment practices of the Indian tribes to be served.]

[(h) MENTAL HEALTH RESEARCH]

[The Secretary, acting through the Service and in consultation with the National Institute of Mental Health, shall enter into contracts with, or make grants to, appropriate institutions for the conduct of research on the incidence and prevalence of mental dis-

orders among Indians on Indian reservations and in urban areas. Research priorities under this subsection shall include—]

[(1) the inter-relationship and inter-dependence of mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence, and]

[(2) the development of models of prevention techniques.]

[The effect of the inter-relationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.]

[(i) FACILITIES ASSESSMENT]

[Within one year after November 28, 1990, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.]

[(j) ANNUAL REPORT]

[The Service shall develop methods for analyzing and evaluating the overall status of mental health programs and services for Indians and shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the mental health status of Indians which shall describe the progress being made to address mental health problems of Indian communities.]

[(k) MENTAL HEALTH DEMONSTRATION GRANT PROGRAM]

[(1) The Secretary, acting through the Service, is authorized to make grants to Indian tribes and inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs to deliver innovative community-based mental health services to Indians. The 25 percent tribal share of such cost may be provided in cash or through the provision of property or services.]

[(2) The Secretary may award a grant for a project under paragraph (1) to an Indian tribe or inter-tribal consortium which meets the following criteria:]

[(A) The project will address significant unmet mental health needs among Indians.]

[(B) The project will serve a significant number of Indians.]

[(C) The project has the potential to deliver services in an efficient and effective manner.]

[(D) The tribe or consortium has the administrative and financial capability to administer the project.]

[(E) The project will deliver services in a manner consistent with traditional Indian healing and treatment practices.]

[(F) The project is coordinated with, and avoids duplication of, existing services.]

[(3) For purposes of this subsection, the Secretary shall, in evaluating applications for grants for projects to be operated under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], use

the same criteria that the Secretary uses in evaluating any other application for such a grant.]

[(4) The Secretary may only award one grant under this subsection with respect to a service area until the Secretary has awarded grants for all service areas with respect to which the Secretary receives applications during the application period, as determined by the Secretary, which meet the criteria specified in paragraph (2).]

[(5) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a report evaluating the effectiveness of the innovative community-based projects demonstrated pursuant to this subsection. Such report shall include findings and recommendations, if any, relating to the reorganization of the programs of the Service for delivery of mental services to Indians.]

[(6) Grants made pursuant to this section may be expended over a period of three years and no grant may exceed $1,000,000 for the fiscal years involved.]

[*(l)* LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS]

[Any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this chapter or through a contract pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et. seq.] shall—]

[(1) in the case of a person employed as a psychologist, be licensed as a clinical psychologist or working under the direct supervision of a licensed clinical psychologist;]

[(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or]

[(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.]

[(m) INTERMEDIATE ADOLESCENT MENTAL HEALTH SERVICES]

[(1) The Secretary, acting through the Service, may make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents, including—]

[(A) inpatient and outpatient services;]

[(B) emergency care;]

[(C) suicide prevention and crisis intervention; and]

[(D) prevention and treatment of mental illness, and dysfunctional and self-destructive behavior, including child abuse and family violence.]

[(2) Funds provided under this subsection may be used—]

[(A) to construct or renovate an existing health facility to provide intermediate mental health services;]

[(B) to hire mental health professionals;]

[(C) to staff, operate, and maintain an intermediate mental health facility, group home, or youth shelter where intermediate mental health services are being provided; and]

[(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units.]

[(3) Funds provided under this subsection may not be used for the purposes described in section 1621*o*(b)(1) of this title.]

[(4) An Indian tribe or tribal organization receiving a grant under this subsection shall ensure that intermediate adolescent mental health services are coordinated with other tribal, Service, and Bureau of Indian Affairs mental health, alcohol and substance abuse, and social services programs on the reservation of such tribe or tribal organization.]

[(5) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this subsection.]

[(6) There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§210. Comprehensive school health education programs

(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—In addition to carrying out any other program for health promotion or disease prevention, the Secretary, acting through the Service, is authorized to award grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop comprehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of Indian and Urban Indian children.

(b) USE OF GRANT FUNDS.—A grant awarded under this section may be used for purposes which may include, but are not limited to, the following:

(1) Developing and implementing health education curricula both for regular school programs and afterschool programs.

(2) Training teachers in comprehensive school health education curricula.

(3) Integrating school-based, community-based, and other public and private health promotion efforts.

(4) Encouraging healthy, tobacco-free school environments.

(5) Coordinating school-based health programs with existing services and programs available in the community.

(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

(7) Developing behavioral health wellness programs.

(8) Developing chronic disease prevention programs.

(9) Developing substance abuse prevention programs.

(10) Developing injury prevention and safety education programs.

(11) Developing activities for the prevention and control of communicable diseases.

(12) Developing community and environmental health education programs that include traditional health care practitioners.

(13) Violence prevention.

(14) Such other health issues as are appropriate.

(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall 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 FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications for funding provided pursuant to this section.

(e) DEVELOPMENT OF PROGRAM FOR BIA FUNDED SCHOOLS.—

(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, and affected Indian Tribes and Tribal Organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include—

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

(B) behavioral 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) DUTIES OF THE SECRETARY.—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.

[§ 1621i. Managed care feasibility study]

[(a) The Secretary, acting through the Service, shall conduct a study to assess the feasibility of allowing an Indian tribe to purchase, directly or through the Service, managed care coverage for all members of the tribe from—]

[(1) a tribally owned and operated managed care plan; or]

[(2) a State licensed managed care plan.]

[(b) Not later than the date which is 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report containing—]

[(1) a detailed description of the study conducted pursuant to this section; and]

[(2) a discussion of the findings and conclusions of such study.]

§ 211. Indian Youth Program

(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to establish and administer a program 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) ALLOWABLE USES.—Funds made available under this section may be used to—

(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

(B) develop and provide community training and education.

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

(c) DUTIES OF THE SECRETARY.—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 FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

[§ 1621j. California contract health services demonstration program]

[(a) ESTABLISHMENT]

[The Secretary shall establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.]

[(b) AGREEMENT WITH CALIFORNIA RURAL INDIAN HEALTH BOARD]

[(1) In establishing such program, the Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred, during the period of the demonstration program, in providing medical treatment under contract to California Indians described in section 1679(b) of this title throughout the California contract health services delivery area described in section 1680 of this title with respect to high-cost contract care cases.]

[(2) Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the Board during such fiscal year.]

[(3) No payment may be made for treatment provided under the demonstration program to the extent payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 1621a of this title or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.]

[(c) ADVISORY BOARD]

[There is hereby established an advisory board which shall advise the California Rural Indian Health Board in carrying out the demonstration pursuant to this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under such demonstration, at least one half of whom are not affiliated with the California Rural Indian Health Board.]

[(d) COMMENCEMENT AND TERMINATION DATES]

[The demonstration program described in this section shall begin on January 1, 1993, and shall terminate on September 30, 1997.]

[(e) REPORT]

[Not later than July 1, 1998, the California Rural Indian Health Board shall submit to the Secretary a report on the demonstration program carried out under this section, including a statement of its findings regarding the impact of using a contract care intermediary on—]

[(1) access to needed health services;]

[(2) waiting periods for receiving such services; and]

[(3) the efficient management of high-cost contract care cases.]

[(f) "HIGH-COST CONTRACT CARE CASES" DEFINED]

[For the purposes of this section, the term "high-cost contract care cases" means those cases in which the cost of the medical treatment provided to an individual—]

[(1) would otherwise be eligible for reimbursement from the Catastrophic Health Emergency Fund established under section 1621a of this title, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 1621a(b)(2) of this title; and]

[(2) exceeds $1,000.]

[(g) AUTHORIZATION OF APPROPRIATIONS]

[There are authorized to be appropriated for each of the fiscal years 1996 through 2000 such sums as may be necessary to carry out the purposes of this section.]

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

(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, and 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, Tribal Organizations, and Urban Indian Organizations for the following:

(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and H. Pylori.

(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

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

(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

(1) may, at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance; and

(2) shall prepare and submit a report to Congress biennially 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.

[§ 1621k. Coverage of screening mammography]

[The Secretary, through the Service, shall provide for screening mammography (as defined in section 1861(jj) of the Social Security Act [42 U.S.C.A. § 1395x9JJ0]) for Indian and urban Indian women 35 years of age or older at a frequency, determined by the Secretary (in consultation with the Director of the National Cancer Institute), appropriate to such women, 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 [42 U.S.C.A. § 1395j et. seq.].**]**

§ 213. Authority for provision of other services

(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act, including—

(1) hospice care;

(2) assisted living;

(3) long-term health care;

(4) home- and community-based services, in accordance with subsection (d); and

(5) public health functions.

(b) SERVICES TO OTHERWISE INELIGIBLE PERSONS.—Subject to section 807, at the discretion of the Service, Indian Tribes, or Tribal Organizations, services provided for hospice care, home- and com-

munity-based care, assisted living, and long-term care may be provided (subject to reimbursement) to persons 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 the Service or an Indian Tribe or Tribal Organization.

(c) TERMS AND CONDITIONS.—The Secretary shall require that any service provided under this section shall be in accordance with such terms and conditions as the Secretary determines to be consistent with accepted and appropriate standards relating to the service, including any licensing term or condition under this Act.

(d) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

(1)(A) The term 'home- and community-based services' means 1 or more of the following:

(i) Home health aide services.

(ii) Personal care services.

(iii) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

(iv) Respite care.

(v) Training for family members.

(vi) Adult day care.

(vii) Such other home- and community-based services as the Secretary, an Indian Tribe, or a Tribal Organization may approve.

(B) The term 'home- and community-based services' does not include a service provided by an individual that is legally responsible for providing the service.

(2) The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

(3)(A) The term 'personal care services' means services relating to assistance in carrying out activities of daily living.

(B) The term 'personal care services' does not include a service solely relating to assistance in carrying out an ancillary activity, such as housekeeping or household chores, as determined by the Secretary.

(4) The term 'public health functions' means the provision of public health-related programs, functions, and services including assessment, assurance, and policy development which Indian Tribes and Tribal Organizations are authorized and encouraged, in those circumstances where it meets their needs, to do by forming collaborative relationships with all levels of local, State, and Federal Government.

[§1621*l*. Patient travel costs]

[(a) The Secretary, acting through the Service, shall provide funds for the following patient travel costs associated with receiving health care services provided (either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]) under this chapter—**]**

[(1) emergency air transportation; and**]**

[(2) nonemergency air transportation where ground transportation is infeasible.]

[(b) There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 214. Indian women's health care

The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

[§1621m. Epidemiology centers]

[(a)(1) The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in paragraph (3).]

[(2) To assist such centers in carrying out such functions, the Secretary shall perform the following:]

[(A) In consultation with the Centers for Disease Control and Indian tribes, develop sets of data (which to the extent practicable, shall be consistent with the uniform data sets used by the States with respect to the year 2000 health objectives) for uniformly defining health status for purposes of the objectives specified in section 1602(b) of this title. Such sets shall consist of one or more categories of information. The Secretary shall develop formats for the uniform collecting and reporting of information on such categories.]

[(B) Establish and maintain a system for monitoring the progress made toward meeting each of the health status objectives described in section 1602(b) of this title.]

[(3) In consultation with Indian tribes and urban Indian communities, each area epidemiology center established under this subsection shall, with respect to such area—]

[(A) collect data relating to, and monitor progress made toward meeting, each of the health status objectives described in section 1602(b) of this title using the data sets and monitoring system developed by the Secretary pursuant to paragraph (2);]

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

[(C) assist tribes and urban Indian communities 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) work cooperatively with tribal providers of health and social services in order to avoid duplication of existing services; and]

[(G) provide 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.]

[(4) Epidemiology centers established under this subsection shall be subject to the provisions of the Indian Self-Determination Act (25 U.S.C. 450f et seq.).]

[(5) The director of the Centers for Disease Control shall provide technical assistance to the centers in carrying out the requirements of this subsection.]

[(6) The Service shall assign one epidemiologist from each of its area offices to each area epidemiology center to provide such center with technical assistance necessary to carry out this subsection.]

[(b)(1) The Secretary may make grants to Indian tribes, tribal organizations, and eligible intertribal consortia or Indian organization to conduct epidemiological studies of Indian communities.]

[(2) An intertribal consortia or Indian organization is eligible to receive a grant under this subsection if—]

[(A) it is incorporated for the primary purpose of improving Indian health; and]

[(B) it is representative of the tribes or urban Indian communities in which it is located.]

[(3) An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.]

[(4) Applicants for grants under this subsection shall—]

[(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);]

[(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and]

[(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.]

[(5) A grant awarded under paragraph (1) may be used to—]

[(A) carry out the functions described in subsection (a)(3) of this section;]

[(B) provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff, on health care and health services management issues; and]

[(C) provide, in collaboration with tribes and urban Indian communities, the Service with information regarding ways to improve the health status of Indian people.]

[(6) There are authorized to be appropriated to carry out the purposes of this subsection not more that $12,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§215. Environmental and nuclear health hazards

(a) STUDIES AND MONITORING. The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum

contamination, and contamination of water source and of the food chain. Such studies shall include—

(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

(2) an analysis of the potential effect of ongoing and future environmental resource development on or near reservations and Indian communities, including the cumulative effect over time on health;

(3) and evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including uranium mining and milling, uranium mining tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

(5) the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and, in consultation with Indian Tribes and Tribal Organizations, develop health care plans to address the health problems studied under subsection (a). The plans shall include—

(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

(d) INTERGOVERNMENTAL TASK FORCE.—

(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees):

(A) The Secretary of Energy.

(B) The Secretary of the Environmental Protection Agency.

(C) The Director of the Bureau of Mines.

(D) The Assistant Secretary for Occupational Safety and Health.

(E) The Secretary of the Interior.

(F) The Secretary of Health and Human Services.

(G) The Director of the Indian Health Service.

(2) DUTIES.—The Task Force shall—

(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work-related illness or condition;

(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program from the employer for providing medical care for such illness or condition.

[§ 1621n. Comprehensive school health education programs]

[(a) AWARD OF GRANTS]

[The Secretary, acting through the Service and in consultation with the Secretary of the Interior, may award grants to Indian tribes to develop comprehensive school health education programs for children from preschool through grade 12 in schools located on Indian reservations.]

[(b) USE OF GRANTS]

[Grants awarded under this section may be used to—]

[(1) develop health education curricula;]

[(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, and fitness;]

[(7) develop mental health wellness programs;]

[(8) develop chronic disease prevention programs;]

[(9) develop substance abuse prevention programs;]

[(10) develop accident prevention and safety education programs;]

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

[(12) develop community and environmental health education programs.]

[(c) ASSISTANCE]

[The Secretary shall provide technical assistance to Indian tribes in the development of health education plans, and the dissemination of health education materials and information on existing health programs and resources.]

[(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS]

[The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this section.]

[(e) REPORT OF RECIPIENT]

[Recipients of grants under this section shall submit to the Secretary an annual report on activities undertaken with funds provided under this section. Such reports shall include a statement of—]

[(1) the number of preschools, elementary schools, and secondary schools served;]

[(2) the number of students served;]

[(3) any new curricula established with funds provided under this section;]

[(4) the number of teachers trained in the health curricula; and]

[(5) the involvement of parents, members of the community, and community health workers in programs established with funds provided under this section.]

[(f) PROGRAM DEVELOPMENT]

[(1) The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools operated by the Bureau of Indian Affairs.]

[(2) Such program shall include—]

[(A) school programs on nutrition education, personal health, and fitness;]

[(B) mental health wellness programs;]

[(C) chronic disease prevention programs;]

[(D) substance abuse prevention programs;]

[(E) accident prevention and safety education programs; and]

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

[(3) 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.]

[(g) AUTHORIZATION OF APPROPRIATIONS]

[There are authorized to be appropriated to carry out this section $15,000,000 for the fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 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) MAINTENANCE OF SERVICES.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

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

(a) IN GENERAL.—Beginning in fiscal year 2003, the States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of North Dakota and South Dakota.

(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if such curtailment is due to the provision of contract services in such States pursuant to the designation of such States as a contract health service delivery area pursuant to subsection (a).

[§1621o. Indian youth grant program]

[(a) Grants]

[The Secretary, acting through the Service, is authorized to make grants to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian preadolescent and adolescent youths.]

[(b) USE OF FUNDS]

[(1) Funds made available under this section may be used to—]

[(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional healers; and]

[(B) develop and provide community training and education.]

[(2) Funds made available under this section may not be used to provide services described in section 1621h(m) of this title.]

[(c) MODELS FOR DELIVERY OF COMPREHENSIVE HEALTH CARE SERVICES]

[The Secretary shall—]

[(1) disseminate to Indian tribes 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, provide technical assistance in the implementation of such models.]

[(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS]

[The Secretary shall establish criteria for the review and approval of applications under this section.]

[(e) AUTHORIZATION OF APPROPRIATIONS]

[There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 217. California contract health services program

(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the 'CRIHB') as a contract care intermediary to improve the accessibility of health services to California Indians.

(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

(d) LIMITATION ON PAYMENT.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

(e) ADVISORY BOARD.—There is established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving Cali-

fornia Indians covered under this section at least one half of whom are not affiliated with the CRIHB.

§ 218. California as a contract health service delivery area

The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

§ 219. Contract health services for the Trenton Service Area

(a) AUTHORIZATION FOR SERVICES.—The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§ 1621p. American Indians Into Psychology Program]

[(a) GRANTS]

[The Secretary may provide grants to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.]

[(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM]

[The Secretary shall provide one of the grants authorized under subsection (a) of this section to develop and maintain a program at the University of North Dakota to be known as the "Quentin N. Burdick American Indians Into Psychology Program". Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 1616g(b) of this title, the Quentin N. Burdick American Indians Into Nursing Program authorized under section 1616e(e) of this title, and existing university research and communications networks.]

[(c) ISSUANCE OF REGULATIONS]

[(1) The Secretary shall issue regulations for the competitive awarding of the grants provided under this section.]

[(2) Applicants for grants under this section shall agree to provide a program which, at a minimum—]

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

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

[(C) provides summer enrichment programs to expose Indian students to the varied fields of psychology through research, clinical, and experiential activities;]

[(D) provides stipends to undergraduate and graduate students to pursue a career in psychology;]

[(E) develops affiliation agreements with tribal community colleges, the Service, university affiliated programs, and other appropriate entities to enhance the education of Indian students;]

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

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

[(d) Active duty service obligation]

[The active duty service obligation prescribed under section 254m of Title 42 shall be met by each graduate student who receives a stipend described in subsection (c)(2)(D) of this section that is funded by a grant provided under this section. Such obligation shall be met by service—]

[(1) in the Indian Health Service;]

[(2) in a program conducted under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],]

[(3) in a program assisted under subchapter IV of this chapter; or]

[(4) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.]

[§ 1621q. Prevention, control, and elimination of tuberculosis]

[(a) GRANTS]

[The Secretary, acting through the Service after consultation with the Centers for Disease Control, may make grants to Indian tribes and tribal organizations for—]

[(1) projects for the prevention, control, and elimination of tuberculosis;]

[(2) public information and education programs for the prevention, control, and elimination of tuberculosis; and]

[(3) education, training, and clinical skills improvement activities in the prevention, control, and elimination of tuberculosis for health professionals, including allied health professionals.]

[(b) APPLICATION FOR GRANT]

[The Secretary may make a grant under subsection (a) of this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains the assurances required by subsection (c) of this sec-

tion and such other agreements, assurances, and information as the Secretary may require.]

[(c) ELIGIBILITY FOR GRANT]

[To be eligible for a grant under subsection (a) of this section, an applicant must provide assurances satisfactory to the Secretary that—]

[(1) the applicant will coordinate its activities for the prevention, control, and elimination of tuberculosis with activities of the Centers for Disease Control, and State and local health agencies; and]

[(2) the applicant will submit to the Secretary an annual report on its activities for the prevention, control, and elimination of tuberculosis.]

[(d) DUTIES OF SECRETARY]

[In carrying out this section, the Secretary—]

[(1) shall establish criteria for the review and approval of applications for grants under subsection (a) of this section, including requirement of public health qualifications of applicants;]

[(2) shall, subject to available appropriations, make at least one grant under subsection (a) of this section within each area office;]

[(3) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and]

[(4) shall prepare and submit a report to the Committee on Energy and Commerce and the Committee on Natural Resources of the House and the Committee on Indian Affairs of the Senate not later than February 1, 1994, and biennially thereafter, on the use of funds under this section and on the progress made toward the prevention, control, and elimination of tuberculosis among Indian tribes and tribal organizations.]

[(e) REDUCTION OF AMOUNT OF GRANT]

[The Secretary may, at the request of a recipient of a grant under subsection (a) of this section, reduce the amount of such grant by—]

[(1) the fair market value of any supplies or equipment furnished the grant recipient; and]

[(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the grant recipient and the amount of any other costs incurred in connection with the detail of such officer or employee,]

[when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such grant recipient and for the purpose of carrying out a program with respect to which the grant under subsection (a) of this section is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, and such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.]

[§ 1621r. Contract health services payment study]

[(a) DUTY OF SECRETARY]

[The Secretary, acting through the Service and in consultation with representatives of Indian tribes and tribal organizations operating contract health care programs under the Indian Self-Determination Act (25 U.S.C. 450f et seq.) or under self-governance compacts, Service personnel, private contract health services providers, the Indian Health Service Fiscal Intermediary, and other appropriate experts, shall conduct a study—]

[(1) to assess and identify administrative barriers that hinder the timely payment for services delivered by private contract health services providers to individual Indians by the Service and the Indian Health Service Fiscal Intermediary;]

[(2) to assess and identify the impact of such delayed payments upon the personal credit histories of individual Indians who have been treated by such providers; and]

[(3) to determine the most efficient and effective means of improving the Service's contract health services payment system and ensuring the development of appropriate consumer protection policies to protect individual Indians who receive authorized services from private contract health services providers from billing and collection practices, including the development of materials and programs explaining patients' rights and responsibilities.]

[(b) FUNCTIONS OF STUDY]

[The study required by subsection (a) of this section shall—]

[(1) assess the impact of the existing contract health services regulations and policies upon the ability of the Service and the Indian Health Service Fiscal Intermediary to process, on a timely and efficient basis, the payment of bills submitted by private contract health services providers;]

[(2) assess the financial and any other burdens imposed upon individual Indians and private contract health services providers by delayed payments;]

[(3) survey the policies and practices of collection agencies used by contract health services providers to collect payments for services rendered to individual Indians;]

[(4) identify appropriate changes in Federal policies, administrative procedures, and regulations, to eliminate the problems experienced by private contract health services providers and individual Indians as a result of delayed payments; and]

[(5) compare the Service's payment processing requirements with private insurance claims processing requirement to evaluate the systemic differences or similarities employed by the Service and private insurers.]

[(c) REPORT TO CONGRESS]

[Not later than 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report that includes—]

[(1) a detailed description of the study conducted pursuant to this section; and]

[(2) a discussion of the findings and conclusions of such study.]

[§ 1621s. Prompt action on payment of claims]

[(a) TIME OF RESPONSE]

[The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase

order or a denial of the claim within 5 working days after the receipt of such notification.]

[(b) FAILURE TO TIMELY RESPOND]

[If the Service fails to respond to a notification of a claim in accordance with subsection (a) of this section, the Service shall accept as valid the claim submitted by the provider of a contract care service.]

[(c) TIME OF PAYMENT]

[The Service shall pay a completed contract care service claim within 30 days after completion of the claim.]

[§ 1621t. Demonstration of electronic claims processing]

[(a) Not later than June 15, 1993, the Secretary shall develop and implement, directly or by contract, 2 projects to demonstrate in a pilot setting the use of claims processing technology to improve the accuracy and timeliness of the billing for, and payment of, contract health services.]

[(b) The Secretary shall conduct one of the projects authorized in subsection (a) of this section in the Service area served by the area office located in Phoenix, Arizona.]

[§ 1621u. Liability for payment]

[(a) A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.]

[(b) 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.]

[§ 1621v. Office of Indian Women's Health Care]

[There is established within the Service an Office of Indian Women's Health Care to oversee efforts of the Service to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.]

§ 220. Programs operated by Indian tribes and tribal organizations

The Service shall provide funds for health care programs and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

§ 221. Licensing

Health care professionals employed by a Tribal Health Program shall, if licensed or certified in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

§ 222. Notification of provision of 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.

§ 223. Prompt action on payment of claims

(a) DEADLINE FOR RESPONSE.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

(b) EFFECT OF UNTIMELY RESPONSE.—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) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

§ 224. Liability for payment

(a) NO PATIENT 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 not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 233(b), the provider shall have no further recourse against the patient who received the services.

§ 225. Office of Indian men's health

(a) ESTABLISHMENT.—The Secretary shall establish within the Service an office to be known as the 'Office of Indian Men's Health' (referred to in this section as the 'Office').

(b) DIRECTOR.—

(1) IN GENERAL.—The Office shall be headed by a Director, to be appointed by the Secretary.

(2) DUTIES.—The Director shall coordinate and promote the status of the health of Indian men in the United States.

(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Director of the Office, shall submit to Congress a report describing—

(1) any activity carried out by the Director as of the date on which the report is prepared; and

(2) any finding of the Director with respect to the health of Indian men.

§ 1621w. Authorization of appropriations

[Except as provided in sections 1621h(m), 1621j, 1621*l*, 1621m(b)(5), 1621n, and 1621*o* of this title, t] *T*here are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* [2000] to carry out this *title* [subchapter].

[§ 1621x. Limitation on use of funds]

[Amounts appropriated to carry out this subchapter may not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C.A. § 14401 et seq.].

[§ 1622. Transferred]

TITLE [SUBCHAPTER] III—[HEALTH] FACILITIES

§ 1631. Consultation*; Construction and Renovation of Facilities*; [closure of facilities; r]*R*eports

(a) *PREREQUISITES FOR EXPENDITURE OF FUNDS.*—[CONSULTATION; STANDARDS FOR ACCREDITATION]

Prior to the expenditure of, or the making of any *binding* [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')* [section 13 of this title, popularly known as the Snyder Act], the Secretary, acting through the Service, shall—

(1) consult with any Indian [t] *T*ribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made[,]*;* and

(2) ensure, whenever practicable *and applicable,* that such facility meets the *construction* standards of *any accrediting body recognized by the Secretary for the purposes of the medicare, medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act* [the Joint Commission on Accreditation of Health Care Organizations] by not later than 1 year after the date on which the construction or renovation of such facility is completed.

(b) CLOSURES.—[; REPORT ON PROPOSED CLOSURE]

(1) *EVALUATION REQUIRED.*—Notwithstanding any *other* provision of law, *no facility operated by the Service* [other than this subsection, no Service hospital or outpatient health care facility of the Service, or any portion of such a hospital or facility,] may be closed if the Secretary has not submitted to [the] Congress at least 1 year prior to the date *of the proposed closure* [such hospital or facility (or portion thereof) is proposed to be closed] an evaluation of the impact of *the* [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 [t] *T*ribes served by such [hospital or] facility concerning such closure;

(F) the level of *use of such* [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) *EXCEPTION FOR CERTAIN TEMPORARY CLOSURES.*—Paragraph (1) shall not apply to any temporary closure of a facility or [of] any portion of a facility if such closure is necessary for medical, environmental, or *construction* safety reasons.

(c) *HEALTH CARE FACILITY PRIORITY SYSTEM.*—[ANNUAL REPORT ON HEALTH FACILITY PRIORITY SYSTEM]

(1) IN GENERAL.—

(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a health care facility priority system, which shall—

(i) be developed with Indian Tribes and Tribal Organizations through negotiated rulemaking under section 802;

(ii) give Indian Tribes' needs the highest priority; and

(iii) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E).

(B) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of the Indian Health Care Improvement Act Amendments of 2005 shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as 1 of the 10 top-priority inpatient projects, 1 of the 10 top-priority outpatient projects, 1 of the 10 top-priority staff quarters developments, or 1 of the 10 top-priority Youth Regional Treatment Centers in the fiscal year 2005 Indian Health Service budget justification, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of the enactment of such Act.

(2) [(1)] REPORT; CONTENTS.—The Secretary shall submit to the President, for inclusion in [each] *the* report required to be transmitted to [the] Congress under section *801* [1671 of this title], a report which sets forth the *following:*[—]

(A) *A description of* the [current] health care facility priority system of the Service, *established under paragraph (1).*

(B) HEALTH CARE FACILITIES LISTS, INCLUDING—[the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters),]

(i) the 10 top-priority inpatient health care facilities;

(ii) the 10 top-priority outpatient health care facilities;

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

(iv) the 10 top-priority staff quarters developments associated with health care facilities; and

(v) the 10 top-priority hostels associated with health care facilities.

(C) ⟦t⟧*T*he justification for such order of priority⟦,⟧.

(D) ⟦t⟧*T*he projected cost of such projects.⟦, and⟧

(E) ⟦t⟧*T*he methodology adopted by the Service in establishing priorities under its health facility priority system.

(3)⟦(2)⟧ *REQUIREMENTS FOR PREPARATION OF REPORTS.*—In preparing each report required under paragraph *(2)* ⟦(1)⟧ (other than the initial report), the Secretary shall *annually*—

(A) consult with *and obtain information on all health care facilities needs from* Indian [t]*T*ribes, *Tribal Organizations, and Urban Indian Organizations;* ⟦and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],⟧ and

(B) review the *total unmet* needs of *all Indian* ⟦such t⟧*T*ribes, *Tribal Organizations, and Urban Indian Organizations* ⟦and tribal organizations⟧ for *health care* ⟦inpatient and outpatient⟧ facilities *(including hostels and staff quarters)*, including ⟦their⟧ needs for renovation and expansion of existing facilities.

(4)⟦(3)⟧ *CRITERIA FOR EVALUATING NEEDS.*—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any contract *or compact* ⟦entered into with the Service⟧ under the Indian Self-Determination and Education Act (25 U.S.C. 450 et seq.) [25 U.S.C. § 450f et seq],⟧ use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

(5)⟦(4)⟧ *NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.*—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities *operated under contracts or compacts in accordance with the* ⟦which are the subject of a contract for health services entered into with the Service under the⟧ Indian Self-Determination *and Education Assistance* Act *(25 U.S.C. 450 et seq.)* [25 U.S.C. § 450f et seq] are fully and equitably integrated into [the development of] the health *care* facility priority system.

(d) REVIEW OF NEED FOR FACILITIES

(1) INITIAL REPORT.—In the year 2006, the Government Accountability Office shall prepare and finalize a report which sets forth the needs of the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, for the facilities listed under subsection (c)(2)(B), including the needs for renovation and expansion of existing facilities. The Government Accountability Office shall submit the report to the appropriate

authorizing and appropriations committees of Congress and to the Secretary.

(2) Beginning in the year 2006, the Secretary shall update the report required under paragraph (1) every 5 years.

(3) In preparing an updated report under paragraph (2), the Secretary shall consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. The Secretary shall submit the report under paragraph (2) for inclusion in the report required to be transmitted to Congress under section 801.

(4) For purposes of this subsection, the reports shall, regarding the needs of facilities operated under any contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), be based on the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

(5) The planning, design, construction, and renovation needs of facilities operated under contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be fully and equitably integrated into the development of the health facility priority system.

(6) Beginning in the year 2007 and each fiscal year thereafter, the Secretary shall provide an opportunity for nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the health care facility priority system.

(e) FUNDING CONDITION.—**[**(d) FUNDS APPROPRIATED SUBJECT TO SECTION 450F OF THIS TITLE**]**

All funds appropriated under the *Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'),* **[**section 13 of this title,**]** for the planning, design, construction, or renovation of health facilities for the benefit of *1 or more* **[**an**]** Indian [tribe or t]*T*ribes shall be subject to the provisions of **[**section 102 of**]** the Indian Self-Determination *and Education Assistance Act (25 U.S.C. 450 et seq.).*

(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

§ 1632. *Sanitation* **[Safe water and sanitary waste disposal f]*F*acilities**

(a) **[**CONGRESSIONAL F**]***F*INDINGS.—

[The**]** Congress **[**hereby**]** finds *the following:* **[**and declares that—**]**

(1) **[**t**]***T*he provision of *sanitation facilities* **[**safe water supply systems and sanitary sewage and solid waste disposal systems**]** 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 *sanitation facilities.* **[**such systems;**]**

(3) **[**t**]***T*he 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 *sanitation facilities* [such systems] and other preventive health measures[;].

(4) [m]*M*any Indian homes and *Indian* communities still lack *sanitation facilities.* [safe water supply systems and sanitary sewage and solid waste disposal systems; and]

(5) [i]*I*t 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 *sanitation facilities.* [safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible.]

(b) *FACILITIES AND SERVICES.*—[AUTHORITY; ASSISTANCE; TRANSFER OF FUNDS]

[(1)] In furtherance of the findings [and declarations] made in subsection (a) [of this section], Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section *7 of the Act of August 5, 1954 (42 U.S.A. 2004a)* [2004a of Title 42]. *Under such authority,* [(2) T]*t*he Secretary, acting through the Service, is authorized to provide *the following:* [under section 2004a of Title 42.]

(1)[(A) f]*F*inancial and technical assistance to Indian [t]*T*ribes, *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 Indian Tribe, Tribal Organization, or Indian community.

(2)[(B) o]*O*ngoing technical assistance and training *to Indian Tribes, Tribal Organizations, and Indian communities* in the management of utility organizations which operate and maintain sanitation facilities.[; and]

(3)[(C)] *Priority funding for* operation and maintenance assistance for, and emergency repairs to, [tribal] sanitation facilities *operated by an Indian Tribe, Tribal Organization or Indian community* when necessary to avoid *an imminent* [a] health *threat* [hazard] or to protect the [Federal] investment in *sanitation facilities and the investment in the health benefits gained through the provision of* sanitation facilities.

(c) FUNDING.—[(3)] Notwithstanding any other provision of law—

(*1*)[(A)] the Secretary of Housing and Urban *Development* [Affairs] is authorized to transfer funds appropriated under the *Native American* Housing *Assistance* and *Self-Determination* [Community Development] Act of *1996* [1974 (42 U.S.C. 5301 et seq.)] to the Secretary of Health and Human Services;[, and]

(*2*)[(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);* [2004a of Title 42.]

(3) unless specifically authorized when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to pro-

vide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purposes of providing sanitation facilities and services and place these funds into contracts or compacts under the Indian Self-Determination and Education Act (25 U.S.C. 450 et seq.);

(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

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

(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act; and

(9) 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 sanitation facilities funded under this Act.

[(c) 10-YEAR PLAN]

[Beginning in fiscal year 1990, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.]

(d) *CERTAIN CAPABILITIES NOT PREREQUISITE.*—[TRIBAL CAPABILITY]

The financial and technical capability of an Indian [t]*T*ribe, *Tribal Organization,* or *Indian* community to safely operate, *manage,* and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

(e) *FINANCIAL* [AMOUNT OF A]*A*SSISTANCE.—

[(1)] The Secretary is authorized to provide financial assistance to Indian [t]*T*ribes, *Tribal Organizations* and *Indian* communities *for operation, management, and maintenance of their sanitation facilities.* [in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (c) of this section.]

[(2) For the purposes of paragraph (1), the term "Federal share" means 80 percent of the costs described in paragraph (1).]

[(3) With respect to Indian tribes with fewer than 1,000 enrolled members, the non-Federal portion of the costs of operating, managing, and maintaining such facilities may be provided, in part, through cash donations or in kind property, fairly evaluated.]

(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving a community that is operated by an Indian Tribe or Tribal Organization is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

(g) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

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

(2) any funds appropriated for the purpose of providing sanitation facilities.

[(f) ELIGIBILITY OF PROGRAMS ADMINISTERED BY INDIAN TRIBES]

[Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be eligible for—]

[(1) any funds appropriated pursuant to this section, and]

[(2) any funds appropriated for the purpose of providing water supply or sewage disposal services,]

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

(h) REPORT.—[(g) ANNUAL REPORT; SANITATION DEFICIENCY LEVELS]

(1) *REQUIRED; CONTENTS.*—The Secretary, *in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103))* shall submit to the President, for inclusion in [each] *the* report required to be transmitted to [the] Congress under section *801*[1671 of this title], a report which sets forth—

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

(B) the methodology for determining sanitation deficiencies *and needs*;

(C) the level of *initial and final* sanitation deficiency for each *type of* sanitation *facility* [facilities] *for each type of* project of each Indian [t]*T*ribe or *Indian* community;

(D) the amount *and most effective use* of funds, *derived from whatever source,* necessary to *accommodate the sani-*

tation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act, and to reduce the identified sanitation deficiency levels of [raise] all Indian [t]*T*ribes and *Indian* communities to [a] level I sanitation deficiency *as defined in paragraph (4)(A);* and

(E) *a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.* [the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.]

(2) CRITERIA.—The criteria on which the deficiencies and needs will be evaluated shall be developed through negotiated rulemaking pursuant to section 802.

[(2) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]) to determine the sanitation needs of each tribe.]

(3) *UNIFORM METHODOLOGY.*—The methodology used by the Secretary in determining, *preparing cost estimates for, and reporting* sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian [t]*T*ribes and Indian communities.

(4) *SANITATION DEFICIENCY LEVELS.*—For purposes of this subsection, the sanitation deficiency levels for an *individual,* Indian [t]*T*ribe or *Indian* community *sanitation facility to serve Indian homes* are *determined* as follows:

(A) *A* level I *deficiency exists if a sanitation facility serving* [is] an *individual,* Indian [t]*T*ribe or *Indian* community [with a sanitation system]—

(i) [which] complies with all applicable water supply, [and] pollution control, *and solid waste disposal* laws[,]; and

(ii) [in which the] deficiencies relate to routine replacement, repair, or maintenance needs[;].

(B) *A* level II *deficiency exists if a sanitation facility serving an individual,* [is an] Indian [t]*T*ribe, or *Indian* community *substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to* [with a sanitation system]—

(i) *small or minor capital improvements needed to bring the facility back into compliance;* [which complies with all applicable water supply and pollution control laws, and]

(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 [of such tribe or community] for domestic sanitation facilities; *or*

(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

(C) *A* level III *deficiency exists if a sanitation facility serving an individual,* [is an] Indian [t]*T*ribe or *Indian* community *meets one or more of the following conditions* [with a sanitation system which]—

(i) *water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;* [has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or]

(ii) *major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or* [has no solid waste disposal facility;]

(iii) there is no access to or no approved or permitted solid waste facility available.

(D) *A LEVEL IV DEFICIENCY EXISTS.*—[(IV) is an Indian tribe or community with a sanitary system which lacks either a safe water supply system or a sewage disposal system: and]

(i) if a sanitation facility of an individual home, an Indian Tribe, or an Indian community exists but—

(I) lacks—

(aa) a safe water supply system; or

(bb) a waste disposal system;

(II) contains no piped water or sewer facilities; or

(III) has become inoperable due to a major component failure; or

(ii) if only a washeteria or central facility exists in the community.

(E) *A* level *V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.* [(V) is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.]

(i) DEFINITIONS.—For purposes of this section, the following terms apply:

(1) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

(2) SANITATION FACILITIES.—The terms 'sanitation facility' and 'sanitation facilities' mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

[(5) For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.]

§1633. Preference to Indians and Indian firms

(a) *BUY INDIAN ACT.*—[DISCRETIONARY AUTHORITY; COVERED ACTIVITIES]

The Secretary, acting through the Service, may *use* [utilize] the negotiating authority of section *23* [47] of *the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the 'Buy Indian Act')* [this title], 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 [t]*T*ribes 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* [1631 of this title] and in the construction of *sanitation* [safe water and sanitary waste disposal] facilities pursuant to section 302 [1632 of this title]. Such preference may be accorded by the Secretary unless *the Secretary* [he] finds, pursuant to [rules and] regulations [promulgated] *adopted pursuant to section 802* [by him], that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at *such a* [his] 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) *LABOR STANDARDS.*—[PAY RATES]

(1) IN GENERAL.—For the purpose of implementing the provisions of this *title* [subchapter], *contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the 'Davis-Bacon Act'), unless such construction or renovation*—[the secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this subchapter are not less than the prevailing local wage rates for similar work as determined in accordance with sections 3141 to 3144, 3146, 3147 of Title 40.]

(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract or compact authorized by the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other statutory authority; and

(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal Organizations to be served by the construction or renovation.

(2) EXCEPTION.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

§ 1634. Expenditure of [n]*N*on[-S]*s*ervice [f]*F*unds for [r]*R*enovation

(a) *IN GENERAL.*—[AUTHORITY OF SECRETARY] [(1)] Notwithstanding any other provision of law, *if the requirements of subsection (c) are met,* the Secretary, *acting through the Service,* is authorized to accept any major *expansion,* renovation or modernization by any Indian [t]*T*ribe *or Tribal Organization* of any Service facility or of any other Indian health facility operated pursuant to a contract *or compact* [entered into] under the Indian Self-Determination Act *and Education Assistance Act* (25 U.S.C. 450 et seq.), [25 U.S.C.A. § 450f et seq.] including—

(*1*)[(A)] any plans or designs for such *expansion,* renovation or modernization; and

(*2*)[(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) of this section are met.]

(b) *PRIORITY LIST.*—

(*1*)[(2)] *IN GENERAL.*—The Secretary shall maintain a separate priority list to address the needs *for increased operating expenses,* [of such facilities for] personnel, or equipment *for such facilities. The methodology for establishing priorities shall be developed through negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.*

(*2*)[(3)] *REPORT.*—The Secretary shall submit to the President, for inclusion in [each] *the* report required to be transmitted to [the] Congress under section *801* [1671 of this section], the priority list maintained pursuant to paragraph (*1*)[(2)].

(c)[(b)] REQUIREMENTS—The requirements of this subsection are met with respect to any *expansion,* renovation or modernization if—

(1) the *Indian T*[t]ribe or [t]*T*ribal [o]*O*rganization—

(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 T*[t]ribe or *Tribal Organization* in accordance with *any applicable* [the rules and] regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—In addition to the requirements in subsection (c), for any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information developed through negotiated rulemaking under section 802, including additional staffing, equipment, and other costs associated with the expansion.

(e) *CLOSURE OR CONVERSION OF FACILITIES.*—[(c) RECOVERY FOR NON-USE AS SERVICE FACILITY]

If any Service facility which has been *expanded,* renovated or modernized by an Indian [t]*T*ribe *or Tribal Organization* under this section ceases to be used as a Service facility during the 20-year period beginning on the date such *expansion,* renovation or modernization is completed, such Indian [t]*T*ribe *or Tribal Organization* shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such *expansion,* renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such *expansion,* renovation or modernization) bore to the value of such facility at the time of the completion of such *expansion,* renovation or modernization.

[§1635. Repealed. Pub. L. 100–713, Title III, § 303(b), Nov. 23, 1988, 102 Stat. 4817]

§1636. *Funding* [Grant program] for the [c]*C*onstruction, [e]*E*xpansion, and [m]*M*odernization of [s]*S*mall [a]*A*mbulatory [c]*C*are [f]*F*acilities

(a) *FUNDING.*—[AUTHORIZATION]

(1) *IN GENERAL.*—The Secretary, acting through the Service, shall make grants to *Indian T*[t]ribes and [t]*T*ribal [o]*O*rganizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons *pursuant to subsections (b)(2) and (c)(1)(C)* [as provided in subsection (c)(1)(C) of this section)]. A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term ["]'construction'["] includes the replacement of an existing facility.

(2) *GRANT AGREEMENT REQUIRED.*—A grant under paragraph (1) may only be *available* [made] to a *Tribal Health Program* [tribe or tribal organization] operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to a *Indian T*[t]ribe or [t]*T*ribal [o]*O*rganization) [pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]].

(b) USE OF [G] Grant *FUNDS*

(1) *ALLOWABLE USES.*—A grant provided under this section may be used [only] for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

(A) located apart from a hospital;

(B) not funded under section *301*[1631] or section *307*[1637 of this title]; 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 no fewer than 150 patient visits by eligible Indians and other users who are eligible for*

services in such facility in accordance with section 807(c)(2) [serve no less than 500 eligible Indians annually]; and

(iii) provide ambulatory care in a [s]*S*ervice [a]*A*rea (specified in the contract *or compact* [entered into] under the Indian Self-Determination *and Education Assistance* Act (25 U.S.C. 450 et seq.)[25 U.S.C.A. § 450f et seq.]]) with a population of *no fewer than 1,500* [not less than 2,000] eligible Indians *and other users who are eligible for services in such facility in accordance with section 807(c)(2).*

(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the construction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—A grant provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C)(ii) and (iii). [(2)] The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to *an Indian Tribe* [a tribe] or [t]*T*ribal [o]*O*rganization applying for a grant under this section *for a health care facility* [whose tribal government offices are] located *or to be constructed* on an island *or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.*

(c) [APPLICATION FOR G]GRANTS.—

(1) *APPLICATION.*—No grant may be made *available* under this section unless an application *or proposal* for [the] *a* grant has been [submitted to and] approved by the Secretary *in accordance with applicable regulations and has 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*—[. An application for a grant under this section shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to a grant received under this section—]

(A) adequate financial support will be available for the provision of services at such facility;

(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

(2) *PRIORITY.*—In awarding grants under this section, the Secretary shall give priority to *Indian T*[t]ribes and [t]*T*ribal [o]*O*rganizations that demonstrate—

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

(B) insufficient capacity to deliver such services.

(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed during consultations pursuant to subsection (a)(1).

(d) *REVERSION OF FACILITIES.*—[TRANSFER OF INTEREST TO UNITED STATES UPON CESSATION OF FACILITY] If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, *within 5 years* [at any time] after completion of the construction, expansion, or modernization carried out with such funds, to be *used* [utilized] for the purposes of providing *health* [ambulatory] care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States *unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.*

(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or for reallocation or redesign thereunder.

§ 1637. Indian [h]*H*ealth [c]*C*are [d]*D*elivery [d]*D*emonstration [p]*P*roject

(a) HEALTH [C]*C*ARE [DELIVERY D]*D*EMONSTRATION [P]*P*ROJECTS.—THE SECRETARY, ACTING THROUGH THE SERVICE, *and in consultation with Indian Tribes and Tribal Organizations*, is authorized to enter into *construction agreements under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)* with[, or make grants to,] Indian [t]*T*ribes or [t]*T*ribal [o]*O*rganizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through [health] facilities [to Indians].

(b) USE OF [F]*F*unds.—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* [non-Service Federal funds and non-Federal] funds;

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

(5) provide for the reversion of donated real or personal property to the donor[.]*; and*

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

(c) *REGULATIONS.*—[CRITERIA]

[(1) Within 180 days after November 28, 1990, t]*T*he Secretary[, after consultation with Indian tribes and tribal organizations,] shall develop and *promulgate regulations not later than 1 year after the enactment of the Indian Health Care Improvement Act Amendments of 2005. If the Secretary has not promulgated regulations by that date, the Secretary shall develop and* publish *regulations, through rulemaking under 802,* [in the Federal Register criteria] for the review and approval of applications submitted under this section.

(d) CRITERIA.—The Secretary may *approve* [enter into a contract or award a grant under this section for] projects *that* [which] meet the following criteria:

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

(2)[(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.]

(3)[(D)] The project has the potential to deliver services in an efficient and effective manner.

(4)[(E)] The project is economically viable.

(5)[(F)] The Indian [t]*T*ribe or [t]*T*ribal [o]*O*rganization has the administrative and financial capability to administer the project.

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

(e) PEER REVIEW PANELS.—[(2)] The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications [and to advise the Secretary regarding such applications] using the criteria developed pursuant to *subsection (d)* [paragraph (1)].

(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects [(3)(A) On or before September 30, 1995, the Secretary shall enter into contracts or award grants under this section for a demonstration project] in each of the following [s]*S*ervice [u]*U*nits *to the extent that such applications are timely filed and meet the criteria specified in subsection (d):* [which meets the criteria specified in paragraph (1) and for which a completed application has been received by the Secretary:]

(1)[(i)] Cass Lake, Minnesota.

(2)[(ii)] Clinton, Oklahoma.

(3)[(iii)] Harlem, Montana.

(4)[(iv)] Mescalero, New Mexico.

(5)[(v)] Owyhee, Nevada.

(6)[(vi)] Parker, Arizona.

(7)[(vii)] Schurz, Nevada.

(8)[(viii)] Winnebago, Nebraska.

(9)[(ix)] Ft. Yuma, California.

[(B) The Secretary may also enter into contracts or award grants under this section taking into consideration applications received under this section from all service areas. The Secretary may not award a greater number of such contracts or grants in one service area than in any other service area until there is an equal number of such

contracts or grants awarded with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria specified in paragraph (1).]

(g)[(d)] TECHNICAL [A]*A*SSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

(h)[(e)] SERVICE TO [I]*I*NELIGIBLE [P]*P*ERSONS.—*Subject to section 807,* [T]*t*he authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in [s]*S*ervice facilities to non-Service health care practitioners as provided in section *807*[1680c of this title] may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

(i)[(f)] EQUITABLE [T]*T*REATMENT.—For purposes of subsection *(d)(1)*[(c)(1)(A) of this section], the Secretary shall, in evaluating facilities operated under any contract *or compact* entered into with the Service under the Indian Self-Determination *and Education Assistance Act (25 U.S.C. 450 et seq.)* [25 U.S.C.A. § 450f et seq.], use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

(j)[(g)] EQUITABLE [I]*I*NTEGRATION OF [F]*F*ACILITIES.—The Secretary shall ensure that the planning, design, construction, [and] renovation, *and expansion* needs of Service and non-Service facilities which are the subject of a contract *or compact* [entered into with the Service] under the Indian Self-Determination *and Education Assistance Act (25 U.S.C. 450 et seq.)* (25 U.S.C. 450 et seq.) [25 U.S.C.A. 450f et seq.],] for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

[(h) REPORT TO CONGRESS]

[(1) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 1671 of this title for fiscal year 1997, an interim report on the findings and conclusions derived from the demonstration projects established under this section.]

[(2) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 1671 of this title for fiscal year 1999, a final report on the findings and conclusions derived from the demonstration projects established under this section, together with legislative recommendations.]

§1638. Land [t]*T*ransfer

Notwithstanding any other provision of law, [T]*t*he Bureau of Indian Affairs *and all other agencies and departments of the United States are* [is] 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.* [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.]

§308. Leases, contracts, and other agreements

The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organization which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450j(l)) and regulations thereunder.

§309. Study on loans, loan guarantees, and loan repayment

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

(1) inpatient facilities;

(2) outpatient facilities;

(3) staff quarters;

(4) hostels; and

(5) specialized care facilities, such as behavioral health and elder care facilities.

(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;

(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

(6) whether acceptance by the Secretary of an assignment of the revenue of an Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate;

(7) whether, in the planning and design of health facilities under this section, users eligible under section 807(c) may be included in any projection of patient population;

(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

(c) REPORT.—Not later than September 30, 2007, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

(1) the manner of consultation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.

§310. Tribal leasing

A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

§311. Indian health service/tribal facilities joint venture program

(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent, it—

(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project; or

(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project.

(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

(2) the Indian Tribe or Tribal Organization meets the need criteria which shall be developed through the negotiated rulemaking process provided for under section 802.

(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding

the continued operation of the facility at the end of the initial 10 year no-cost lease period.

(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

(f) DEFINITION.—For the purposes of this section, the term 'health facility' or 'health facilities' includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

§312. Location of facilities

(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands, or lands owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act, or any lands allotted to any Alaska Native, if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

(b) DEFINITION.—For purposes of this section, the term 'Indian lands' means—

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

(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.

§313. Maintenance and improvement of health care facilities

(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the negotiated rulemaking process provided for under section 802.

(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

§314. Tribal management of federally owned quarters

(a) RENTAL RATES.—

(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objections:

(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

(b) DIRECT COLLECTION OF RENT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise

its authority to collect rents directly from such Federal employees.

(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

[§ 1638a. Authorization of appropriations]

[There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this subchapter.]

§ 1638b. Applicability of Buy American *Act R*[r]equirement

(a) *APPLICABILITY.*—[DUTY OF SECRETARY]

The Secretary shall ensure that the requirements of the Buy American Act [[41 U.S.C.A. § 10a et seq.]] apply to all procurements made with funds provided pursuant to [the authorization contained in] section *317*[1638a of this title]. *Indian Tribes and Tribal Organizations shall be exempt from these requirements.*

[(b) REPORT TO CONGRESS]

[The Secretary shall submit to the Congress a report on the amount of procurements from foreign entities made in fiscal years 1993 and 1994 with funds provided pursuant to the authorization contained in section 1638a of this title. Such report shall separately indicate the dollar value of items procured with such funds for which the Buy American Act [41 U.S.C.A. § 10a et seq.] was waived pursuant to the Trade Agreement Act of 1979 [19 U.S.C.A. § 2501 et seq.] or any international agreement to which the United States is a party.]

(b)[(c)] *EFFECT OF VIOLATION.*—[FRAUDULENT USE OF MADE-IN-AMERICA LABEL] 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 *317* [1638a of this title], pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(c)[(d)] *DEFINITIONS.*—["BUY AMERICAN ACT" DEFINED] For purposes of 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.).

§ 316. Other funding for facilities

(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

(c) TRANSFERRED FUNDS.—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.

(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation, developed by rulemaking under section 802, for the planning, design, and construction of health care facilities serving Indians under this Act.

§ 317. 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.

[§ 1638c. Contracts for personal services in Indian Health Service facilities]

[In fiscal year 1995 and thereafter—]

[(a) IN GENERAL]

[The Secretary may enter into personal services contracts with entities, either individuals or organizations, for the provision of services in facilities owned, operated or constructed under the jurisdiction of the Indian Health Service.]

[(b) EXEMPTION FROM COMPETITIVE CONTRACTING REQUIREMENTS]

[The Secretary may exempt such a contract from competitive contracting requirements upon adequate notice of contracting opportunities to individuals and organizations residing in the geographic vicinity of the health facility.]

[(c) CONSIDERATION OF INDIVIDUALS AND ORGANIZATIONS]

[Consideration of individuals and organizations shall be based solely on the qualifications established for the contract and the proposed contract price.]

[(d) LIABILITY]

[Individuals providing health care services pursuant to these contracts are covered by the Federal Tort Claims Act.]

[§ 1638d. Credit to appropriations of money collected for meals at Indian Health Service facilities]

[Money before, on, and after September 30, 1994, collected for meals served at Indian Health Service facilities will be credited to the appropriations from which the services were furnished and shall be credited to the appropriation when received.]

TITLE IV [SUBCHAPTER III–A]—ACCESS TO HEALTH SERVICES

§ 1641. Treatment of [p]*P*ayments [u]*U*nder *Social Security Act Health Care* [medicare] *P*[*p*]rograms

(a) DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS [DETERMINATION OF APPROPRIATIONS]

Any payments received by *an Indian Health Program or by an Urban Indian Organization made under title XVIII, XIX, or XXI of the Social Security Act* [a hospital or skilled nursing facility of the Service (whether operated by the Service or by an Indian tribe or tribal organization pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A.§ 450f et seq.])] for services provided to Indians eligible for benefits under *such respective titles* [Title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et seq.]] shall not be considered in determining appropriations for *the provision of* health care and services to Indians.

(b) *NONPREFERENTIAL TREATMENT.*—[PREFERENCES] Nothing in this *Act* [chapter] authorizes the Secretary to provide services to an Indian [beneficiary] with coverage under title XVIII, *XIX, or XXI* of the Social Security Act [[42 U.S.C.A. § 1395 et seq.], as amended,] in preference to an Indian [beneficiary] without such coverage.

[§ 1642. Treatment of payments under medicaid program]

(c)[(a)] *USE OF FUNDS.*—[PAYMENTS TO SPECIAL FUND]

(1) SPECIAL FUND.—Notwithstanding any other provision of law, *but subject to paragraph (2),* payments to which a[ny] fa-

cility of the Service [(including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under Title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.])] is entitled [under a State plan] by reason of *a provision of the Social Security Act* [section 1911 of such Act [42 U.S.C.A.§1396j]] shall be placed in a special fund to be held by the Secretary and *first* used [by him] (to such extent or in such amounts as are provided in appropriation Acts) [exclusively] for the purpose of making any improvements in the *programs* [facilities] of *the* [such] Service which may be necessary to achieve *or maintain* compliance with the applicable conditions and requirements of [such] titles *XVIII, XIX, and XXI of the Social Security Act. Any amounts to be reimbursed that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with Indian 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 [s]*S*ervice [u]*U*nit of the Service receives *100* [at least 80] percent of the amount[s] to which the facilities of the Service, for which such [s]*S*ervice [u]*U*nit makes collections, are entitled by reason of *a provision* [section 1911] of the Social Security Act [[42 U.S.C.A. § 1396j]].

(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply upon the election of a Tribal Health Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided during the period of such election.

(d) DIRECT BILLING.—

(1) IN GENERAL.—A Tribal Health Program may directly bill for, and receive payment for, health care items and services provided by such Indian Tribe or Tribal organization for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

(2) DIRECT REIMBURSEMENT.—

(A) USE OF FUNDS.—Each Tribal Health Program exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to section 401(c), but all amounts so reimbursed shall be used by the Tribal Health Program for the purpose of making any improvements in Tribal facilities or Tribal Health Programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and Tribal Health Programs, any health care-related purpose, or otherwise to achieve the objectives provided in section 3 of this Act.

(B) AUDITS.—The amounts paid to an Indian Tribe or Tribal Organization exercising the option described in

paragraph (1) with respect to a program under a title of the Social Security Act shall be subject to all auditing requirements applicable to programs administered by an Indian Health Program.

(C) 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 (25 U.S.C. 450 et seq.) 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.

(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under a title of the Social Security Act.

(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

[(b) DETERMINATION OF APPROPRIATIONS**]**

[Any payments received by such facility for services provided to Indians eligible for benefits under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.] shall not be considered in determining appropriations for the provision of health care and services to Indians.**]**

[§ 1643. Amount and use of funds reimbursed through medicare and medicaid available to Indian Health Service]

[The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 1671 of this title, an accounting on the amount and use of funds made available to the Service pursuant to this subchapter as a result of reimbursements through Titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq., 1396 et seq.], as amended.**]**

§ 1644. Grants to and *C*[c]ontracts with *the Service, Indian Tribes, T* [t]ribal [*o*]*O*rganizations*, and Urban Indian Organizations*

(a) *INDIAN TRIBES AND TRIBAL ORGANIZATIONS.*—[ACCESS TO HEALTH SERVICES] The Secretary, acting through the Service, shall make grants to or enter into contracts with *Indian Tribes and T* [t]ribal *O*[o]rganizations to assist such *Tribes and Tribal O*[o]rganizations 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) *to* enroll *for benefits* under *title XVIII, XIX, or* XXI [section 1818 of part A and sections 1836 and 1837 of part B of Title XVIII] of the Social Security Act *and other health benefits programs* [42 U.S.C.A. §§ 1395i–2, 1395o, 1395p]; *and*

(2) *to* pay [monthly] premiums for coverage *for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Tribe or Tribes).* [due to financial need of such individual; and]

[(3) apply for medical assistance provided pursuant to Title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.].]

(b) [TERMS AND C]*CONDITIONS.*—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any [contract or] grant *or contract* which the Secretary makes with any *Indian Tribe or T*[t]ribal *O*[o]rganization pursuant to this section. Such conditions shall include[, by are not limited to,] requirements that the *Indian Tribe or Tribal O*[o]rganization successfully undertake [to]—

(1) *to* determine the population of Indians *eligible for the* [to be served that are or could be recipients of] benefits *described in subsection (a)* [under Titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq., 1396 et seq.]];

(2) *to educate* [assist individual] Indians *with respect to the benefits available under the respective programs* [in becoming familiar with and utilizing such benefits];

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

(4) *to* develop and implement[—]

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

[(B)] methods of improving the participation of Indians in receiving the benefits provided under titles XVIII, [and] XIX, *and XXI* of the Social Security Act [[42 U.S.C.A. §§ 1395 et seq. And 1396 et seq.]].

(c) *AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT PROGRAMS.*—[APPLICATION FOR MEDICAL ASSISTANCE]

(1) AGREEMENTS WITH SECRETARY TO IMPROVE RECEIPT AND PROCESSING OF APPLICATIONS.—

(A) AUTHORIZATION.—The Secretary, acting through the Service, may enter into an agreement with an Indian [t]*T*ribe, [t]*T*ribal [o]*O*rganization, or [u]*U*rban Indian [o]*O*rganization which provides for the receipt and proc-

essing of applications *by Indians* for ⟦medical⟧ assistance under titles XIX *and XXI* of the Social Security Act, ⟦[42 U.S.C.A. § 1396 et seq.]⟧ and benefits under title XVIII of *such* ⟦the Social Security⟧ Act, *by an Indian Health Program or Urban Indian Organization.* ⟦[42 U.S.C.A. § 1395 et seq.⟧ at a Service facility or a health care facility administered by such tribe or organization pursuant to a contract under the Indian Self-Determination Act ⟦25 U.S.C.A. § 450f et seq.].⟧

(B) REIMBURSEMENT OF COSTS.—Such agreements may provide for reimbursement of costs of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may, as appropriate, be added to the applicable rate per encounter or be provided as a separate fee-for-service payment to the Indian Tribe or Tribal Organization.

(C) PROCESSING CLARIFIED.—In this paragraph, the term 'processing' does not include a final determination of eligibility.

(2) AGREEMENTS WITH STATES FOR OUTREACH ON OR NEAR RESERVATION.—

(A) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under title XIX or XXI of the Social Security Act, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with Indian Tribes and Tribal Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are provided.

(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting arrangements entered into between States and Indian Tribes and Tribal Organizations for such Indian Tribes and Tribal Organizations to conduct administrative activities under such titles.

(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations.

(e) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to Urban Indian Organizations with respect to populations served by such organizations in the same manner they apply to grants and contracts with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

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

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

(B) appropriate to Urban Indian Organizations and Urban Indians; and

(C) necessary to effect the purposes of this section.

[§ 1645. Direct billing 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 (25 U.S.C. 450 et seq.) 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 title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (In this section referred to as the "medicare program"), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (In this section referred to as the "medicaid program"), or from any other third party payor.]

[(2) APPLICATION OF 100 PERCENT FMAP]

[The third sentence of section 1396d(b) of Title 42 shall apply for purposes of reimbursement under the medicaid program 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 the medicare and medicaid programs 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 1642(a) and 1680c(b)(2)(A) of this title, 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 the medicare or medicaid programs. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—]

[(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.]

[(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.A. § 1395qq(c)) or section 1642(a) of this title, no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or clinic participates in the program established under this section.]

[(c) REQUIREMENTS FOR PARTICIPATION]

[(1) APPLICATION]

[Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—]

[(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;]

[(B) the facility is eligible to participate in the medicare or medicaid programs under section 1395qq or 1396j of Title 42;]

[(C) the facility meets the requirements that apply to programs operated directly by the Service; and]

[(D) the facility—]

[(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or]

[(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.]

[(2) APPROVAL]

[(A) IN GENERAL]

[The Secretary shall review and approve a qualified application not later than 90 days after the date that 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 November 1, 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 Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement—]

[(A) any administrative changes that may be necessary to facilitate direct bill and reimbursement under the program established under this section, including any agree-

ments with States that may be necessary to provide for direct billing under the medicaid program; 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 November 1, 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.A. § 450f 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.]

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

(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges as determined by the Secretary, and billed by the Secretary, an Indian Tribe, or Tribal Organization in providing health services, through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

(1) such services had been provided by a nongovernmental provider; and

(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

(1) workers' compensation laws; or

(2) a no-fault automobile accident insurance plan or program.

(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other

health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

(e) ENFORCEMENT.—

(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

(A) intervening or joining in any civil action or proceeding brought—

(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

(ii) by any representative or heirs of such individual, or

(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

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

(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

(h) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

(i) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to Urban Indian Organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations

with respect to populations served by such Indian Tribes and Tribal Organizations.

(j) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

(k) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.).

§ 404. Crediting of reimbursements

(a) USE OF AMOUNTS.—

(1) RETENTION BY PROGRAM.—Except as provided in section 202(g) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an Urban Indian Organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

(A) Titles XVIII, XIX, and XXI of the Social Security Act.

(B) This Act, including section 807.

(C) Public Law 87–693.

(D) Any other provision of law.

(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

§ 405. Purchasing health care coverage

(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health benefits for Service beneficiaries, Indian Tribes, Tribal Organizations, and Urban Indian Organizations may use such amounts to purchase health benefits coverage for such beneficiaries in any manner, including through—

(1) a tribally owned and operated health care plan;

(2) a State or locally authorized or licensed health care plan;

(3) a health insurance provider or managed care organization; or

(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

§ 406. Sharing arrangements with Federal agencies

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

(2) the quality of health care services provided to any Indian through the Service;

(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

§ 407. Payor of last resort

Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

§ 408. Nondiscrimination in qualifications for reimbursement for services

For purposes of determining the eligibility of an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization to receive payment or reimbursement from any federally funded health care program for health care services it furnishes to an Indian, such program must provide that such entity, meeting generally applicable State or other requirements applicable for participation, must be accepted as a provider on the same basis as any other qualified provider, except that any requirement that the entity be licensed or recognized under State or local law to furnish such services shall be deemed to have been met if the entity meets all the applicable standards for such licensure, but the entity need not obtain a license or other documentation. In determining whether the entity meets such standards, the absence of licensure of any staff member of the entity may not be taken into account.

§ 409. Consultation

(a) TRIBAL INDIAN TECHNICAL ADVISORY GROUP (TTAG).—The Secretary shall maintain within the Centers for Medicare & Medicaid Services (CMS) a Tribal Indian Technical Advisory Group, established in accordance with requirements of the charter dated September 30, 2003, and in such group shall include a representative of the Urban Indian Organizations and the Service. The representative of the Urban Indian Organization shall be deemed to be an elected officer of a tribal government for purposes of applying section 204(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534(b)).

(b) SOLICITATION OF MEDICAID ADVICE.—

(1) IN GENERAL.—As part of its plan for payment under title XIX of the Social Security Act, a State in which the Service operates or funds health care programs or in which 1 or more Indian Health Programs or Urban Indian Organizations provide health care in the State for which medical assistance is available under such title, may establish a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of such title to and likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations.

(2) MANNER OF ADVICE.—The process described in paragraph (1) should include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations. Such process may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its medicaid plan.

(3) PAYMENT OF EXPENSES.—The reasonable expenses of carrying out this subsection shall be eligible for reimbursement under section 1903(a) of the Social Security Act.

(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding existing advisory committees, working groups, or other advisory procedures established by the Secretary or by any State.

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

(a) OPTIONAL USE OF FUNDS FOR INDIAN HEALTH PAYMENTS.—Subject to the succeeding provisions of this section, a State may provide under its State child health plan under title XXI of the Social Security Act (regardless of whether such plan is implemented under such title, title XIX of such Act, or both) for payments under this section to Indian Health Programs and Urban Indian Organizations operating in the State. Such payment shall be treated under title XXI of the Social Security Act as expenditures described in section 2105(a)(1)(A) of such Act.

(b) USE OF FUNDS.—Payments under this section may be used only for expenditures described in clauses (i) through (iii) of section 2105 (a)(1)(D) of the Social Security Act for targeted low-income children or other low-income children (as defined in 2110 of such Act) who are—

(1) Indians; or

(2) otherwise eligible for health services from the Indian Health Program involved.

(c) SPECIAL RESTRICTIONS.—The following conditions apply to a State electing to provide payments under this section:

(1) NO LIMITATION ON OTHER SCHIP PARTICIPATION OF, OR PROVIDER PAYMENTS TO, INDIAN HEALTH PROGRAMS.—The State may not exclude or limit participation of otherwise eligible Indian Health Programs in its State child health program under title XXI of the Social Security Act or its medicaid program under title XIX of such Act or pay such Programs less then they otherwise would as participating providers on the basis that payments are made to such Programs under this section.

(2) NO LIMITATION ON OTHER SCHIP ELIGIBILITY OF INDIANS.—The State may not exclude or limit participation of otherwise eligible Indian children in such State child health or medicaid program on the basis that payments are made for assistance for such children under this section.

(3) LIMITATION ON ACCEPTANCE OF CONTRIBUTIONS.—

(A) IN GENERAL.—The State may not accept contributions or condition making of payments under this section upon contribution of funds from an Indian Health Program to meet the State's non-Federal matching fund requirements under titles XIX and XXI of the Social Security Act.

(B) CONTRIBUTION DEFINED.—For purposes of subparagraph (A), the term 'contribution' includes any tax, donation, fee, or other payment made, whether made voluntarily or involuntarily.

(d) APPLICATION OF SEPARATE 10 PERCENT LIMITATION.—Payment may be made under section 2105(a) of the Social Security Act to a State for a fiscal year for payments under this section up to an amount equal to 10 percent of the total amount available under title XXI of such Act (including allotments and reallotments available from previous fiscal years) to the State with respect to the fiscal year.

(e) GENERAL TERMS.—A payment under this section shall only be made upon application to the State from the Indian Health Program involved and under such terms and conditions, and in a form and manner, as the Secretary determines appropriate.

§ 411. Social Security Act sanctions

(a) REQUESTS FOR WAIVER OF SANCTIONS.—

(1) IN GENERAL.—For purposes of applying any authority under a provision of title XI, XVIII, XIX, or XXI of the Social Security Act to seek a waiver of a sanction imposed against a health care provider insofar as that provider provides services to individuals through an Indian Health Program, the Indian Health Program shall request the State to seek such waiver, and if such State has not sought the waiver within 60 days of the Indian Health Program request, the Indian Health Program itself may petition the Secretary for such waiver.

(2) PROCEDURE.—In seeking a waiver under paragraph (1), the Indian Health Program much provide notice an a copy of the request, including the reasons for the waiver sought, to the State. The Secretary may consider the State's views in the determination of the waiver request, but may not withhold or delay a determination based on the lack of the State's views.

(b) SAFE HARBOR FOR TRANSACTIONS BETWEEN AND AMONG INDIAN HEALTH CARE PROGRAMS.—For purposes of applying section 1128B(b) of the Social Security Act, the exchange of anything of value between or among the following shall not be treated as remuneration if the exchange arises from or relates to any of the following health programs:

(1) An exchange between or among the following:

(A) Any Indian Health Program.

(B) Any Urban Indian Organization.

(2) An exchange between an Indian Tribe, Tribal Organization, or an Urban Indian Organization and any patient served or eligible for service from an Indian Tribe, Tribal Organization, or Urban Indian Organization, including patients served or eligible for service pursuant to section 807, but only if such exchange—

(A) is for the purpose of transporting the patient for the provision of health care items or services;

(B) is for the purpose of providing housing to the patient (including a pregnant patient) and immediate family members or an escort incidental to assuring the timely provision of health care items and services to the patient;

(C) is for the purpose of paying premiums, copayments, deductibles, or other cost-sharing on behalf of patients; or

(D) consists of an item or service of small value that is provided as a reasonable incentive to secure timely and necessary preventive and other items and services.

(3) Other exchanges involving an Indian Health Program, an Urban Indian Organization, or an Indian Tribe or Tribal Organization that meet such standards as the Secretary of Health and Human Services, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations and of

patients served by Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations.

§ 412. Cost sharing

(a) COINSURANCE, COPAYMENTS, AND DEDUCTIBLES.—Notwithstanding any other provision of Federal or State law—

(1) PROTECTION FOR ELIGIBLE INDIANS UNDER SOCIAL SECURITY ACT HEALTH PROGRAMS.—No Indian who is furnished an item or service for which payment may be made under title XIX or XXI of the Social Security Act may be charged a deductible, copayment, or coinsurance.

(2) PROTECTION FOR INDIANS.—No Indian who is furnished an item or service by the Service may be charged a deductible, copayment, or coinsurance.

(3) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—The payment or reimbursement due to the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization under title XIX or XXI of the Social Security Act may not be reduced by the amount of the deductible, copayment, or coinsurance that would be due from the Indian but for the operation of this section.

(b) EXEMPTION FROM MEDICAID AND SCHIP PREMIUMS.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for services under title XIX of the Social Security Act (relating to the medicaid program) or title XXI of such Act (relating to the State children's health insurance program) may be charged a premium as a condition of receiving benefits under the program under the respective title.

(c) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID ELIGIBILITY.—Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services under title XIX of the Social Security Act:

(1) Property, including real property and improvements, located on the reservation, including any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act and Indian allotments on or near the reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, or other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law and custom.

(d) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Income, resources, and property that are exempt from medicaid estate recovery

under title XIX of the Social Security Act as of April 1, 2003, under manual instructions issued to carry out section 1917 (b)(3) of such Act because of Federal responsibility for Indian Tribes and Alaska Native Villages shall remain so exempt. Nothing in this subsection shall be construed as preventing the Secretary from providing additional medicaid estate recovery exemptions for Indians.

§ 413. Treatment under Medicaid Managed Care

(a) PROVISION OF SERVICES, TO ENROLLEES WITH NON-INDIAN MEDICAID MANAGED CARE ENTITIES, BY INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.—

(1) PAYMENT RULES.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of an Indian who is enrolled with a non-Indian medicaid managed care entity (as defined in subsection (c)) and who receives covered medicaid managed care services from an Indian Health Program or an Urban Indian Organization, whether or not it is a participating provider with respect to such entity, the following rules apply:

(i) DIRECT PAYMENT.—The entity shall make prompt payment (in accordance with rules applicable to medicaid managed care entities under title XIX of the Social Security Act) to the Indian Health Program or Urban Indian Organization at a rate established by the entity for such services that is equal to the rate negotiated between such entity and the Program or Organization involved or, if such a rate has not been negotiated, a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Program or Organization.

(ii) PAYMENT THROUGH STATE.—If there is no arrangement for direct payment under clause (i) or if the State provides for this clause to apply in lieu of clause (i), the State shall provide for payment to the Indian Health Program or Urban Indian Organization under its State program under title XIX of such Act at the rate that would be otherwise applicable for such services under such program and shall provide for an appropriate adjustment of the capitation payment made to the entity to take into account such payment.

(B) COMPLIANCE WITH GENERALLY APPLICABLE REQUIREMENTS.—

(i) IN GENERAL.—Except as otherwise provided, as a condition of payment under subparagraph (A), the Indian Health Program or Urban Indian Organization shall comply with the generally applicable requirements of title XIX of the Social Security Act with respect to covered services.

(ii) SATISFACTION OF CLAIM REQUIREMENT.—Any requirement for the submission of a claim or other documentation for services covered under subparagraph (A) by the enrollee is deemed to be satisfied through the submission of a claim or other documentation by the

Indian Health Program or Urban Indian Organization consistent with section 403(h).

(C) CONSTRUCTION.—Nothing in this subsection shall be construed as waiving the application of section 1902(a)(30)(A) of the Social Security Act (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(2) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH PROGRAM OR URBAN INDIAN ORGANIZATION AS PRIMARY CARE PROVIDER.—In the case of a non-Indian medicaid managed care entity that—

(A) has an Indian enrolled with the entity; and

(B) has an Indian Health Program or Urban Indian Organization that is participating as a primary care provider within the network of the entity, insofar as the Indian is otherwise eligible to receive services from such Program or Organization and the Program or Organization has the capacity to provide primary care services to such Indian, the Indian shall be allowed to choose such Program or Organization as the Indian's primary care provider under the entity.

(b) OFFERING OF MANAGED CARE THROUGH INDIAN MEDICAID MANAGED CARE ENTITIES.—if—

(1) a State elects to provide services through medicaid managed care entities under its medicaid managed care program; and

(2) an Indian Health Program or Urban Indian Organization that is funded in whole or in part by the Service, or a consortium thereof, has established an Indian medicaid managed care entity in the State that meets generally applicable standards required of such an entity under such medicaid managed care program, the State shall offer to enter into an agreement with the entity to serve as a medicaid managed care entity with respect to eligible Indians served by such entity under such program.

(c) SPECIAL RULES FOR INDIAN MANAGED CARE ENTITIES.—The following are special rules regarding the application of a medicaid managed care program to Indian medicaid managed care entities:

(1) ENROLLMENT.—

(A) LIMITATION TO INDIANS.—An Indian medicaid managed care entity may restrict enrollment under such program to Indians and to members of specific Tribes in the same manner as Indian Health Programs may restrict the delivery of services to such Indians and tribal members.

(B) NO LESS CHOICE OF PLANS.—Under such program the State may not limit the choice of an Indian among medicaid managed care entities only to Indian medicaid managed care entities or to be more restrictive than the choice of managed care entities offered to individual who are not Indians.

(C) DEFAULT ENROLLMENT.—

(i) IN GENERAL.—If such program of a State required the enrollment of Indians in a medicaid managed care entity in order to receive benefits, the State shall provide for the enrollment of Indians described in clause

(ii) who are not otherwise enrolled with such an entity in an Indian medicaid managed care entity described in such clause.

(ii) INDIAN DESCRIBED.—An Indian described in this clause, with respect to an Indian medicaid managed care entity, is an Indian who, based upon the service area and capacity of the entity, is eligible to be enrolled with the entity consistent with subparagraph (A).

(D) EXCEPTION TO STATE LOCK-IN.—A request by an Indian who is enrolled under such program with a non-Indian medicaid managed care entity to change enrollment with that entity to enrollment with an Indian medicaid managed care entity shall be considered cause for granting such request under procedures specified by the Secretary.

(2) FLEXIBILITY IN APPLICATION OF SOLVENCY.—In applying section 1903(m)(1) of the Social Security Act to an Indian medicaid managed care entity—

(A) any reference to a 'State' in subparagraph (A)(ii) of that section shall be deemed to be a reference to the 'Secretary'; and

(B) the entity shall be deemed to be a public entity described in subparagraph (C)(ii) of that section.

(3) EXCEPTIONS TO ADVANCE DIRECTIVES.—The Secretary may modify or waive the requirement of section 1902(w) of the Social Security Act (relating to provision of written materials of advance directives) insofar as the Secretary finds that the requirements otherwise imposed are not an appropriate or effective way of communicating the information to Indians.

(4) FLEXIBILITY IN INFORMATION AND MARKETING.—

(A) MATERIALS.—The Secretary may modify requirements under section 1932(a)(5) of the Social Security Act in a manner that improves the materials to take into account the special circumstances of such entities and their enrollees while maintaining and clearly communicating to potential enrollees their rights, protections, and benefits.

(B) DISTRIBUTION OF MARKETING MATERIALS.—The provisions of section 1931(d)(2)(B) of the Social Security Act requiring the distribution of marketing materials to an entire service area shall be deemed satisfied in the case of an Indian medicaid managed care entity that distributes appropriate materials only to those Indians who are potentially eligible to enroll with the entity in the service area.

(d) MALPRACTICE INSURANCE.—Insofar as, under a medicaid managed care program, a health care provider is required to have a medical malpractice insurance coverage as a condition of contracting as a provider with a medicaid managed care entity, an Indian Health Program, or an Urban Indian Organization that is a Federally-qualified health center under title XIX of the Social Security Act, that is covered under the Federal Tort Claims Act 28 U.S.C. 1346(b), 2671 et seq.) is deemed to satisfy such requirement.

(e) DEFINITIONS.—For purposes of this section:

(1) MEDICAID MANAGED CARE ENTITY.—The term 'medicaid managed care entity' means a managed care entity (whether a managed care organization or a primary care case manager) under title XIX of the Social Security Act, whether pursuant to

section 1903(m) or section 1932 of such Act, a waiver under section 1115 or 1915(b) of such Act, or otherwise.

(2) INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'Indian medicaid managed care entity' means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Social Security Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4), or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(3) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'non-Indian medicaid managed care entity' means a medicaid managed care entity that is not an Indian medicaid managed care entity.

(4) COVERED MEDICAID MANAGED CARE SERVICES.—The term 'covered medicaid managed care services' means, with respect to an individual enrolled with a medicaid managed care entity, items and services that are within the scope of items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(5) MEDICAID MANAGED CARE PROGRAM.—The term 'medicaid managed care program' means a program under sections 1903(m) and 1932 of the Social Security Act and includes a managed care program operating under a waiver under section 1915(b) or 1115 of such Act or otherwise.

§ 414. Navajo Nation Medicaid Agency Feasibility Study

(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and

(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State chil-

dren's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

(c) REPORT.—Not later then 3 years after the date of enactment of the Indian Health Act Improvement Act Amendments of 2005, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

(1) the results of the study under this section;

(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

[§ 1646. Authorization for emergency contract health services]

[With respect to an elderly or disabled Indian receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this chapter, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.]

§ 1647. Authorization of [a]*Appropriations*

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* [2000] to carry out this *title* [subchapter].

TITLE V [SUBCHAPTER IV]—HEALTH SERVICES FOR URBAN INDIANS

§ 1651. Purpose

The purpose of this *title* [subchapter] is to establish *and maintain* programs in [u]*U*rban [c]*C*enters to make health services more accessible *and available* to [u]*U*rban Indians.

§ 1652. Contracts [w]*W*ith, and [g]*G*rants to, [u]*U*rban Indian [o]*O*rganizations

Under authority of the Act of November 2, 1921 (25 U.S.C. 13), *(commonly* [popularly] known as the 'Snyder Act'), the Secretary, *acting* through the Service, shall enter into contracts with, or make grants to, [u]*U*rban Indian [o]*O*rganizations to assist such organizations in the establishment and administration, within [the u]*U*rban [c]*C*enters [in which such organizations are situated], of programs which meet the requirements set forth in this *title* [subchapter]. *Subject to section 506, t*[T]he Secretary, *acting* through the Service, shall include such conditions as the Secretary con-

siders necessary to effect the purpose of this *title* [subchapter] in any contract *into* which the Secretary enters [into] with, or in any grant the Secretary makes to, any *U*[u]rban Indian *O*[o]rganization pursuant to this *title* [subchapter].

§ 1653. Contracts and *G*[g]rants for *the P*[p]rovision of *H*[h]ealth *C*[c]are and *R*[r]eferral *S*[s]ervices

(a) REQUIREMENTS *FOR GRANTS AND CONTRACTS.*—Under authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] *(commonly* known as the 'Snyder Act'), the Secretary, *acting* through the Service, shall enter into contracts with, and make grants to, [u]*U*rban Indian [o]*O*rganizations for the provision of health care and referral services for [u]*U*rban Indians [residing in the urban centers in which such organizations are situated]. Any such contract or grant shall include requirements that the [u]*U*rban Indian [o]*O*rganization successfully undertake to—

(1) estimate the population of [u]*U*rban Indians residing in the [u]*U*rban [c]*C*enter *or centers that the organization proposes to serve* [in which such organization is situated] who are or could be recipients of health care or referral services;

(2) estimate the current health status of [u]*U*rban Indians residing in such [u]*U*rban [c]*C*enter *or centers*;

(3) estimate the current health care needs of [u]*U*rban Indians residing in such [u]*U*rban [c]*C*enter *or centers;*

(4) *provide basic health education, including health promotion and disease prevention education, to Urban Indians* [identify all public and private health services resources within such urban center which are or may be available 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* [determine the use of public and private health services resources by the urban Indians residing in such urban center]; and

(6) *where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.* [assist such health services resources in providing services to urban Indians;]

[(7) assist urban Indians in becoming familiar with and utilizing such health services resources;]

[(8) provide basic health education, including health promotion and disease prevention education, to urban Indians;]

[(9) establish and implement training programs to accomplish the referral and education tasks set forth in paragraphs (6) through (8) of this subsection;]

[(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;]

[(11) 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]

[(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.]

(b) CRITERIA [FOR SELECTION OF ORGANIZATIONS TO ENTER INTO CONTRACTS OR RECEIVE GRANTS].—The Secretary, *acting* through the Service, shall, by regulation, prescribe the criteria for selecting [u]*U*rban Indian [o]*O*rganizations 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 [u]*U*rban Indians in the [u]*U*rban [c]*C*enter *or centers* involved;

(2) the size of the [u]*U*rban Indian population in the [u]*U*rban [c]*C*enter *or centers* involved;

[(3) the accessibility to, and utilization of, health care services (other than services provided under this subchapter) by urban Indians in the urban center involved;]

(3)[(4)] the extent, if any, to which the activities set forth in subsection (a) [of this section] would duplicate *any project funded under this title;*[—]

[(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this subchapter; or]

[(B) any project funded under this subchapter;]

(4)[(5)] the capability of an [u]*U*rban Indian [o]*O*rganization to perform the activities set forth in subsection (a) [of this section] and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

(5)[(6)] the satisfactory performance and successful completion by an [u]*U*rban Indian [o]*O*rganization of other contracts with the Secretary under this *title* [subchapter];

(6)[(7)] the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) [of this section] in an [u]*U*rban [c]Center *or centers*; and

(7)[(8)] the extent of existing or likely future participation in the activities set forth in subsection (a) [of this section] by appropriate health and health-related Federal, State, local, and other agencies.

(c) *ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.*—[*GRANTS FOR HEALTH PROMOTION AND DISEASE PREVENTION SERVICES*] The Secretary, acting through the Service, shall facilitate access to[,] or provide[,] health promotion and disease prevention services for [u]*U*rban Indians through grants made to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section].

(d) [*GRANTS FOR I*]*I*MMUNIZATION [S]*S*ERVICES

(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for [u]*U*rban Indians through grants made to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under [subsection (a) of] this section.

(2) DEFINITION.—For purposes of this subsection, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

[(2) In making any grant to carry out this subsection, the Secretary shall take into consideration—]

[(A) the size of the urban Indian population to be served;]

[(B) the immunization levels of the urban Indian population, particularly the immunization levels of infants, children, and the elderly;]

[(C) the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population; and]

[(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.]

[(3) For purposes of this subsection, the term "immunization services" means services to provide without charge immunizations against vaccine-preventable diseases.]

(e) *BEHAVIORAL* [GRANTS FOR PROVISION OF MENTAL H]*H*EALTH [S]*S*ERVICES.—

(1) *ACCESS OR SERVICES PROVIDED*.—The Secretary, acting through the Service, shall facilitate access to, or provide, *behavioral* [mental] health services for [u]*U*rban Indians through grants made to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section].

(2) *ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a* [A] grant may not be made under this subsection to an [u]*U*rban Indian [o]*O*rganization until that organization has prepared, and the Service has approved, an assessment of the *following*: [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.]

(A) The behavioral health needs of the Urban Indian population concerned.

(B) The behavioral health services and other related resources available to that population.

(C) The barriers to obtaining those services and resources.

(D) The needs that are unmet by such services and resources.

(3) *PURPOSES OF GRANTS*.—Grants may be made under this subsection[—] *for the following:*

(A) [t]*T*o prepare assessments required under paragraph (2)[;].

(B) [t]*T*o provide outreach, educational, and referral services to [u]*U*rban Indians regarding the availability of direct *behavioral* [mental] health services, to educate [u]*U*rban Indians about *behavioral* [mental] health issues and services, and effect coordination with existing *behavioral* [mental] health providers in order to improve services to [u]*U*rban Indians[;].

(C) [t]*T*o provide outpatient *behavioral* [mental] health services to [u]*U*rban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.[; and]

(D) [t]*T*o develop innovative *behavioral* [mental] health service delivery models which incorporate Indian cultural support systems and resources.

(f) [GRANTS FOR P]*P*REVENTION [AND TREATMENT] OF [C]*C*HILD [A]*A*BUSE

(1) *ACCESS OR SERVICES PROVIDED*.—The Secretary, acting through the Service, shall facilitate access to[,] or provide[,] services for [u]*U*rban Indians through grants to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section] to prevent and treat child abuse (including sexual abuse) among [u]*U*rban Indians.

(2) *EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a* [A] grant may not be made under this subsection to an [u]*U*rban Indian [o]*O*rganization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the [u]*U*rban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

(3) *PURPOSES OF GRANTS*.—Grants may be made under this subsection[—] *for the following*:

(A) [t]*T*o prepare assessments required under paragraph (2)[;].

(B) [f]*F*or the development of prevention, training, and education programs for [u]*U*rban Indians [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) [t]*T*o provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to [u]*U*rban 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 [u]*U*rban Indian perpetrators of child abuse (including sexual abuse).

(4) *CONSIDERATIONS WHEN MAKING GRANTS*.—In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the support for the [u]*U*rban Indian [o]*O*rganization 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 [u]*U*rban Indian [o]*O*rganization to address the complex problem of child sexual abuse in the community; and (C) the assessment required under paragraph (2).

(C) the assessment required under paragraph (2).

(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an Urban Indian Organization that provides or arranges for the provision of health

care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

§ 1654. Contracts and [g]*G*rants for the [d]*D*etermination of [u]*U*nmet [h]*H*ealth [c]*C*are [n]*N*eeds

(a) *GRANTS AND CONTRACTS AUTHORIZED.*—[AUTHORITY] Under authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] (*commonly* known as the 'Snyder Act'), the Secretary, *acting* through the Service, may enter into contracts with[,] or make grants to[, u]*U*rban Indian [o]*O*rganizations situated in [u]*U*rban [c]*C*enters for which contracts have not been entered into[,] or grants have not been made[,] under section *503* [1653 of this title].

(*b*) *PURPOSE.*—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection *(c)*[(b)](1) [of this section] in order to assist the Secretary in assessing the health status and health care needs of [u]*U*rban Indians in the [u]*U*rban [c]*C*enter involved and determining whether the Secretary should enter into a contract or make a grant under section *503*[1653 of this title] with respect to the [u]*U*rban Indian [o]*O*rganization which the Secretary has entered into a contract with, or made a grant to, under this section.

(*c*)[(b)] *GRANT AND CONTRACT* REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

(1) the [u]*U*rban Indian [o]*O*rganization successfully undertakes to—

(A) document the health care status and unmet health care needs of [u]*U*rban Indians in the [u]*U*rban [c]*C*enter involved; and

(B) with respect to [u]*U*rban Indians in the [u]*U*rban [c]*C*enter involved, determine the matters described in *paragraphs* [clauses] (2), (3), (4), and (7)[(8)] of section *503(b)*[1653(b) of this title]; and

(2) the [u]*U*rban Indian [o]*O*rganization complete performance of the contract, or carry out the requirements of the grant, within *1*[one] year after the date on which the Secretary and such organization enter into such contract, or within *1*[one] year after such organization receives such grant, whichever is applicable.

(d)[(c)] *NO* RENEWALS.—The Secretary may not renew any contract entered into [,] or grant made [,] under this section.

§ 1655. Evaluations; [r]*R*enewals

(a) *PROCEDURES FOR EVALUATIONS.*—[CONTRACT COMPLIANCE AND PERFORMANCE] The Secretary, *acting* through the Service, shall develop procedures to evaluate compliance with grant requirements [under this subchapter] and compliance with[,] and performance of contracts entered into by [u]*U*rban Indian [o]*O*rganizations under this *title* [subchapter]. Such procedures shall include provisions for carrying out the requirements of this section.

(b) [ANNUAL ONSITE E]*E*VALUATIONS.—The Secretary, *acting* through the Service, shall *evaluate the compliance* [conduct an annual onsite evaluation] of each [u]*U*rban Indian [o]*O*rganization

which has entered into a contract or received a grant under section *503 with the terms of* [1653 of this title for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract or the terms of] such *contract or* grant. *For purposes of this evaluation, in determining the capacity of an Urban Indian Organization to deliver quality patient care the Secretary shall—*

(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

(c) NONCOMPLIANCE; [OR U]*U*NSATISFACTORY [P]*P*ERFORMANCE.— If, as a result of the evaluations conducted under this section, the Secretary determines that an [u]*U*rban Indian [o]*O*rganization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section *503* [1653 of this title], the Secretary shall, prior to renewing such contract or grant, attempt to resolve with *the* [such] organization the areas of noncompliance or unsatisfactory performance and modify *the* [such] contract or grant to prevent future occurrences of [such] noncompliance or unsatisfactory performance. If the Secretary determines that *the* [such] noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew *the* [such] contract or grant with *the* [such] organization and is authorized to enter into a contract or make a grant under section *503* [1653 of this title] with another [u]*U*rban Indian [o]*O*rganization which is situated in the same [u]*U*rban [c]*C*enter as the [u]*U*rban Indian [o]*O*rganization whose contract or grant is not renewed under this section.

(d) *CONSIDERATIONS FOR* [CONTRACT AND GRANT R]*R*ENEWALS.— In determining whether to renew a contract or grant with an [u]*U*rban Indian [o]*O*rganization under section *503* [1653 of this title] which has completed performance of a contract or grant under section *504* [1654 of this title], the Secretary shall review the records of the [u]*U*rban Indian [o]*O*rganization, the reports submitted under section *507* [1657 of this title, and, in the case of a renewal of a contract or grant under section 1653 of this title], *and* shall consider the results of the onsite evaluations *or accreditations* [conducted] under subsection (b) [of this section].

§ 1656. Other [c]*C*ontract and [g]*G*rant [r]*R*equirements

(a) *PROCUREMENT.*—[FEDERAL REGULATIONS; EXCEPTIONS] Contracts with [u]*U*rban Indian [o]*O*rganizations entered into pursuant to this *title* [subchapter] 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 sections *1304 and 3131 through* [3131 to] 3133 of [T]*t*itle 40, *United States Code*.

(b) *PAYMENT UNDER CONTRACTS OR GRANTS.*—Payments under any contracts or grants pursuant to this *title shall, notwithstanding*

any term or condition of such contract or grant—[subchapter may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this subchapter.]

(1) be made in their entirety by the Secretary to the Urban Indian Organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

(2) if any portion thereof is unexpended by the Urban Indian Organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the availability for expenditure of such funds.

(c) REVISION OR [A]*AMENDMENT OF CONTRACTS.*—Notwithstanding any provision of law to the contrary, the Secretary may, at the request and consent of an [u]*U*rban Indian [o]*O*rganization, revise or amend any contract entered into by the Secretary with such organization under this *title* [subchapter] as necessary to carry out the purposes of this *title* [subchapter].

[(d) EXISTING GOVERNMENT FACILITIES]

[In connection with any contract or grant entered into pursuant to this subchapter, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract or grant, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.]

(d) *FAIR AND* [(e)] UNIFORM [PROVISION OF S]*S*ERVICES AND [A]*A*SSISTANCE.—Contracts with[,] or grants to[, u]*U*rban Indian [o]*O*rganizations and regulations adopted pursuant to this *title* [subchapter] shall include provisions to assure the fair and uniform provision to [u]*U*rban Indians of services and assistance under such contracts or grants by such organizations.

[(f) ELIGIBILITY FOR HEALTH CARE OR REFERRAL SERVICES]

[Urban Indians, as defined in section 1603(f) of this title, shall be eligible for health care or referral services provided pursuant to this subchapter.]

§ 1657. Reports and [r]*R*ecords

(a) [QUARTERLY R]*R*EPORTS.—For each fiscal year during which an [u]*U*rban Indian [o]*O*rganization receives or expends funds pursuant to a contract entered into[,] or a grant received[,] pursuant to this *title* [subchapter], such *Urban Indian O*[o]rganization shall submit to the Secretary *not more frequently than every 6 months,* a [quarterly] report *that includes the following:* [including—]

(1) [i]*I*n the case of a contract or grant under section *503, recommendations pursuant to section 503(a)(5).* [1653 of this title, information gathered pursuant to clauses (10) and (11) of this subsection (a) of such section;]

(2) [i]*I*nformation on activities conducted by the organization pursuant to the contract or grant[;].

(3) [a]*A*n accounting of the amounts and purpose[s] for which Federal funds were expended.[; and]

(4) *A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with Urban Indian Organizations.* [such other information as the Secretary may request.]

(b) AUDIT [BY SECRETARY AND COMPTROLLER GENERAL].—The reports and records of the [u]*U*rban Indian [o]*O*rganization with respect to a contract or grant under this *title* [subchapter] shall be subject to audit by the Secretary and the Comptroller General of the United States.

(c) COST OF [ANNUAL PRIVATE A]*A*UDITS.—The Secretary shall allow as a cost of any contract or grant entered into *or awarded* under section *502 or 503* [1653 of this title] the cost of an annual *independent financial* [private] audit conducted by—

(1) a certified public accountant[.]*; or*

(2) a certified public accounting firm qualified to conduct Federal compliance audits.

[(d) HEALTH STATUS, SERVICES, AND AREAS OF UNMET NEEDS; CHILD WELFARE]

[(1) The Secretary, acting through the Service, shall submit a report to the Congress not later than March 31, 1992, evaluating—]

[(A) the health status of urban Indians;]

[(B) The services provided to Indians through this subchapter;]

[(C) areas of unmet needs in urban areas served under this subchapter; and]

[(D) areas of unmet needs in urban areas not served under this subchapter.]

[(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.]

[(3) The Secretary and the Secretary of the Interior shall—]

[(A) assess the status of the welfare of urban Indian children, including the volume of child protection cases, the prevalence of child sexual abuse, and the extent of urban Indian coordination with tribal authorities with respect to child sexual abuse; and]

[(B) submit a report on the assessment required under subparagraph (A), together with recommended legislation to improve Indian child protection in urban Indian populations, to the Congress no later than March 31, 1992.]

§ 1658. Limitation on [c]*Contract* [a]*Authority*

The authority of the Secretary to enter into contracts *or to award grants* under this *title* [subchapter] shall be to the extent, and in an amount, provided for in appropriation Acts.

§ 1659. FACILITIES [RENOVATION]

(a) GRANTS.—The Secretary*, acting through the Service,* may make grants [funds available] to contractors or grant recipients under this *title* [subchapter] for *the lease, purchase, renovation, construction, or expansion of* [minor renovations to] facilities, including leased facilities, *in order* to assist such contractors or grant recipients in *complying with applicable licensure or certification requirements* [meeting or maintaining the Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards].

(b) LOAN FUND STUDY.—The Secretary, acting through the Services, may carry out a study to determine the feasibility of establishing a loan fund to provide to Urban Indian Organizations direct loans or guarantees for loans for the construction of health care facilities in a manner consistent with Section 309.

§ 1660. *Division of* Urban *Indian* Health [Programs Branch]

[(a) ESTABLISHMENT]

There is established within the Service *a Division* [a Branch] of Urban *Indian* Health, [Programs] which shall be responsible for—

(1) carrying out the provisions of this *title;* [subchapter and for]

(2) providing central oversight of the programs and services authorized under this *title; and* [subchapter.]

(3) providing technical assistance to Urban Indian Organizations.

[(b) STAFF, SERVICES, AND EQUIPMENT]

[The Secretary shall appoint such employees to work in the branch, including a program director, and shall provide such services and equipment, as may be necessary for it to carry out its responsibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request.]

§ 1660a. Grants for [a]*Alcohol* and [s]*Substance* [a]*Abuse* [r]*R*elated [s]*Services*

(a) GRANTS *AUTHORIZED.*—The Secretary, *acting through the Service,* may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education *regarding* [in], alcohol and substance abuse in [u]*U*rban [c]*C*enters to those [u]*U*rban Indian [o]*O*rganizations with *which* [whom] the Secretary has entered into a contract under this *title* [subchapter] or under section *201*[1621 of this title].

(b) GOALS [OF GRANT].—Each grant made pursuant to subsection (a) [of this section] shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) [of this section], including criteria relating to the *following:*[—]

(1) *The* size of the [u]*U*rban Indian population[;].

[(2) accessibility to, and utilization of, other health resources available to such population;]

[(3) duplication of existing Service or other Federal grants or contracts;]

(2) [(4) c]*C*apability of the organization to adequately perform the activities required under the grant[;].

(3)[(5) s]*S*atisfactory performance standards for the organization in meeting the goals set forth in such grant.[, which] *The* standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis.[; and]

(4)[(6) i]*I*dentification of need for services.

(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on *the* [such] criteria *established pursuant to subsection (c).*

(e)[(d)] *GRANTS SUBJECT TO CRITERIA*.—[TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS] Any funds received by an [u]*U*rban Indian [o]*O*rganization under this *Act* [chapter] for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c) [of this section].

§ 1660b. Treatment of [c]*C*ertain [d]*D*emonstration [p]*P*rojects

[(a)] Notwithstanding any other provision of law, the *Tulsa Clinic and* Oklahoma City Clinic demonstration projects *shall*—[and the Tulsa Clinic demonstration project shall be treated as service units in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.]

(1) be permanent programs within the Service's direct care program;

(2) continue to be treated as Service Units in the allocation of resources and coordination of care; and

(3) continue to meet the requirements and definitions of an Urban Indian Organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

[(b) The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects specified in subsection (a) of this section.]

[(c) In addition to the amounts made available under section 1660d of this title to carry out this section through fiscal year 2000, there are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2001 and 2002.]

§ 1660c. Urban NIAAA [t]*T*ransferred [p]*P*rograms

(a) *GRANTS AND CONTRACTS*.—[DUTY OF SECRETARY] The Secretary, *through the Division* [shall, within the Branch] of Urban *Indian* Health, *shall* [Programs of the Service,] make grants or enter into contracts *with Urban Indian Organizations, to take effect not later than September 30, 2008,* for the administration of [u]*U*rban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse

(hereafter in this section referred to as [“] ‘NIAAA’ [”]) and transferred to the Service.

(b) USE OF *FUNDS*.—[GRANTS] 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 [u]*U*rban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

(c) ELIGIBILITY.—[FOR GRANTS] Urban Indian [o]*O*rganizations that operate Indian alcohol programs originally funded under *the* NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

[(d) COMBINATION OF FUNDS]

[For the purpose of carrying out this section, the Secretary may combine NIAAA alcohol funds with other substance abuse funds currently administered through the Branch of Urban Health Programs of the Service.]

(d)[(e) EVALUATION AND R]*R*EPORT.—[TO CONGRESS] The Secretary shall evaluate and report to [the] Congress on the activities of programs funded under this section *not less than* [at least] every 5 years.

§ 514. Consultation with Urban Indian Organizations

(a) IN GENERAL.—The Secretary shall ensure that the Service consults, to the greatest extent practicable, with Urban Indian Organizations.

(b) DEFINITION OF CONSULTATION.—For purposes of subsection (a), consultation is the open and free exchange of information and opinions which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

§ 515. Federal Tort Claim Act Coverage

(a) IN GENERAL.—With respect to claims resulting from the performance of functions during fiscal year 2005 and thereafter, or claims asserted after September 30, 2004, but resulting from the performance of functions prior to fiscal year 2005, under a contract, grant agreement, or any other agreement authorized under this title, an Urban Indian Organization is deemed hereafter to be part of the Service in the Department of Health and Human Services while carrying out any such contract or agreement and its employees are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or agreement. After September 30, 2003, any civil action or proceeding involving such claims brought hereafter against any Urban Indian Organization or any employee of such Urban Indian Organization covered by this provision shall be deemed to be an action against the United States and will be defended by the Attorney General and be afforded the full protection and coverage of the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.). Future coverage under that Act shall be contingent on cooperation of the Urban Indian Organization with the Attorney General in prosecuting past claims.

(b) CLAIMS RESULTING FROM PERFORMANCE OF CONTRACT OR GRANT.—Beginning for fiscal year 2005 and thereafter, the Secretary shall request through annual appropriations funds sufficient

to reimburse the Treasury for any claims paid in the prior fiscal year pursuant to the foregoing provisions.

§ 516. Urban Youth Treatment Center Demonstration

(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, through grant or contract, is authorized to fund the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

(b) DEFINITION OF STATE.—A State described in this subsection is a State in which—

(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and

(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

§ 517. Use of Federal Government Facilities and Sources of Supply

(a) AUTHORIZATION FOR USE.—The Secretary, acting through the Service, shall allow 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) DONATIONS.—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 FOR DONATION.—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 donation of a specific item of personal or real property described in subsection (b) or (c) from both an Urban Indian Organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation of the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically to the Urban Indian Organization.

(e) URBAN INDIAN ORGANIZATIONS DEEMED EXECUTIVE AGENCY FOR CERTAIN PURPOSES.—For purposes of section 501 of title 40, United States Code, (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.

§ 518. Grants for Diabetes Prevention, Treatment, and Control

(a) GRANTS AUTHORIZED.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

(1) the size and location of the Urban Indian population to be served;

(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served;

(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

(4) the capability of the organization to adequately perform the activities required under the grant; and

(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

§ 519. Community Health Representatives

The Secretary, acting through the Service, may enter into contracts with, and make grants to, Urban Indian Organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to Urban Indians.

§ 520. Effective Date

The amendments made by the Indian Health Care Improvement Act Amendments of 2005 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

§ 521. Eligibility for Services

Urban Indians shall be eligible and the ultimate beneficiaries for health care or referral services provided pursuant to this title.

§ 1660d. Authorization of [a]*A*ppropriations

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* [2000] to carry out this *title* [subchapter].

TITLE VI [SUBCHAPTER V]— ORGANIZATIONAL IMPROVEMENTS

§ 1661. Establishment of *the* Indian Health Service as an *A* [*a*]gency 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 [t]*T*ribes, as are or may be *hereafter* [on and after November 23,1988,] provided by Federal statute or treaties, there is established within the Public Health Service of the Department [of Health and Human Services] the Indian Health Service.

(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The [Indian Health] Service shall be administered by *an Assistant Secretary of Indian Health* [a Director], who shall be appointed by the President, by and with the advice and consent of the Senate. The *Assistant Secretary* [Director of the Indian Health Service] shall report to the Secretary. [through the Assistant Secretary for Health of the Department of Health and Human Services.] Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, *2005*[1993], the term of service of the *Assistant Secretary* [Director] shall be 4 years. *An Assistant Secretary* [A Director] may serve more that 1 term.

(3) INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2005 shall serve as Assistant Secretary.

(4) ADVOCACY AND CONSULTATION—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

(A) facilitate advocacy for the development of appropriate Indian health policy; and

(B) promote consultation on matters relating to Indian health.

(b) AGENCY.—[STATUS] The [Indian Health] Service shall be an agency within the Public Health Service of the Department [of Health and Human Services], and shall not be an office, component, or unit of any other agency of the Department.

(c) DUTIES.—The *Assistant* Secretary [shall carry out through the Director] of [the] Indian Health [Service] *shall*—

(1) *perform* all functions *that* [which] were, on the day before *the date of enactment of the Indian Health Care Improvement Act Amendments of 2005,* [November 23, 1988,] carried

out by or under the direction of the individual serving as Director of the Indian Health Service on *that* [such] day;

(2) *perform* all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

(3) *administer* all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including [(but not limited to)] programs under—

(A) this *Act* [chapter];

(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 *and Education Assistance* Act (25 U.S.C. 450[f] et seq.); [and]

(4) *administer* all scholarship and loan functions carried out under *title* [subchapter] I [of this chapter.];

(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

(9) coordinate the activities of the Department concerning matters of Indian health; and

(10) perform such other functions as the Secretary may designate.

(d) AUTHORITY.—[OF SECRETARY]

(1) *IN GENERAL*.—The Secretary, acting through the *Assistant Secretary* [Director of the Indian Health Service], shall have the authority—

(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with [T]*t*itle 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 *provisions of* law, the provisions of section *12* [472] of *the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472)* [this title], shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establish*ment* under subsection (a) [of this section].

(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or in any document of or relating

to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

§ 1662. Automated [m]*M*anagement [i]*I*nformation [s]*S*ystem

(a) ESTABLISHMENT.—

(1) *IN GENERAL*.—The Secretary shall establish an automated management information system for the Service.

(2) *REQUIREMENTS OF SYSTEM*.—The information system established under paragraph (1) shall include—

(A) a financial management system[,]*;*

(B) a patient care information system for each area served by the [s]*S*ervice[,]*;*

(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service[, and]*;*

(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each [a]*A*rea 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 [INDIAN T]*T*RIBES AND [O]*O*RGANIZATIONS.—[; REIMBURSEMENT] [(1)] The Secretary shall provide each *Tribal Health Program* [Indian tribe and tribal organization] that provides health services under a contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]] automated management information systems which—

(1)[(A)] meet the management information needs of such *Tribal Health Program* [Indian tribe or tribal organization] with respect to the treatment by the *Tribal Health Program* [Indian tribe or tribal organization] of patients of the Service[,]*;* and

(2)[(B)] meet the management information needs of the Service.

[(2) The Secretary shall reimburse each Indian tribe or tribal organization for the part of the cost of the operation of a system provided under paragraph (1) which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Service.]

[(3) The Secretary shall provide systems under paragraph (1) to Indian tribes and tribal organizations providing health services in California by no later than September 30, 1990.]

(c) ACCESS TO RECORDS.—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.

§ 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 [SUBCHAPTER V—A—SUBSTANCE ABUSE] PROGRAMS

§ 701. Behavioral Health Prevention and Treatment Services

(a) PURPOSES.—The purposes of this section are as follows:

(1) To authorize and direct the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavior health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

(b) PLANS.—

(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

(ii) an estimate of the financial and human cost attributable to such illness or behavior.

(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to meet their responsibilities under the plans.

(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, Urban Indian Organization, or the Service.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

(c) PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, to the extent feasible and if funding is available, programs including the following:

(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

(B) detoxification (social and medical);

(C) acute hospitalization;

(D) intensive outpatient/day treatment;

(E) residential treatment;

(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

(G) emergency shelter;

(H) intensive case management;

(I) Traditional Health Care Practices; and

(J) diagnostic services.

(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

(C) identification and treatment of co-occurring disorders and comorbidity;

(D) prevention of alcohol, drug, inhalant, and tobacco use;

(E) early intervention, treatment, and aftercare;

(F) promotion of healthy approaches to risk and safety issues; and

(G) identification and treatment of neglect and physical, mental, and sexual abuse.

(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of healthy approached to risk-related behaviors;

(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

(F) sex specific treatment for sexual assault and domestic violence.

(4) FAMILY CARE.—Behavioral health services for families, including—

(A) early intervention, treatment, and aftercare for affected families;

(B) treatment for sexual assault and domestic violence; and

(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of healthy approaches to managing conditions related to aging;

(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

(F) identification and treatment of dementias regardless of cause.

(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Or-

ganization, or Urban Indian Organization in the development and implementation of such plan.

(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

§ 702. Memoranda of Agreement with the Department of the Interior

[§ 1665. Indian Health Service responsibilities]

(a) CONTENTS.—Not later than 12 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

(B) The right of Indians to participate in, and receive the benefit of, such services.

(C) The actions necessary to protect the exercise of such right.

(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area,

and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

(b) *SPECIFIC PROVISIONS REQUIRED.*—The [Memorandum] *memoranda* of [A]agreement *updated or* entered into pursuant to *subsection (a)* [section 2411 of this title] shall include specific provisions pursuant to which the Service shall assue responsibility for—

(1) the determination of the scope of the problem of alcohol and substance abuse among Indian*s* [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 alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

(c) CONSULTATION.—The Secretary, acting through the Service, and the Secretary of the Interior shall, in developing the memoranda of agreement under subsection (a), consult with and solicit the comments from—

(1) Indian Tribes and Tribal Organizations;

(2) Indians;

(3) Urban Indian Organizations and other Indian organizations; and

(4) behavioral health service providers.

(d) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereof) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and Urban Indian Organization.

[§ 1665a. Indian Health Service program]

***§ 703.* [(a)] Comprehensive *Behavioral Health* [p] *P*revention and [t]*T*reatment [p]*P*rogram**

(a) ESTABLISHMENT.—

(1) *IN GENERAL.*—The Secretary, acting through the Service, *Indian Tribes, and Tribal Organizations,* shall provide a program of comprehensive *behavioral health*, [alcohol and substance abuse] prevention, [and] treatment, *and aftercare, including Traditional Health Care Practices,* which shall include—

(A) prevention, through educational intervention, in Indian communities;

(B) acute detoxification, *psychiatric hospitalization, residential, and intensive outpatient* [and] treatment;

(C) community-based rehabilitation *and aftercare;*

(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; [and]

(E) *specialized* residential treatment programs for *high-risk populations, including* pregnant and *postpartum* [post partum] women and their children[.]; *and*

(F) diagnostic services.

(2) *TARGET POPULATIONS.*—The target population of such programs shall be members of Indian [t]*T*ribes. Efforts to train and educate key members of the Indian community shall *also* target employees of health, education, judicial, law enforcement, legal, and social service programs.

(b) CONTRACT [H]*H*EALTH [S]*S*ERVICES.—

(1) *IN GENERAL.*—The Secretary, acting through the Service, *Indian Tribes, and Tribal Organizations,* may enter into contracts with public or private providers of *behavioral health* [alcohol and substance abuse] treatment services for the purpose of [assisting the Service in] carrying out the program required under subsection (a) [of this section].

(2) *PROVISION OF ASSISTANCE.*—In carrying out this subsection, the Secretary shall provide assistance to Indian [t]*T*ribes *and Tribal Organizations* to develop criteria for the certification of *behavioral health* [alcohol and substance abuse] service providers and accreditation of service facilities which meet minimum standards for such services and facilities [as may be determined pursuant to section 2411(a)(3) of this title].

§ 704. Mental Health Technician Program

(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

(1) provides for the training of Indians as mental health technicians; and

(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall supervise and evaluate the mental health technicians in the training program.

(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served.

[(c) GRANTS FOR MODEL PROGRAM]

[(1) The Secretary, acting through the Service shall make a grant to the Standing Rock Sioux Tribe to develop a community-based demonstration project to reduce drug and alcohol abuse on the Standing Rock Sioux Reservation and to rehabilitate Indian families afflicted by such abuse.]

[(2) Funds shall be used by the Tribe to—]

[(A) develop and coordinate community-based alcohol and substance abuse prevention and treatment services for Indian families;]

[(B) develop prevention and intervention models for Indian families;]

[(C) conduct community education on alcohol and substance abuse; and]

[(D) coordinate with existing Federal, State, and tribal services on the reservation to develop a comprehensive alcohol and substance abuse program that assists in the rehabilitation of Indian families that have been or are afflicted by alcoholism.]

[(3) The Secretary shall submit to the President for inclusion in the report to be transmitted to the Congress under section 1671 of this title for fiscal year 1995 an evaluation of the demonstration project established under paragraph (1).]

§ 705. Licensing Requirement for Mental Health Care Workers

Subject to the provisions of section 221, 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 this Act is required to be licensed as a clinical psychologist, social worker, or marriage and family therapist, respectively, or working under the direct supervision of a licensed clinical psychologist, social worker, or marriage and family therapist, respectively.

§ 1665b. Indian [w]*W*omen [t]*T*reatment [p]*P*rograms

(a) GRANTS.—The Secretary*, consistent with section 701,* may make grants to Indian [t]*T*ribes, [and t]*T*ribal [o]*O*rganizations*, and Urban Indian Organizations* to develop and implement a comprehensive *behavioral health* [alcohol and substance abuse] 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 GRANT[S] *FUNDS.—A* grant made pursuant to this section may be used to—

(1) develop and provide community training, education, and prevention programs for Indian women relating to *behavioral health* [alcohol and substance abuse] issues, including fetal alcohol *disorders* [syndrome and fetal alcohol effect];

(2) identify and provide *psychological services,* [appropriate] counseling, advocacy, support, and relapse prevention to Indian women and their families; and

(3) develop prevention and intervention models for Indian women which incorporate [t]*T*raditional *Health Care Practices* [healers], cultural values, and community and family involvement.

(c) CRITERIA.—[FOR REVIEW AND APPROVAL OF GRANT APPLICATIONS]The Secretary*, in consultation with Indian Tribes and Tribal Organizations,* shall establish criteria for the review and approval of applications *and proposals* for *funding* [grants] under this section.

(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations.

[(d) AUTHORIZATION OF APPROPRIATIONS]

[(1) There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1993 and such sums as are necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

[(2) Twenty percent of the funds appropriated pursuant to this subsection shall be used to make grants to urban Indian organizations funded under subchapter IV of this chapter.]

§ 1665c. Indian [Health Service y]*Y*outh [p]*P*rogram

(a) DETOXIFICATION AND [R]*R*EHABILITATION.—The Secretary*, acting through the Service, consistent with section 701,* shall develop and implement a program for acute detoxification and treatment for Indian youths*, including behavioral health services* [who are alcohol and substance abusers]. 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 (25 U.S.C. 450 et seq.). [These r]*R*egional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

(b) *ALCOHOL AND SUBSTANCE ABUSE* TREATMENT [C]*C*ENTERS OR [F]*F*ACILITIES

(1) ESTABLISHMENT.—

[(1)]*(A) IN GENERAL.*—The Secretary*, acting through the Service, Indian Tribes, and Tribal Organizations,* shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, *at least 1*[a] youth regional treatment center *or treatment network* in each area under the jurisdiction of an [a]*A*rea [o]*O*ffice.

(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the [area offices of the Service in Tucson and Phoenix, Arizona, shall be considered one area office and the a]*A*rea [o]*O*ffice in California shall be considered to be *2* [two a]*A*rea [o]*O*ffices, *1*[one] office whose jurisdiction shall be considered to encompass the northern area of the State of California, and *1*[one] office whose jurisdiction shall be considered to encompass the remainder of the State of California *for the purpose of implementing California treatment networks*.

(2) *FUNDING.*—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

(3) *LOCATION.*—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the *Indian T*[t]ribes to be served by such center.

(4) *SPECIFIC PROVISION OF FUNDS.*—

(A) *IN GENERAL.*—Notwithstanding any other provision of this *title* [subchapter], the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

(i) The Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4[50b](*l*) of *the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l))* [this title].

(B) *PROVISION OF SERVICES TO ELIGIBLE YOUTHS.*—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in *Alaska* [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 Tra-

ditional Health Care Practices, to Indian children and adolescents, including—

(A) pretreatment assistance;

(B) inpatient, outpatient, and aftercare services;

(C) emergency care;

(D) suicide prevention and crisis intervention; and

(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) USE OF FUNDS.—Funds provided under this subsection may be used—

(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

(B) to hire behavioral health professionals;

(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

(E) for intensive home- and community-based services.

(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

(d)[(c)] FEDERALLY [O]*O*WNED [S]*S*TRUCTURES.—

(1) *IN GENERAL*.—The Secretary, [acting through the Service, shall,] in consultation with Indian [t]*T*ribes *and Tribal Organizations, shall—*

(A) identify and use, where appropriate, federally owned structures suitable *for* [as] local residential or regional *behavioral health* [alcohol and substance abuse] treatment [centers] for Indian youth*s*; 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* [as a] local residential or regional *behavioral health* [alcohol and substance abuse] treatment [center] for Indian youths.

(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)[(d)] REHABILITATION AND [A]*A*FTERCARE [S]*S*ERVICES.—

(1) IN GENERAL.—The Secretary, *Indian Tribes, or Tribal Organizations,* in cooperation with the Secretary of the Interior, shall develop and implement within each Service [service u]*U*nit, community-based rehabilitation and follow-up services for Indian youth*s* who are *having significant behavioral health problems and require* [alcohol or substance abusers which are designed to integrate] long-term treatment, *community re-*

integration, and *monitoring* to [monitor and] support the Indian youth*s* after their return to their home community.

(2) *ADMINISTRATION.*—Services under paragraph (1) shall be *provided* [administered within each service unit] by trained staff within the community who can assist the Indian youth*s* in *their* continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff *may* [shall] include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

(f)[(e)] INCLUSION OF [F]*F*AMILY IN [Y]*Y*OUTH [T]*T*REATMENT [P]*P*ROGRAM.—IN PROVIDING THE TREATMENT AND OTHER SERVICES TO INDIAN YOUTHS AUTHORIZED BY THIS SECTION, THE SECRETARY, *acting through the Service, Indian Tribes, and Tribal Organizations,* shall provide for the inclusion of family members of such youth*s* in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection *(e)*[(d) of this section] shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

(g)[(f)] MULTIDRUG [A]*A*BUSE *PROGRAM.*—[STUDY]

[(1)] The Secretary*, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations,* shall *provide, consistent with section 701, programs and services to prevent and treat* [conduct a study to determine the incidence and prevalence of] the abuse of multiple forms of *substances* [drugs], including alcohol, *drugs, inhalants, and tobacco,* among Indian youths residing *in Indian communities,* on *or near* [Indian] reservations, and in urban areas and *provide appropriate mental health services to address* [the interrelationship of such abuse with] the incidence of mental illness among such youths.

[(2) The Secretary shall submit a report detailing the findings of such study, together with recommendations based on such findings, to the Congress no later than two years after October 29, 1992.]

(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data from the report under section 801 with respect to—

(1) the number of Indian youth who are being provided mental health services through the Service and Tribal Health Programs;

(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and Tribal Health Programs;

(3) the number of youth referred to the Service or Tribal Health Programs for mental health services;

(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and Tribal Health Programs, reported separately for on-and off-reservation facilities; and

(5) the cost of the services described in paragraph (4).

§ 708. Indian Youth Telemental Health Demonstration Project

(a) PURPOSE.—The purpose of this section is to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention and treatment of Indian youth, including through—

(1) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

(2) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

(3) training and related support for community leaders, family members and health and education workers who work with Indian youth;

(4) the development of culturally-relevant educational materials on suicide; and

(5) data collection and reporting.

(b) DEFINITIONS.—For the purpose of this section, the following definitions shall apply:

(1) DEMONSTRATION PROJECT.—The term 'demonstration project' means the Indian youth telemental health demonstration project authorized under subsection (c).

(2) TELEMENTAL HEALTH.—The term 'telemental health' means the use of electronic information and telecommunications technologies to support long distance mental health care, patient and professional-related education, public health, and health administration.

(c) AUTHORIZATION.—

(1) IN GENERAL.—The Secretary is authorized to award grants under the demonstration project for the provision of telemental health services to Indian youth who—

(A) have expressed suicidal ideas;

(B) have attempted suicide; or

(C) have mental health conditions that increase or could increase the risk of suicide.

(2) ELIGIBILITY FOR GRANTS.—Such grants shall be awarded to Indian Tribes, Tribal Organizations, and Urban Indian Organizations that operate 1 or more facilities—

(A) located in Alaska and part of the Alaska Federal Health Care Access Network;

(B) reporting active clinical telehealth capabilities; or

(C) offering school-based telemental health services relating to psychiatry to Indian youth.

(3) GRANT PERIOD.—The Secretary shall award grants under this section for a period of up to 4 years.

(4) AWARDING OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian Tribes, Tribal Organizations, and Urban Indian Organizations that—

(A) serve a particular community or geographic area where there is a demonstrated need to address Indian youth suicide;

(B) enter into collaborative partnerships with Indian Health Service or other Tribal Health Programs or facilities to provide services under this demonstration project;

(C) serve an isolated community or geographic area which has limited or no access to behavioral health services; or

(D) operate a detention facility at which youth are detained.

(d) USE OF FUNDS.—An Indian Tribe, Tribal Organization, or Urban Indian Organization shall use a grant received under subsection (c) for the following purposes:

(1) To provide telemental health services to Indian youth, including the provision of—

(A) psychotherapy;

(B) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

(C) alcohol and substance abuse treatment.

(2) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service, tribal, or urban clinicians and health services providers working with youth being served under this demonstration project.

(3) To assist, educate and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals and with State and local health services providers.

(4) To develop and distribute culturally appropriate community educational materials on—

(A) suicide prevention;

(B) suicide education;

(C) suicide screening;

(D) suicide intervention; and

(E) ways to mobilize communities with respect to the identification of risk factors for suicide.

(5) For data collection and reporting related to Indian youth suicide prevention efforts.

(e) APPLICATIONS.—To be eligible to receive a grant under subsection (c), an Indian Tribe, Tribal Organization, or Urban Indian Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(1) a description of the project that the Indian Tribe, Tribal Organization, or Urban Indian Organization will carry out using the funds provided under the grant;

(2) a description of the manner in which the project funded under the grant would—

(A) meet the telemental health care needs of the Indian youth population to be served by the project; or

(B) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

(3) evidence of support for the project from the local community to be served by the project;

(4) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

(5) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

(6) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

(f) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the demonstration project established pursuant to this section involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes of the youth to be served.

(g) COLLABORATION; REPORTING TO NATIONAL CLEARINGHOUSE.—

(1) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving grants under this section to collaborate to enable comparisons about best practices across projects.

(2) REPORTING TO NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall also encourage Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse authorized under section 701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

(h) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

(1) describes the number of telemental health services provided; and

(2) includes any other information that the Secretary may require.

(i) REPORT TO CONGRESS.—Not later than 270 days after the termination of the demonstration project, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources and Committee on Energy and Commerce of the House of Representatives a final report, based on the annual reports provided by grant recipients under subsection (h), that—

(1) describes the results of the projects funded by grants awarded under this section, including any data available which indicates the number of attempted suicides; and

(2) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth.

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2006 through 2009."

§709. Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing

Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

§1665d. Training and [c]Community [e]*E*ducation

(a) *PROGRAM.*—[COMMUNITY EDUCATION] The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement *or provide funding for Indian Tribes and Tribal Organizations to develop and implement,* within each [s]*S*ervice [u]*U*nit *or tribal program,* a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education *about behavioral health issues* [in alcohol and substance abuse] to political leaders, [t]*T*ribal judges, law enforcement personnel, members of tribal health and education boards, *health care providers including traditional practitioners,* and other critical members of each tribal community. *Community-based training (oriented toward local capacity development) shall also include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment, and aftercare.)*

(b) *INSTRUCTION.*—[TRAINING] The Secretary, *acting through the Service,* shall, either directly or *through Indian Tribes and Tribal Organizations* [by contract], provide instruction in the area of *behavioral health issues* [alcohol and substance abuse], 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* [syndrome] 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)* [2433 of this title].

(c) *TRAINING* [COMMUNITY-BASED TRAINING M]*M*ODELS.— In carrying out the education and training programs required by this section, the Secretary, [acting through the Service and] in consultation with *Indian T*[t]ribes, *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* [substance abuse] faced by children of alcoholics;

(2) the cultural, *spiritual,* and multigenerational aspects of *behavioral health problem* [alcohol and substance abuse] prevention and recovery; and

(3) community-based and multidisciplinary strategies for preventing and treating *behavioral health problems* [alcohol and substance abuse].

§ 711. Behavioral Health Program

(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

(b) FUNDING; CRITERIA.—The Secretary may award such funding for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

(1) The project will address significant unmet behavioral health needs among Indians.

(2) The project will serve a significant number of Indians.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

(5) The project may deliver services in a manner consistent with Traditional Health Care Practices.

(6) The project is coordinated with, and avoids duplication of, existing services.

(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

[§ 1665e. Gallup alcohol and substance abuse treatment center]

[(a) GRANTS FOR RESIDENTIAL TREATMENT]

[The Secretary shall make grants to the Navajo Nation for the purpose of providing residential treatment for alcohol and substance abuse for adult and adolescent members of the Navajo Nation and neighboring tribes.]

[(b) PURPOSES OF GRANTS]

[Grants made pursuant to this section shall (to the extent appropriations are made available) be used to—]

[(1) provide at least 15 residential beds each year for adult long-term treatment, including beds for specialized services such as polydrug abusers, dual diagnosis, and specialized services for women with fetal alcohol syndrome children;]

[(2) establish clinical assessment teams consisting of a clinical psychologist, a part-time addictionologist, a master's level assessment counselor, and a certified medical records technician which shall be responsible for conducting individual assessments and matching Indian clients with the appropriate available treatment;]

[(3) provide at least 12 beds for an adolescent shelterbed program in the city of Gallup, New Mexico, which shall serve as a satellite facility to the Acoma/Canoncito/Laguna Hospital

and the adolescent center located in Shiprock, New Mexico, for emergency crisis services, assessment, and family intervention;]

[(4) develop a relapse program for the purposes of identifying sources of job training and job opportunity in the Gallup area and providing vocational training, job placement, and job retention services to recovering substance abusers; and]

[(5) provide continuing education and training of treatment staff in the areas of intensive outpatient services, development of family support systems, and case management in cooperation with regional colleges, community colleges, and universities.]

[(c) CONTRACT FOR RESIDENTIAL TREATMENT]

[The Navajo Nation, in carrying out the purposes of this section, shall enter into a contract with an institution in the Gallup, New Mexico area which is accredited by the Joint Commission of the Accreditation of Health Care Organizations to provide comprehensive alcohol and drug treatment as authorized in subsection (b) of this section.]

[(d) AUTHORIZATION OF APPROPRIATIONS]

[There are authorized to be appropriated, for each of fiscal years 1996 through 2000, such sums as may be necessary to carry out subsection (b) of this section.]

[§ 1665f. Reports]

[(a) COMPILATION OF DATA]

[The Secretary, with respect to the administration of any health program by a service unit, directly or through contract, including a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], shall require the compilation of data relating to the number of cases or incidents in which any Service personnel or services were involved and which were related, either directly or indirectly, to alcohol or substance abuse. Such report shall include the type of assistance provided and the disposition of these cases.]

[(b) REFERRAL OF DATA]

[The data compiled under subsection (a) of this section shall be provided annually to the affected Indian tribe and Tribal Coordinating Committee to assist them in developing or modifying a Tribal Action Plan under section 2412 of this title.]

[(c) COMPREHENSIVE REPORT]

[Each service unit director shall be responsible for assembling the data compiled under this section and section 2434 of this title into an annual tribal comprehensive report. Such report shall be provided to the affected tribe and to the Director of the Service who shall develop and publish a biennial national report based on such tribal comprehensive reports.]

§ 1665g. Fetal [a]*Alcohol Disorder Programs.*— [syndrome and fetal alcohol effect grants]

(a) *PROGRAMS.*—[AWARD; USE; REVIEW CRITERIA]

(1) *ESTABLISHMENT.*—The Secretary*, consistent with section 701, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to* establish *and operate* fetal alcohol *disorder* [syndrome and fetal alcohol effect] programs as pro-

vided in this section for the purposes of meeting the health status objectives specified in section *3*[1602(b) of this title].

(2) *USE OF FUNDS.—Funding provided* [Grants made] pursuant to this section shall be used *for the following:*[to—]

(A) *To* develop and provide *for Indians* community and in[-]school training, education, and prevention programs relating to *fetal alcohol disorders.* [FAS and FAE;]

(B) *To* identify and provide *behavioral health* [alcohol and substance abuse] treatment to high-risk *Indian* women *and high-risk women pregnant with an Indian's child.*[;]

(C) *To* identify and provide appropriate *psychological services,* educational and vocational support, counseling, advocacy, and information to *fetal alcohol disorder* [FAS and FAE] affected *Indians* [persons] and their families or caretakers[;].

(D) *To* develop and implement counseling and support programs in schools for *fetal alcohol disorder* [FAS and FAE] affected *Indian* children[;].

(E) *To* develop prevention and intervention models which incorporate *practitioners of T*[t]raditional *Health Care Practices* [healers], cultural *and spiritual* values, and community involvement[;].

(F) *To* develop, print, and disseminate education and prevention materials on *fetal alcohol disorder.* [FAS and FAE; and]

(G) *To* develop and implement, through the tribal consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, culturally sensitive assessment and diagnostic tools *including dysmorphology clinics and multidisciplinary fetal alcohol and disorder clinics* for use in [tribal and urban] Indian communities *and Urban Centers.*

(H) To develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

(I) To develop—

(i) community-based support service for Indians and for women pregnant with Indian children; and

(ii) to the extent funding is available, community-based housing for adult Indians with fetal alcohol disorder.

(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for *funding* [grants] under this section.

(b) *SERVICES.*—[PLAN; STUDY; NATIONAL CLEARINGHOUSE] The Secretary, acting through the Service *and Indian Tribes, Tribal Organizations, and Urban Indian Organizations*, shall—

(1) develop *and provide services* [an annual plan] for the prevention, intervention, treatment, and aftercare for those affected by *fetal alcohol disorder* [FAS and FAE] in Indian communities; *and*

(2) *provide supportive services, directly or through an Indian Tribe, Tribal Organization, or Urban Indian Organization, including services to meet* [conduct a study, directly or by con-

tract with any organization, entity, or institution of higher education with significant knowledge of FAS and FAE and Indian communities, of] the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians *with fetal alcohol disorder*. [and Alaska Natives with FAS or FAE; and]

[(3) establish a national clearinghouse for prevention and educational materials and other information of FAS and FAE effect in Indian and Alaska Native communities and ensure access to clearinghouse materials by any Indian tribe or urban Indian organization.]

(c) TASK [F]*F*ORCE.—The Secretary shall establish a task force to be known as the *Fetal Alcohol Disorder* [FAS/FAE] Task Force to advise the Secretary in carrying out subsection (b) [of this section]. Such task force shall be composed of representatives from the *following*:

(1) The National Institute on Drug Abuse.[,]

(2) T[t]he National Institute on Alcohol and Alcoholism.[,]

(3) T[t]he Office of Substance Abuse Prevention.[,]

(4) T[t]he National Institute of Mental Health.[,]

(5) T[t]he Service.[,]

(6) T[t]he Office of Minority Health of the Department of Health and Human Services.[,]

(7) T[t]he Administration for Native Americans.[,]

(8) The National Institute of Child Health and Human Development (NICHD).

(9) The Centers for Disease Control and Prevention.

(10) T[t]he Bureau of Indian Affairs.[,]

(11) Indian *T*[t]ribes.[,]

(12) T[t]ribal *O*[o]rganizations.[,]

(13) U[u]rban Indian *Organizations*. [communities, and]

(14) Indian *fetal alcohol disorder* [FAS/FAE] experts.

(d) [COOPERATIVE PROJECTS;] *APPLIED R*[R]ESEARCH *P*[P]ROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian *T*[t]ribes, *T*[t]ribal *O*[o]rganizations, *and Urban Indian Organizations* [universities working with Indian tribes on cooperative projects, *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 *U*[u]rban Indians affected by *fetal alcohol disorder* [FAS or FAE].

[(e) REPORT]

[(1) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the status of FAS and FAE in the Indian population. Such report shall include, in addition to the information required under section 1602(d) of this title with respect to the health status objective specified in section 1602(b)(27) of this title, the following:]

[(A) The progress of implementing a uniform assessment and diagnostic methodology in Service and tribally based service delivery systems.]

[(B) The incidence of FAS and FAE babies born for all births by reservation and urban-based sites.]

[(C) The prevalence of FAS and FAE affected Indian persons in Indian communities, their primary means of support, and recommendations to improve the support system for these individuals and their families or caretakers.]

[(D) The level of support received from the entities specified in subsection (c) of this section in the area of FAS and FAE.]

[(E) The number of inpatient and outpatient substance abuse treatment resources which are specifically designed to meet the unique needs of Indian women, and the volume of care provided to Indian women through these means.]

[(F) Recommendations regarding the prevention, intervention, and appropriate vocational, educational and other support services for FAS and FAE affected individuals in Indian communities.]

[(2) The Secretary may contract the production of this report to a national organization specifically addressing FAS and FAE in Indian communities.]

[(f) AUTHORIZATION OF APPROPRIATIONS]

[(1) There are authorized to be appropriated to carry out this section $22,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—[(2)] Ten percent of the funds appropriated pursuant to this section shall be used to make grants to *U*[u]rban Indian *O*[o]rganizations funded under *title V* [subchapter IV of this chapter].

[§ 1665h. Pueblo substance abuse treatment project for San Juan Pueblo, New Mexico]

[The Secretary, acting through the Service, shall continue to make grants, through fiscal year 1995, to the 8 Northern Indian Pueblos Council, San Juan Pueblo, New Mexico, for the purpose of providing substance abuse treatment services to Indians in need of such services.]

[§ 1665i. Thunder Child Treatment Center]

[(a) The Secretary, acting through the Service, shall make a grant to the Intertribal Addictions Recovery Organization, Inc. (commonly known as the Thunder Child Treatment Center) at Sheridan, Wyoming, for the completion of construction of a multiple approach substance abuse treatment center which specializes in the treatment of alcohol and drug abuse of Indians.]

[(b) For the purposes of carrying out subsection (a) of this section, there are authorized to be appropriated $2,000,000 for fiscal years 1993 and 1994. No funding shall be available for staffing or operation of this facility. None of the funding appropriated to carry out subsection (a) of this section shall be used for administrative purposes.]

[§ 1665j. Substance abuse counselor education demonstration project]

[(a) CONTRACTS AND GRANTS]

[The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible community colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.]

[(b) USE OF FUNDS]

[Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.]

[(c) EFFECTIVE PERIOD OF CONTRACT OR GRANT; RENEWAL]

[A contract entered into or a grant provided under this section shall be for a period of one year. Such contract or grant may be renewed for an additional one year period upon the approval of the Secretary.]

[(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS]

[Not later than 180 days after October 29, 1992, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to education substance abuse counselors.]

[(e) ASSISTANCE TO RECIPIENTS]

[The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.]

[(f) REPORT]

[The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.]

§ 713. Child Sexual Abuse and Prevention Treatment Programs

(a) ESTABLISHMENT.—The Secretary, acting through the Service, and the Secretary of the Interior, Indian Tribes, and Tribal Organizations shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

(1) victims of sexual abuse who are Indian children or children in an Indian household; and

(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in

an Indian household, and to their family members who are affected by sexual abuse.

(3) To develop prevention and intervention models which incorporate Traditional Health Care Practices, cultural and spiritual values, and community involvement.

(4) To develop and implement, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, cultural sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

§ 714. Behavioral Health Research

The Secretary, in consultation with appropriate Federal agencies, shall provide grants to, or enter into contracts with, Indian Tribes, Tribal Organizations, and Urban Indian Organizations or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

(1) the multifactorial causes of Indian youth suicide, including—

(A) protective and risk factors and scientific data that identifies those factors; and

(B) the effects of loss of cultural identity and the development of scientific data on those effects;

(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

(3) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (2) on children, and the development of prevention techniques under paragraph (3) applicable to children, shall be emphasized.

§ 715. **[(g)] Definitions**

For the purposes of this *title* **[**section**]**, the following definitions *shall* apply:

(1) *ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.* **[**The term "educational curriculum" means one or more of the following:**]**

[(A) Classroom education.**]**

[(B) Clinical work experience.**]**

[(C) Continuing education workshops.**]**

(2) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means, with a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual, deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers (mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, ministers, etc.)

[(3) The term "tribally controlled community college" has the meaning given such term in section 1801(a)(4) of this title.**]**

(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

[(4) The term "tribally controlled postsecondary vocational institution" has the meaning given such term in section 2397h(2) of Title 20.**]**

(5) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome and alcohol related neurodevelopmental disorder (ARND).

(6) FETAL ALCOHOL SYNDROME OR FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

(C) Prenatal or postnatal growth delay.

(7) PARTIAL FAS.—The term 'partial FAS' means, with a history of maternal alcohol consumption during pregnancy, having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

(8) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to engage in usual and customary life activities through education and therapy.

(9) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

§ *716.* [(h)] Authorization of *A*[a]ppropriations

There *is* [are] authorized to be appropriated [for each of fiscal years 1996 through 2000,] such sums as may be necessary *for each fiscal year through fiscal year 2015* to carry out the *provisions* [purposes] of this *title* [section]. [Such sums shall remain available until expended.]

[§ 1665k. Gila River alcohol and substance abuse treatment facility]

[(a) REGIONAL CENTER]

[The Secretary, acting through the Service, shall establish a regional youth alcohol and substance abuse prevention and treatment center in Sacaton, Arizona, on the Gila River Indian Reservation. The center shall be established within facilities leased, with the consent of the Gila River Indian Community, by the Service from such Community.]

[(b) NAME OF REGIONAL CENTER]

[The center established pursuant to this section shall be known as the "Regional Youth Alcohol and Substance Abuse Prevention and Treatment Center".]

[(c) UNIT OF REGIONAL CENTER]

[The Secretary, acting through the Service, shall establish, as a unit of the regional center, a youth alcohol and substance abuse prevention and treatment facility in Fallon, Nevada.]

[§ 1665*l*. Alaska Native drug and alcohol abuse demonstration project]

[(a) The Secretary, acting through the Service, shall make grants to the Alaska Native Health Board for the conduct of a two-part community-based demonstration project to reduce drug and alcohol abuse in Alaska Native villages and to rehabilitate families afflicted by such abuse. Sixty percent of such grant funds shall be used by the Health Board to stimulate coordinated community development programs in villages seeking to organize to combat alcohol and drug use. Forty percent of such grant funds shall be transferred to a qualified nonprofit corporation providing alcohol recovery services in the village of St. Mary's, Alaska, to enlarge and strengthen a family life demonstration program of rehabilitation for families that have been or are afflicted by alcoholism.]

[(b) The Secretary shall submit to the President for inclusion in the report required to be submitted to the Congress under section 1671 of this title for fiscal year 1995 an evaluation of the demonstration project established under subsection (a) of this section.]

[§ 1665m. Authorization of appropriations]

[Except as provided in sections 1665b, 1665e, 1665g, 1665i, and 1665j of this title, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out the provisions of this subchapter.]

TITLE VIII [SUBCHAPTER VI]—MISCELLANEOUS

§ 1671. Reports

For each fiscal year following the date of enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary shall transmit to Congress a report containing the following:

[The President shall, at the time the budget is submitted under section 1105 of Title 31, for each fiscal year transmit to the Congress a report containing—]

(1) *A*[a] report on the progress made in meeting the objectives of this *Act* [chapter], including a review of programs established or assisted pursuant to this *Act* [chapter] and [an] assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians[,] and ensure a health status for Indians, which are at a parity with the health services available to and the health status of[,] the general population, *including specific comparisons of appropriations provided and those required for such parity.*[;]

(2) *A*[a] report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this *Act* [chapter] and any steps that the Secretary may have taken to consult with Indian [t]*T*ribes, *Tribal Organizations, and Urban Indian Organizations* to address such impact, *including a report on proposed changes in allocation of funding pursuant to section 808.*[;]

(3) *A*[a] report on the use of health services by Indians—

(A) on a national and area or other relevant geographical basis;

(B) by gender and age;

(C) by source of payment and type of service; [and]

(D) comparing such rates of use with rates of use among comparable non-Indian populations[.]*; and*

(E) provided under contracts.

(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(n).

(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 125(f).

(7)[(4) a]*A* separate statement which specifies the amount of funds requested to carry out the provisions of section *201.* [1621 of this title;]

(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

(9) A biennial report to Congress on infectious diseases as required by section 212.

(10) A report on environmental and nuclear health hazards as required by section 215.

(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2) and 301(d).

(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

(13) An annual report on the expenditure of nonservice funds for renovation as required by sections 304(b)(2).

(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

(16) A report on any arrangements for the sharing of medical facilities or services as authorized by section 406.

(17) A report on evaluation and renewal of Urban Indian programs under section 505.

(18) A report on the evaluation of programs as required by section 513(d).

(19) A report on alcohol and substance abuse as required by section 701(f).

(20) A report on Indian youth mental health services are required by section 707(h).

[(5) a separate statement of the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in section 1680d of this title, relating to infant and maternal mortality and fetal alcohol syndrome;**]**

[(6) the reports required by the sections 1602(d), 1616a(n), 1621b(b), 1621h(j), 1631(c), 1632(g), 1634(a)(3), 1643, 1665g(e), and 1680g(a), and 1680*l*(f) of this title;**]**

[(7) for fiscal year 1995, the report required by sections 1665a(c)(3) and 1665*l*(b) of this title;**]**

[(8) for fiscal year 1997, the interim report required by section 1637(h)(1) of this title; and**]**

[(9) for fiscal year 1999, the reports required by sections 1637(h)(2), 1660b(b), 1665j(f), and 1680k(g) of this title.**]**

§ 1672. Regulations

(a) DEADLINES.—

(1) PROCEDURES.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out titles I (except section 105, 115 and 117), II, III, and VII. The Secretary may promulgate regulations to carry out sections 105,115, 117, and titles IV and V, using the procedures required by chapter V of title 5, United States Code (commonly known as the 'Administrative Procedure Act'). The Secretary shall issue no regulations to carry out titles VI and VIII.

(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 1 year after the date of the enactment

of the Indian Health Care Improvement Act Amendments of 2005 and shall have no less than a 120-day comment period.

(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 24 months from the date of the enactment of this Act.

(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United State 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. The representative of the Urban Indian Organizations shall be deemed to be an elected officer of a tribal government for purposes fo applying section 204(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534(b).

(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law in effect on the day before the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

[Prior to any revision of or amendment to rules or regulations promulgated pursuant to this chapter, the Secretary shall consult with Indian tribes and appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.**]**

[§ 1673. Repealed.]

[§ 1674. Leases with Indian tribes]

[(a) Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this chapter, to enter into leases with Indian tribes for periods not in excess of twenty years. Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.**]**

[(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—**]**

[(1) title to;**]**

[(2) a leasehold interest in; or**]**

[(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);**]**

[facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal or-

ganizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable.]

§ 803. Plan of Implementation.

Not later than 9 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, the Secretary in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule (including a schedule of appropriation requests), by title and section, by which the Secretary will implement the provisions of this Act.

§ 1675. Availability of *F*[f]unds

The funds appropriated pursuant to this *Act* [chapter] shall remain available until expended.

§ 1676. Limitation on *U*[u]se of *F*[f]unds *A*[a]ppropriated to *the* Indian Health Service

Any limitation on the use of funds contained in an Act providing appropriations for the Department [of Health and Human Services] for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the [Indian Health] Service.

[§ 1677. Nuclear resource development health hazards]

[(a) STUDY]

[The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, a study of the health hazards to Indian miners and Indians on or near Indian reservations and in Indian communities as a result of nuclear resource development. Such study shall include—]

[(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;]

[(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;]

[(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal;]

[(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the five years prior to December 17, 1980, that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and]

[(5) the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the

health and safety hazards of such nuclear resource development.]

[(b) HEALTH CARE PLAN; DEVELOPMENT]

[Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studied under subsection (a) of this section. The plan shall include—]

[(1) methods for diagnosing and treating Indians currently exhibiting such health problems;]

[(2) preventive care for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other nuclear development activities that have had or could have a serious impact upon the health of such individuals; and]

[(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear development activities, may experience health problems.]

[(c) REPORTS TO CONGRESS]

[The Secretary and the Service shall submit to Congress the study prepared under subsection (a) of this section no later than the date eighteen months after December 17, 1980. The health care plan prepared under subsection (b) of this section shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) of this section is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.]

[(d) INTERGOVERNMENTAL TASK FORCE; ESTABLISHMENT AND FUNCTIONS]

[(1) There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees): the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the United States Bureau of Mines, the Assistant Secretary for Occupational Safety and Health, and the Secretary of the Interior.]

[(2) The Task Force shall identify existing and potential operations related to nuclear resource development that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community and enter into activities to correct existing health hazards and insure that current and future health problems resulting from nuclear resource development activities are minimized or reduced.]

[(3) The Secretary shall be Chairman of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.]

[(e) MEDICAL CARE]

[In the case of any Indian who—]

[(1) as a result of employment in or near a uranium mine or mill, suffers from a work related illness or condition;]

[(2) is eligible to receive diagnosis and treatment services from a Service facility; and]

[(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator;]

[the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator from such operator. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.]

[§ 1678. Arizona as a contract health service delivery area]

[(a) DESIGNATION]

[For the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, 2000, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of Arizona.]

[(b) CURTAILMENT OF HEALTH SERVICES PROHIBITED]

[The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a) of this section.]

§ 1679. Eligibility of California Indians

(a) *IN GENERAL.*—[REPORT TO CONGRESS] *The following California Indians shall be eligible for health services provided by the Service:*

[(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth—]

[(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,]

[(B) the geographic location of such Indians,]

[(C) the Indian tribes of which such Indians are members,]

[(D) an assessment of the current health status, and health care needs, of such Indians, and]

[(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.]

[(2) The report required under paragraph (1) shall be prepared by the Secretary—]

[(A) in consultation with the Secretary of the Interior, and]

[(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.]

[(b) ELIGIBLE INDIANS]

[Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:]

(1) Any member of a federally recognized Indian *T*[t]ribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, [but only] if such descendant—

[(A) is living in California,]

(*A*)[(B)] is a member of the Indian community served by a local program of the Service[,]; and

(*B*)[(C)] is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or [Indian] reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of [California] rancherias and reservations *located within the State of California* under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(*b*)[(c)] *CLARIFICATION.*—[SCOPE OF ELIGIBILITY] Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§ 1680. California as a contract health service delivery area]

[The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Sant Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.]

[§ 1680a. Contract health facilities]

[The Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Service entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]—]

[(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,]

[(2) for employee training,]

[(3) for cost-of-living increases for employees, and]

[(4) for any other expenses relating to the provision of health services,]

[on the same basis as such funds are provided to programs and facilities operated directly by the Service.]

[§ 1680b. National Health Service Corps]

[The Secretary of Health and Human Services shall not—]

[(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], or]

[(2) withdraw funding used to support such member,]

[unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.]

§ 1680c. Health *S*[s]ervices for *I*[i]neligible *P*[p]ersons

(a) *CHILDREN*.—[INDIVIDUALS NOT OTHERWISE ELIGIBLE]

[(1)] Any individual who—

(1)[(A)] has not attained 19 years of age[,]*;*

(2)[(B)] is the natural or adopted child, step[-]child, foster[-]child, legal ward, or orphan of an eligible Indian[,]*;* and

(3)[(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 1[one] year after the date *of a determination of competency* [such disability has been removed].

(b) *SPOUSES*.—[(2)] Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses *or spouses who are married to members of each Indian Tribe 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* [of the eligible Indian]. 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.

(c)[(b)] *PROVISION OF SERVICES TO OTHER INDIVIDUALS*.—[HEALTH FACILITIES PROVIDING HEALTH SERVICE]

(1)[(A)] *IN GENERAL*.—The Secretary is authorized to provide health services under this subsection through health *programs* [facilities] operated directly by the Service to individuals who reside within the [service area of a s]*S*ervice [u]*U*nit and who are not *otherwise* eligible for such health services [under any other subsection of this section or under any other provision of law] if—

(A)[(i)] the Indian *T*[t]ribes [(or, in the case of a multi-tribal service are, all the Indian tribes)] served by such [s]*S*ervice [u]*U*nit request[s] such provision of health services to such individuals[,]*;* and

(B)[(ii)] the Secretary and the *served* Indian [tribe or t]*T*ribes have jointly determined that—

(i)[(I)] the provision of such health services will not result in a denial or diminution of health services to eligible Indians[,]*;* and

(ii)[(II)] there is no reasonable alternative health facilit[y]*ies* or services, within or without the [service area of such s]*S*ervice [u]*U*nit, available to meet the health needs of such individuals.

(2)[(B)] *ISDEAA PROGRAMS*.—In the case of health *programs and* facilities operated under a contract *or compact* entered into under the Indian Self-Determination *and Education Assistance* Act *(25 U.S.C. 450 et seq.),* [[25 U.S.C.A. § 450f et seq.],] the governing body of the Indian [t]*T*ribe or *T*[t]ribal *O*[o]rganization providing health services under such contract *or compact* is authorized to determine whether health services should be provided under such contract *or compact* to individuals who are not *otherwise* eligible for such [health] services under any other subsection of this section or under any other provision of law. In making such determination[s], the governing body of the Indian [t]*T*ribe or [t]*T*ribal [o]*O*rganization shall take into account the considerations described in *clauses (i) and (ii) of paragraph (1)(B)* [subparagraph (A)(ii)].

(3)[(2)] *PAYMENT FOR SERVICES*.—

(A) *IN GENERAL*.—Persons receiving health services provided by the Service *under* [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 *404*[1880(c)] of *this* [the Social Security] Act [[42 U.S.C.A. § 1395qq(c)], section 1642(a) of this title,] or any other provision of law, amounts collected under this subsection, including medicare, [or] medicaid *or SCHIP* reimbursements under titles XVIII, [and] XIX, *and XXI* of the Social Security Act [[42 U.S.C.A. §§ 1395 et seq., 1396 et seq.]], shall be credited to the account of the *program* [facility] providing the service and shall be used [solely] for the *purposes listed in section 401(d)(2) and* [provision of health services within that facility. A]*a*mounts collected under this subsection shall be available for expenditure within such *program* [facility for not to exceed one fiscal year after the fiscal year in which collected].

(B) *INDIGENT PEOPLE*.—Health services may be provided by the Secretary through the Service under this subsection to an indigent *individual* [person] who would not be *otherwise* eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent *individual* [person].

(4)[(3)] *REVOCATION OF CONSENT FOR SERVICES.*—

(A) *SINGLE TRIBE SERVICE AREA.*—In the case of a *S*[s]ervice *A*[a]rea which serves only *1*[one] Indian *T*[t]ribe, 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 *T*[t]ribe revokes its concurrence to the provision of such health services.

(B) *MULTITRIBAL SERVICE AREA.*—In the case of a multi[-]tribal *S*[s]ervice *A*[a]rea, 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 *T*[t]ribes in the *S*[s]ervice *A*[a]rea revoke their concurrence to the provision of such health services.

(d)[(c)] *OTHER SERVICES.*—[PURPOSES SERVED IN PROVIDING HEALTH SERVICES TO OTHERWISE INELIGIBLE INDIVIDUALS] 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 *individual* [person] if such care is directly related to the treatment of the eligible *individual* [person].

(*e*)[(d) EXTENSION OF H]*HOSPITAL* [P]*PRIVILEGES FOR* [TO NON-SERVICE HEALTH CARE P]*PRACTITIONERS.*—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract *or compact* [entered into under] *pursuant to* the Indian Self-Determination *and Education Assistance* Act *(25 U.S.C. 450 et seq.)* [[25 U.S.C.A. § 450f et seq.]] may be extended to non-Service health care practitioners who provide services to *individuals* [persons] described in subsection (a), [or] (b), *(c), or (d)* [of this section]. Such non-Service health care practitioners may, *as part of the privileging process*, be *designated* [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 *individuals* [persons] as a part of the conditions under which such hospital privileges are extended.

(*f*)[(e) "]ELIGIBLE INDIAN[" "defined].—For purposes of this section, the term ["] 'eligible Indian' ["] means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

[§ 1680d. Infant and maternal mortality; fetal alcohol syndrome]

[By no later than January 1, 1990, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1994:]

[(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—]

[(A) twelve deaths per one thousand live births, or]

[(B) the rate of infant mortality applicable to the United States population as a whole;]

[(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—]

[(A) five deaths per one hundred thousand live births, or]

[(B) the rate of maternal mortality applicable to the United States population as a whole; and]

[(3) reduction of the rate of fetal alcohol syndrome among Indians served by, or on behalf of, the Service to one per one thousand births.]

[§ 1680e. Contract health services for the Trenton Service Area]

[(a) SERVICE TO TURTLE MOUNTAIN BAND]

[The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.]

[(b) BAND MEMBER ELIGIBILITY NOT EXPANDED]

[Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.]

[§ 1680f. Indian Health Service and Department of Veterans Affairs health facilities and services sharing]

[(a) FEASIBILITY STUDY AND REPORT]

[The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Department of Veterans Affairs and shall, in accordance with subsection (b) of this section, prepare a report on the feasibility of such an arrangement and submit such report to the Congress by no later than September 30, 1990.]

[(b) NONIMPAIRMENT OF SERVICE QUALITY, ELIGIBILITY, OR PRIORITY OF ACCESS]

[The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of Title 38 which would impair—]

[(1) the priority access of any Indian to health care services provided through the Indian Health Service;]

[(2) the quality of health care services provided to any Indian through the Indian Health Service;]

[(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;]

[(4) the quality of health care services provided to any veteran by the Department of Veterans Affairs;]

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

[(6) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.]

[(c) CROSS UTILIZATION OF SERVICES]

[(1) Not later than December 23, 1988, the Director of the Indian Health Service and the Secretary of Veterans Affairs shall implement an agreement under which—]

[(A) individuals in the vicinity of Roosevelt, Utah, who are eligible for health care from the Department of Veterans Affairs could obtain health care services at the facilities of the Indian Health Service located at Fort Duchesne, Utah; and]

[(B) individuals eligible for health care from the Indian Health Service at Fort Duchesne, Utah, could obtain health care services at the George E. Wahlen Department of Veterans Affairs Medical Center located in Salt Lake City, Utah.]

[(2) Not later than November 23, 1990, the Secretary and the Secretary of Veterans Affairs shall jointly submit a report to the Congress on the health care services provided as a result of paragraph (1).]

[(d) RIGHT TO HEALTH SERVICES]

[Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Indian Health Service except as provided in an agreement under subsection (c) of this section.]

§ 1680g. Reallocation of *B*[b]ase*R*[r]esources

(a) REPORT *REQUIRED*.—[TO CONGRESS] 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 *S*[s]ervice *U*[u]nit 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*[1671 of this title], a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

(b) *EXCEPTION*.—[APPROPRIATED AMOUNTS] Subsection (a) [of this section] shall not apply if the total amount appropriated to the Service for a fiscal year is *at least 5 percent* less than the amount appropriated to the Service for *the* previous fiscal year.

[§ 1680h. Demonstration projects for tribal management of health care services]

[(a) ESTABLISHMENT; GRANTS]

[(1) The Secretary, acting through the Service, shall make grants to Indian tribes to establish demonstration projects under which the Indian tribe will develop and test a phased approach to assumption by the Indian tribe of the health care delivery system of the Service for members of the Indian tribe

living on or near the reservations of the Indian tribe through the use of Service, tribal, and private sector resources.]

[(2) A grant may be awarded to an Indian tribe under paragraph (1) only if the Secretary determines that the Indian tribe has the administrative and financial capabilities necessary to conduct a demonstration project described in paragraph (1).]

[(b) HEALTH CARE CONTRACTS]

[During the period in which a demonstration project established under subsection (a) of this section is being conducted by an Indian tribe, the Secretary shall award all health care contracts, including community, behavioral, and preventive health care contracts, to the Indian tribe in the form of a single grant to which the regulations prescribed under part A of title XIX of the Public Health Service Act [42 U.S.C.A. § 300w et seq.] (as modified as necessary by any agreement entered into between the Secretary and the Indian tribe to achieve the purposes of the demonstration project established under subsection (a) of this section) shall apply.]

[(c) WAIVER OF PROCUREMENT LAWS]

[The Secretary may waive such provisions of Federal procurement law as are necessary to enable any Indian tribe to develop and test administrative systems under the demonstration project established under subsection (a) of this section, but only if such waiver does not diminish or endanger the delivery of health care services to Indians.]

[(d) TERMINATION; EVALUATION AND REPORT]

[(1) The demonstration project established under subsection (a) of this section shall terminate on September 30, 1993, or, in the case of a demonstration project for which a grant is made after September 30, 1990, three years after the date on which such grant is made.]

[(2) By no later than September 30, 1996, the Secretary shall evaluate the performance of each Indian tribe that has participated in a demonstration project established under subsection (a) of this section and shall submit to the Congress a report on such evaluations and demonstration projects.]

[(e) JOINT VENTURE DEMONSTRATION PROJECTS]

[(1) The Secretary, acting through the Service, shall make arrangements with Indian tribes to establish joint venture demonstrative projects under which an Indian tribe shall expend tribal, private, or other available nontribal funds, for the acquisition or construction of a health facility for a minimum of 20 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. A tribe may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.]

[(2) The Secretary shall make such an arrangement with an Indian tribe only if the Secretary first determines that the Indian tribe has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in paragraph (1).]

[(3) An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this subsection, and that breaches or terminates without cause such

agreement, shall be liable to the United States for the amount that has been paid to the tribe, or paid to a third party on the tribe's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, or for personnel or staffing, shall be recoverable.]

[§ 1680i. Child sexual abuse treatment programs]

[(a) CONTINUATION OF EXISTING DEMONSTRATION PROGRAMS]

[The Secretary and the Secretary of the Interior shall, for each fiscal year through fiscal year 1995, continue the demonstration programs involving treatment for child sexual abuse provided through the Hopi Tribe and the Assiniboine and Sioux Tribes of the Fort Peck Reservation.]

[(b) ESTABLISHMENT OF NEW DEMONSTRATION PROGRAMS]

[Beginning October 1, 1995, the Secretary and the Secretary of the Interior may establish, in any service area, demonstration programs involving treatment for child sexual abuse, except that the Secretaries may not establish a greater number of such programs in one service area than in any other service area until there is an equal number of such programs established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).]

[§ 1680j. Tribal leasing]

[Indian tribes providing health care services pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.]

[§ 1680k. Home- and community-based care demonstration project]

[(a) AUTHORITY OF SECRETARY]

[The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations providing health care services pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], to establish demonstration projects for the delivery of home- and community-based services to functionally disabled Indians.]

[(b) USE OF FUNDS]

[(1) Funds provided for a demonstration project under this section shall be used only for the delivery of home- and community-based services (including transportation services) to functionally disabled Indians.]

[(2) Such funds may not by used—]

[(A) to make cash payments to functionally disabled Indians;]

[(B) to provide room and board for functionally disabled Indians;]

[(C) for the construction or renovation of facilities or the purchase of medical equipment; or]

[(D) for the provision of nursing facility services.]

[(c) CRITERIA FOR APPROVAL OF APPLICATIONS]

[Not later than 180 days after October 29, 1992, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and issue criteria for the approval of applications submitted under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of tribes and tribal organizations to deliver, or arrange for the delivery of, high quality, culturally appropriate home- and community-based services to functionally disabled Indians;]

[(d) ASSISTANCE TO APPLICANTS]

[The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.]

[(e) SERVICES TO INELIGIBLE PERSONS]

[At the discretion of the tribe or tribal organization, services provided under a demonstration project established under this section may be provided (on a cost basis) to persons otherwise ineligible for the health care benefits of the Service.]

[(f) MAXIMUM NUMBER OF DEMONSTRATION PROJECTS]

[The Secretary shall establish not more than 24 demonstration projects under this section. The Secretary may not establish a greater number of demonstration projects under this section in one service area than in any other service area until there is an equal number of such demonstration projects established with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria issued pursuant to subsection (c) of this section.]

[(g) REPORT]

[The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section, together with legislative recommendations.]

[(h) DEFINITIONS]

[For the purposes of this section, the following definitions shall apply:]

[(1) The term "home- and community-based services" means one or more of the following:]

[(A) Homemaker/home health aide services.]

[(B) Chore services.]

[(C) Personal care services.]

[(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.]

[(E) Respite care.]

[(F) Training for family members in managing a functionally disabled individual.]

[(G) Adult day care.]

[(H) Such other home- and community-based services as the Secretary may approve.]

[(2) The term "functionally disabled" means an individual who is determined to require home- and community-based services based on an assessment that uses criteria (including, at the discretion of the tribe or tribal organization, activities of daily living) developed by the tribe or tribal organization.]

[(i) AUTHORIZATION OF APPROPRIATIONS]

[There are authorized to be appropriated for each of the fiscal years 1996 through 2000 such sums as may be necessary to carry out this section. Such sums shall remain available until expended.]

[§ 1680*l*. Shared services demonstration project]

[(a) AUTHORITY OF SECRETARY]

[The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into contracts with Indian tribes or tribal organizations to establish not more than 6 shared services demonstration projects for the delivery of long-term care to Indians. Such projects shall provide for the sharing of staff or other services between a Service facility and a nursing facility owned and operated (directly or by contract) by such Indian tribe or tribal organization.]

[(b) CONTRACT REQUIREMENTS]

[A contract entered into pursuant to subsection (a) of this section—]

[(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;]

[(2) shall provide that expenses (including salaries) relating to services that are shared between the Service facility and the tribal facility be allocated proportionately between the Service and the tribe or tribal organization; and]

[(3) may authorize such tribe or tribal organization to construct, renovate, or expand a nursing facility (including the construction of a facility attached to a Service facility), except that no funds appropriated for the Service shall be obligated or expended for such purpose.]

[(c) ELIGIBILITY]

[To be eligible for a contract under this section, a tribe or tribal organization, shall, as of October 29, 1992—]

[(1) own and operate (directly or by contract) a nursing facility;]

[(2) have entered into an agreement with a consultant to develop a plan for meeting the long-term needs of the tribe or tribal organization; or]

[(3) have adopted a tribal resolution providing for the construction of a nursing facility.]

[(d) NURSING FACILITIES]

[Any nursing facility for which a contract is entered into under this section shall meet the requirements for nursing facilities under section 1396r or Title 42.]

[(e) ASSISTANCE TO APPLICANTS]

[The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.]

[(f) REPORT]

[The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the findings and conclusions derived from the demonstration projects conducted under this section.]

§ 1680m. Results of [d]*D*emonstration [p]*P*rojects

The Secretary shall provide for the dissemination to Indian *T*[t]ribes*, Tribal Organizations, and Urban Indian Organizations* of the findings and results of demonstration projects conducted under this *Act* [chapter].

[§ 1680n. Priority for Indian reservations]

[(a) FACILITIES AND PROJECTS]

[Beginning on October 29, 1992, the Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian tribe with jurisdiction over such lands.]

[(b) "INDIAN LANDS" DEFINED]

[For purposes of this section, the term "Indian lands" means—]

[(1) all lands within the limits of any Indian reservation; and]

[(2) any lands title which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power.]

§ 810. Provision of Services in Montana

(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

[§ 1680*o*. Authorization of appropriations]

[Except as provided in section 1680k of this title, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this subchapter.]

§ 811. Moratorium

During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration of the

Public Health Service, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

[§ 1681. Omitted]

§ 812. Tribal Employment

For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall not be considered an 'employer'.

[§ 1682. Subrogation of claims by Indian Health Service]

[On and after October 18, 1986, the Indian Health Service may seek subrogation of claims including but not limited to auto accident claims, including no-fault claims, personal injury, disease, or disability claims, and worker's compensation claims, the proceeds of which shall be credited to the funds established by sections 401 and 402 of the Indian Health Care Improvement Act.**]**

[§ 1683. Indian Catastrophic Health Emergency Fund]

[$10,000,000 shall remain available until expended, for the establishment of an Indian Catastrophic Health Emergency Fund (hereinafter referred to as the "Fund"). On and after October 18, 1986, the Fund is to cover the Indian Health Service portion of the medical expenses of catastrophic illness falling within the responsibility of the Service and shall be administered by the Secretary of Health and Human Services, acting through the central office of the Indian Health Service. No part of the Fund or its administration shall be subject to contract or grant under the Indian Self-Determination and Education Assistance Act (Public Law 93–638) [25 U.S.C.A. § 450 et seq.]. There shall be deposited into the Fund all amounts recovered under the authority of the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), which shall become available for obligation upon receipt and which shall remain available for obligation until expended. The Fund shall not be used to pay for health services provided to eligible Indians to the extent that alternate Federal, State, local, or private insurance resources for payment: (1) are available and accessible to the beneficiary; or (2) would be available and accessible if the beneficiary were to apply for them; or (3) would be available and accessible to other citizens similarly situated under Federal, State, or local law or regulation or private insurance program notwithstanding Indian Health Service eligibility or residency on or off a Federal Indian reservation.**]**

§ 813. Severability Provisions

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of

such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

§ 814. Establishment of National Bipartisan Commission on Indian Health Care

(a) ESTABLISHMENT.—There is established the National Bipartisan Indian Health Care Commission (the 'Commission').

(b) DUTIES OF COMMISSION.—The duties of the Commission are the following:

(1) To establish a study committee composed of those members of the Commission appointed by the Director and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:

(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

(B) To make legislative recommendations to the Commission regarding the delivery of Federal health services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

(C) To determine the effect of the enactment of such recommendations on (i) the existing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study committee in the course of carrying out its duties under this section.

(2) To review and analyze the recommendations of the report of the study committee.

(3) To make legislative recommendations to Congress regarding the delivery of health care services to Indians. Such recommendation shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

(4) Not later than 18 months following the date of appointment of all members of the Commission, submit a written report to Congress regarding the delivery of Federal health care services to Indians. Such recommendation shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

(c) MEMBERS.—

(1) APPOINTMENT.—The Commission shall be composed of 25 members, appointed as follows:

(A) Ten members of Congress, including 3 from the House of Representatives and 2 from the Senate, appointed by their respective majority leaders, and 3 from the House of Representatives and 2 from the Senate, appointed by their respective minority leaders, and who shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

(B) Twelve persons chosen by the congressional members of the Commission, 1 from each Service Area as currently designated by the Director to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

(D) All those persons chosen by the congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the congressional members of the Commission.

(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2005, and the remaining members of the Commission shall be appointed not later than 60 days following the appointment of the congressional members.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(d) COMPENSATION.—

(1) CONGRESSIONAL MEMBERS.—Each congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence

in accordance with sections 5702 and 5703 of title 5, United States Code.

(2) OTHER MEMBERS.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(e) MEETINGS.—The Commission shall meet at the call of the Chair.

(f) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—

(1) APPOINTMENT; PAY.—The Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF APPOINTMENT.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

(3) STAFF PAY.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) TEMPORARY SERVICES.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) FACILITIES.—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(h) HEARINGS.—

(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study com-

mittee established in this section may count toward the number of regional hearings required by this subsection.

(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this section, which sum shall not be deducted from or affect any other appropriations for health care for Indian persons.

(j) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

§ 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.

§ 816. Authorization of Appropriations

(a) IN GENERAL.—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.

(b) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking "Assistant Secretaries of Health and Human Services (6)." and inserting "Assistant Secretaries of Health and Human Services (7)".

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking "Director, Indian Health Service, Department of Health and Human Services".

(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(1) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking "Director of the Indian Health Service" and inserting *"Assistant Secretary for Indian Health"*.

(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(A) in section 3 (25 U.S.C. 3902)—

(i) by striking paragraph (2);

(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(iii) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.";

(B) in section 5 (25 U.S.C. 3904), by striking the section heading and inserting the following:

"SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.";

(C) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking "Director" and inserting "*Assistant Secretary*";

(D) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking "Director" and inserting "*Assistant Secretary*"; and

(E) by striking "Director" each place it appears and inserting "*Assistant Secretary*".

(3) Section 5504(d)(2) of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking "Director of the Indian Health Service" and inserting "*Assistant Secretary for Indian Health*".

(4) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking "Director of the Indian Health Service" and inserting "*Assistant Secretary for Indian Health*".

(5) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by

striking "Director of the Indian Health Service" each place it appears and inserting "*Assistant Secretary for Indian Health*".

(6) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(A) by striking "Director of the Indian Health Service" each place it appears and inserting "*Assistant Secretary for Indian Health*"; and

(B) in paragraph (2)(A), by striking "the Directors referred to in such paragraph" and inserting *"the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health"*.

(7) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking "Director of the Indian Health Service" and inserting *"Assistant Secretary for Indian Health"*.

(8) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking "Director of the Indian Health Service" each place it appears and inserting "*Assistant Secretary for Indian Health*".

(9) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking "Director of the Indian Health Service" and inserting "*Assistant Secretary for Indian Health*".

(10) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking "Director of the Indian Health Service" and inserting "*Assistant Secretary for Indian Health*".

SEC. 3. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following new section:

"SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).".

SEC. 4. AMENDMENTS TO THE MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS.

(a) EXPANSION OF MEDICAID PAYMENT FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.—

(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

"SEC. 1911. INDIAN HEALTH PROGRAMS."; and

(B) by amending subsection (a) to read as follows:

"*(a) ELIGIBILITY FOR REIMBURSEMENT FOR MEDICAL ASSISTANCE.—The Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization (as such 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 or under waiver authority with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization if the furnishing of such services meets all the conditions and requirements which are*

applicable generally to the furnishing of items and services under this title and under such plan or waiver authority.".

(2) ELIMINATION OF TEMPORARY DEEMING PROVISION.—Such section is amended by striking subsection (b).

(3) REVISION OF AUTHORITY TO ENTER INTO AGREEMENTS.—Subsection (c) of such section is redesignated as subsection (b) and is amended to read as follows:

"(b) *AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided by the Indian Health Service, an Indian Tribe, Tribal Organizations, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan or under waiver authority.".*

(4) REFERENCE CORRECTION.—Subsection (d) of such section is redesignated as subsection (c) and is amended—

(A) by striking "For" and inserting *"DIRECT BILLING.—For"*; and

(B) by striking "section 405" and inserting *"section 401(d)".*

(b) SPECIAL RULES FOR INDIANS, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

(1) IN GENERAL.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

"(h) SPECIAL RULES FOR INDIANS, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—A State shall comply with the provisions of section 413 of the Indian Health Care Improvement Act (relating to the treatment of Indians, Indian health care providers, and Indian managed care entities under a medicaid managed care program).".

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(1)) is amended by adding at the end the following:

"(E) Subsections (a)(2)(C) and (h) of section 1932.".

(c) SCHIP TREATMENT OF INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended—

(1) in paragraph (2), by adding at the end the following:

"(C) INDIAN HEALTH PROGRAM PAYMENTS.—For provisions relating to authorizing use of allotments under this title for payments to Indian Health Programs and Urban Indian Organizations, see section 410 of the Indian Health Care Improvement Act."; and

(2) in paragraph (6)(B), by inserting *"or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)"* after "Service".

SEC. 5. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) IN GENERAL.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

"TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

"SEC. 801. DEFINITIONS.

"In this title:

"(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

"(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802(f).

"(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

"(4) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

"(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

"SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with this title, the Native American Health and Wellness Foundation.

"(2) FUNDING DETERMINATIONS.—No funds, gift, property, or other item of value (including any interest accrued on such an item) acquired by the Foundation shall—

"(A) be taken into consideration for purposes of determining Federal appropriations relating to the provision of health care and services to Indians; or

"(B) otherwise limit, diminish, or affect the Federal responsibility for the provision of health care and services to Indians.

"(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

"(c) NATURE OF CORPORATION.—The Foundation—

"(1) shall be a charitable and nonprofit federally chartered corporation; and

"(2) shall not be an agency or instrumentality of the United States.

"(d) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

"(e) DUTIES.—The Foundation shall—

"(1) encourage, accept, and administer private gifts of real and personal property, and any income from or interest in such gifts, for the benefit of, or in support of, the mission of the Service;

"(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and

"(3) participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

"(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—

"(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

"(2) DUTIES.—Not later than 180 days after the date of enactment of this section, the Committee shall—

"(A) carry out such activities as are necessary to incorporate the Foundation under the laws of the District of Columbia, including acting as incorporators of the Foundation;

"(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

"(C) establish the constitution and initial bylaws of the Foundation;

"(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

"(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

"(g) BOARD OF DIRECTORS.—

"(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

"(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

"(3) SELECTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the terms of office of the members shall be as provided in the constitution and bylaws of the Foundation.

"(B) REQUIREMENTS.—

"(i) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

"(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board—

"(I) shall be appointed by the Committee not later than 180 days after the date on which the Foundation is established; and

"(II) shall have staggered terms.

"(iii) QUALIFICATION.—The members of the Board shall be United States citizens who are knowledgeable or experienced in Native American health care and related matters.

"(C) COMPENSATION.—A member of the Board shall not receive compensation for service as a member, but shall be reimbursed for actual and necessary travel and subsistence expenses incurred in the performance of the duties of the Foundation.

"(h) OFFICERS.—

"(1) IN GENERAL.—The officers of the Foundation shall be—

"(A) a secretary, elected from among the members of the Board; and

"(B) any other officers provided for in the constitution and bylaws of the Foundation.

"(2) SECRETARY.—The secretary of the Foundation shall serve, at the direction of the Board, as the chief operating officer of the Foundation.

"(3) ELECTION.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

"(i) POWERS.—The Foundation—

"(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

"(2) may adopt and alter a corporate seal;

"(3) may enter into contracts;

"(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or convenient to carry out the purposes of the Foundation;

"(5) may sue and be sued; and

"(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

"(j) PRINCIPAL OFFICE.—

"(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

"(2) ACTIVITIES; OFFICES.—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

"(k) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

"(l) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

"(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

"(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of the duties of the member.

"(m) RESTRICTIONS.—

"(1) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed 10 percent of the sum of—

"(A) the amounts transferred to the Foundation under subsection (o) during the preceding fiscal year; and

"(B) donations received from private sources during the preceding fiscal year.

"(2) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

"(3) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with

the Foundation be considered to be an officer, employee, or agent of the United States.

"(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

"(o) FUNDING.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (e)(1) $500,000 for each fiscal year, as adjusted to reflect changes in the Consumer Price Index for all-urban consumers published by the Department of Labor.

"(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

"SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

"(a) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

"(1) may provide personnel, facilities, and other administrative support services to the Foundation;

"(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board; and

"(3) shall require and accept reimbursements from the Foundation for—

"(A) services provided under paragraph (1); and

"(B) funds provided under paragraph (2).

"(b) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3)—

"(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

"(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

"(c) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the facilities and services—

"(1) are available; and

"(2) are provided on reimbursable cost basis.".

(b) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended—

(1) by redesignating title V (25 U.S.C. 458bbb et seq.) as title VII;

(2) by redesignating sections 501, 502, and 503 (25 U.S.C. 458bbb, 458bbb–1, 458bbb–2) as sections 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking "section 501" and inserting "section 701".

○